Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 16 June 2026 – Monday 22 June 2026

Virtual Meeting

Name of Registrant:	Lucyna Abramowicz
NMC PIN:	09A0007C
Part(s) of the register:	Nurses part of the register Sub part 1 Adult nurse, Level 1 (05 January 2009)
Relevant Location:	Ipswich
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, Lay member) Alison Hayle (Lay member) Claire Cawley (Registrant member)
Legal Assessor:	Alice Robertson Rickard
Hearings Coordinator:	Emma Hotston (16-22 June 2026) Stanley Udealor (17 June 2026)
Facts proved:	Charges 1a), 1b), 1d), 3
Facts not proved:	Charges 1c), 2, 4
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (12 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Abramowicz's registered email address by secure email on 31 March 2026.

The panel accepted the advice of the legal assessor.

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

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

Details of charge

That you, a registered nurse:

1) On 7th July 2022:
    a) Failed to administer medications to Resident A.
    b) Inappropriately delegated the administration of medication for Resident A to a colleague A, when they were not qualified to administer the medication on their own.
    c) Failed to supervise and witness the administration of medication to Resident A by Colleague A.
    d) Inaccurately signed the MAR chart to state that you had administered the medication when you had not.

2) Your actions at 1d) was dishonest as you knew you had not administered the medication and sought to provide a misleading impression that you had.

3) On 14th July 2022, incorrectly recorded and/or presigned the MAR Chart Signature Check Chart that you had completed the checks at the end of your shift at 1900 hours when you had finished your shift at 1200 hours.

4) Your actions at charge 3) was dishonest as you did not complete your checks at 1900 hours and you presigned the Mar Chart Signature Check Chart before carrying out the checks.

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

Background

The charges arose whilst Mrs Abramowicz was employed as a registered nurse at The Orwell Care Home ('the Home') by the Priory Group ('the Priory').

The concerns relate to alleged incidents that took place in July 2022. This referral resulted in an investigation by the NMC, which identified the regulatory concerns set out below.

The regulatory concerns are:

1. Poor medications practice in that you –
    (a) Failed to administer medications to Resident A.
    (b) Inappropriately delegated administering medications to Resident A to a senior carer.
    (c) Failed to witness medications being administered to Resident A.

2. Poor record keeping in that you –
    (a) Inaccurately recorded that you had administered medications to Resident A when you had not.
    (b) Inaccurately recorded and pre signed the MAR Chart Signature Check Chart that you finished your shift at 1900 hours when you had not.

Decision and reasons on facts

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

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

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

- Ms Vicky Osbourne: Home Manager at The Orwell Care Home ('the Home'), at the time of the local investigation.
- Mr Neil Johnstone: Interim Home Manager at The Orwell Care Home ('the Home'), at the material time.
- Ms Kay Fritchley: Home Manager in The Priory Group ('the Priory'), at the material time.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a)

"On 7th July 2022:

a) Failed to administer medications to Resident A."

This charge is found proved.

The panel first considered whether Mrs Abramowicz had a duty to administer the medication to Resident A and noted that she was the only registered nurse in her unit of the Home. It noted the Home's medication policy which states:

> *'In Adult Care settings with permanent nursing services, medicines will be managed and administered in a safe and professional manner, by appropriately trained colleagues, ensuring that records are maintained.'*
>
> *'All medication should be administered by a suitably qualified colleague. All medication must be administered using the procedures detailed in this policy and all related policies.'*
>
> *'The following procedure must be adhered to and conducted in the order stated.*
> *(a) The nurse administering medications ……..'*

The panel determined that the policy was that medication should be administered by a suitably qualified registered nurse, and consequently, Mrs Abramowicz did have a duty to administer the medication.

The panel next considered the witness statement of Mr Neil Johnstone. It noted that Mr Johnstone stated that whilst carrying out routine checks, he entered Resident A's room and found medication left on the bedside table. He checked the MAR chart and observed that the medication had already been signed for by Mrs Abramowicz. He stated:

> *'I was working on the day of the incident. I went in to do some daily checks. I had gone into a resident's room, and noticed medication left on the bedside. I checked the MARR chart, and it had already been*

signed for by Lucyna. I asked one of the carers what was going on, and they said Lucyna had left with them. It was in a medication pot…'

The panel carefully considered the reliability of Mr Johnstone's evidence. It noted that his account contained multiple hearsay. It further noted that he was not sure of the timing of the incident. However, he was clear that the resident's medication had been left on the bedside and had not been administered, and he had directly observed this.

The panel accepted Mr Johnstone's evidence that medication intended for Resident A had been left unadministered in Resident A's room.

The panel next took account of the witness statement of Ms Kay Fritchley, who carried out the internal investigation meeting and who stated that:

'Lucyna openly admitted to everything that I asked her about. Everything on the findings is all the information that I have. Lucyna did have representation. She admitted everything I put forward to her and did get quite upset. We gave her some time with her representative because she was really upset.

….

'*Lucyna was accused of potting medication. She was dispensing medication and rather than going and checking the resident before she potted it, she potted all the medication and then took it to the patient. When she noticed that the patient wasn't awake, instead of following correct medication policy, she handed it on to an unqualified member of staff to administer. Sometimes, as a nurse, you do have to use a different approach when giving medication. We are working in care homes with dementia patients, and sometimes patients do just take a disliking to someone's face. Sometimes it can help to give it to someone else to administer if you stand beside them and watch. Lucyna didn't do this. She gave the medication to someone who had zero medication training and walked away.'* [sic]

The panel next considered the local disciplinary meeting notes. It noted that in this meeting Mrs Abramowicz admitted to not administering any oral medication to Resident A and stated that she had only administered insulin to Resident A. The local disciplinary meeting notes include the following exchange:

> *'KF: Was all the medication that had been signed for administered to the resident?*
>
> *LA: No, no oral medication was administered only the insulin. I didn't check that this had been given.'*

The panel attached significant weight to this admission. It considered that Mrs Abramowicz's acceptance that the oral medication was not administered was clear, unequivocal and consistent with the evidence of both Mr Johnstone and Ms Fritchley.

In light of this, the panel was satisfied that Mrs Abramowicz had a duty to administer Resident A's prescribed oral medication and had not done so. The panel found that the witness evidence, supported by Mrs Abramowicz's own admission, established the charge on the balance of probabilities. The panel therefore found charge 1(a) proved.

Charge 1b)

> "On 7th July 2022:
>
> b) Inappropriately delegated the administration of medication for Resident A to a colleague A, when they were not qualified to administer the medication on their own."

This charge is found proved.

The panel considered the documentary evidence, including the Medication Policy. It noted that section 7.1 of the Policy states:

'All medication should be administered by a suitably qualified colleague. All medication must be administered using the procedures detailed in this policy and all related policies.'

The panel next considered the notes of the local disciplinary meeting. It noted that Mrs Abramowicz made a clear admission that she had given the medication to a carer to administer, who was not qualified in administering medication. The panel noted the following exchange included within the local disciplinary meeting:

'KF: the first allegation is that the medication policy was not followed as medication was given to a carer and administration of the medication to the resident was not witnessed by yourself, is that correct?

LA: Yes, I gave the medication to the carer to give to the resident.

KF: Had you attempted to give the medication to the resident and had they refused the medication?

LA: No, they did not refuse the medication. I had taken the blood sugar reading and administered insulin, but the resident was very sleepy and it was not safe to give her the tablets as she may have had difficulty swallowing them due to being in bed and being sleepy and she was a new resident, was always asking to go home and it was not safe. There was also another resident who kept going into the bedroom and I was worried that the other resident might have tripped on the mats that were on the floor so was also trying to deal with her and ensure she was safe. I didn't know what to do with the medication so I left this with the carer.

KF: You could have gone back to the resident and administered medication at a later time?

LA: I couldn't wake her up properly and the carer had gotten her breakfast ready to give so I gave the medication to the carer as they would have woken the resident up for breakfast. I wouldn't do it again.'

The panel also noted the following exchange in the disciplinary meeting notes:

'KF: Do you know it is in the policy to not allow untrained members of staff to give medication to a resident?

LA: Yes.'

The panel attached significant weight to these admissions. It considered that they amounted to a clear acceptance by Mrs Abramowicz that she had left medication with a carer who was not trained to administer it independently.

The panel had regard to section 10.3(d) of the Medication Policy which states:

'*Should the resident be unable/unwilling to take their medication at the time (e.g. asleep; eating etc.), then colleagues may return to that individual later in the medication round. Colleagues should be aware that medication may be administered up to one hour later than the time specified on the MAR/ Prescription Sheet. However, should non-administration go beyond that time period, then that non-administration should be recorded on the MAR using the appropriate coding.'*

The panel was satisfied that by delegating the administration of medication to Colleague A and not witnessing them administer the medication, Mrs Abramowicz' actions did not follow the medication policy. The panel noted that the medication policy also outlined a clear alternative course of action, where rather than leaving the medication with an unqualified carer, Mrs Abramowicz should have returned to administer the medication to Resident A later, or recorded the medication as not administered in accordance with the policy.

The panel next considered the witness evidence. It noted that Mr Johnstone recalled finding medication left in Resident A's room and being informed by a carer that Mrs Abramowicz had left the medication with them. He stated:

> *'I asked one of the carers what was going on, and they said Lucyna had left with them* [sic]*. It was in a medication pot. I don't remember which medication it was… I did not directly witness Lucyna delegating this task to the carer…*
>
> *Normal protocol for a nurse at The Orwell should be to do the medication round using the trolleys. All medications are to be dispensed from the trolley by the nurse and given to the residents. The nurse would ensure they are taken, and then sign off the medication on the sheet, often this would be witnessed by a Carer. Any controlled medication would need to be witnessed and counter signed at the time of administration… I do not recall the name of the senior carer.'*

The panel noted that Mr Johnstone did not directly witness the delegation of the medication and therefore attached limited weight to that aspect of his evidence. However, it accepted his evidence regarding the normal medication administration procedures within the Home, namely that medication should be administered by a nurse, who would ensure that it had been taken by the resident before signing the MAR chart.

The panel next considered the evidence of Ms Vicky Osbourne. In her witness statement, she states:

> *'My memory is that Lucy had gone into administer some medication to a resident. Colleague A, senior carer, was there assisting with feeding a resident a meal. Lucy had asked him to give the medication when he had finished, and she then left the room. Colleague A forgot about the medication and left the room too. Neil Johnstone then went in and found the medication on the table.'*

'Normally, we would advise that Lucy could have given the medication to Colleague A as long as she stayed to see it being administered. She also could have kept the medication with her and gone back later.'

The panel also considered the evidence of Ms Fritchley. In her witness statement, she states:

'Lucyna was accused of potting medication. She was dispensing medication and rather than going and checking the resident before she potted it, she potted all the medication and then took it to the patient. When she noticed that the patient wasn't awake, instead of following correct medication policy, she handed it on to an unqualified member of staff to administer… Sometimes it can help to give it to someone else to administer if you stand beside them and watch. Lucyna didn't do this. She gave the medication to someone who had zero medication training and walked away.'

The panel found Ms Osbourne's and Ms Fritchley's evidence to be consistent with the documentary evidence.

Having considered all of the evidence, the panel was satisfied that Mrs Abramowicz delegated responsibility for administering Resident A's medication to Colleague A and left the medication in their care. The panel was further satisfied that Colleague A was not qualified to administer medication independently and that Mrs Abramowicz did not remain to supervise or witness any administration.

The panel found that this conduct was contrary to the Priory's medication policy and amounted to an inappropriate delegation of responsibility for medication administration. The panel therefore found charge 1(b) proved.

Charge 1c)

"On 7th July 2022:

c) Failed to supervise and witness the administration of medication to Resident A by Colleague A."

This charge is found NOT proved.

The panel noted from the evidence already referred to above, that Colleague A did not administer the medication in question to Resident A. In light of the fact that the medication was not administered by Colleague A, the panel found that there was nothing for Mrs Abramowicz to supervise and witness. In these circumstances, it could not find this charge proved. The panel noted, however, that the mischief of this charge is reflected by its findings in relation to charges 1a) and 1b).

Charge 1d)

"On 7th July 2022:

c) Inaccurately signed the MAR chart to state that you had administered the medication when you had not."

This charge is found proved.

The panel first considered the documentary evidence. It noted that the MAR chart had been initialled to indicate oral medication had been administered to Resident A on 7 July 2022. The panel noted that Mrs Abramowicz did not dispute that these were her initials and her work colleagues believed they were.

The panel noted the following exchange within the disciplinary meeting notes:

'KF: Was all the medication that had been signed for administered to the resident?

LA: No, no oral medication was administered, only the insulin. I didn't check that this had been given.'

The panel was of the view that Mrs Abramowicz had clearly admitted that the oral medication recorded on the MAR chart had not, in fact, been administered to Resident A, despite having been signed for.

The panel next considered the witness evidence of Mr Johnstone, who stated:

> *'I was working on the day of the incident. I went in to do some daily checks. I had gone into a resident's room, and noticed medication left on the bedside. I checked the MARR chart, and it had already been signed for by Lucyna. I asked one of the carers what was going on, and they said Lucyna had left with them. It was in a medication pot. I don't remember which medication it was. I don't remember exactly, but I think the medication was due around 8pm, and Lucyna had pre-signed the MARR chart at around 6pm.'*

The panel noted that Mr Johnstone was unable to recall the timing of the events and did not directly witness Mrs Abramowicz signing the MAR chart, however, he did directly observe both the signed MAR chart and the medication left on the bedside.

The panel next considered the Priory's medication policy. It noted that section 10.5(o) states:

> *'Once the medication has been taken, the MAR sheet should then be signed using both initials in the appropriate place, by the person administering the medication.'*

The panel also noted section 10.5(p) of the medication policy, which states:

> *'Only those items that have been given and witnessed are to be signed for. Where there is a choice of dosage e.g. 1 or 2 tablets, the number of tablets that have been actually taken should be recorded…MAR sheets should never be signed for in advance or retrospectively of a drug round.'*

The panel was of the view that the medication policy clearly states that MAR charts should never be signed for in advance and only medication that has been given and witnessed should be signed for. It therefore determined that Mrs Abramowicz's actions did not follow this policy.

In considering all of the evidence, the panel was satisfied that the oral medication had not been administered to Resident A. The panel was further satisfied, on the basis of both the witness evidence and Mrs Abramowicz's own admission, that the medication was recorded by Mrs Abramowicz as administered when it had not been given and that the MAR chart inaccurately indicated that the medication had been administered.

In light of all of the evidence, the panel concluded that Mrs Abramowicz inaccurately signed the MAR chart to state that she had administered the medication, when in fact, she had not. It therefore found charge 1(d) proved.

Charge 2)

> "Your actions at 1d) was dishonest as you knew you had not administered the medication and sought to provide a misleading impression that you had."

This charge is found NOT proved.

The panel considered that by pre-signing the MAR chart, Mrs Abramowicz did create a document which gave the misleading impression that the medication had been administered and had the missed tablets not been found, this impression would have continued. It acknowledged that to pre-sign the chart went against policy and was an unwise and potentially unsafe action. When she made the assessment that it was not safe to administer oral medication at that time, since the patient was drowsy, she had already created a document which indicated to anyone reading it that the medication had been administered. Her errors were further compounded, when she was diverted from the medication round to care for another resident and left the tablets with a carer to administer. The mischief of this conduct has been captured in charge 1.

However, in order to determine if there was dishonesty involved, the panel needed to assess Mrs Abramowicz's state of mind when she signed the chart.

The panel determined that when she actually signed the chart, Mrs Abramowicz had every intention of administering the medication to Resident A.

The panel noted Mrs Abramowicz's account as set out in the local disciplinary hearing:

> *LA: ... I had taken the blood sugar reading and administered insulin, but the resident was very sleepy and it was not safe to give her the tablets as she may have had difficulty swallowing them due to being in bed and being sleepy and she was a new resident, was always asking to go home and it was not safe. There was also another resident who kept going into the bedroom and I was worried that the other resident might have tripped on the mats that were on the floor so was also trying to deal with her and ensure she was safe. I didn't know what to do with the medication so I left this with the carer.*

The panel accepted this account and determined that at the time she signed the MAR chart Mrs Abramowicz believed that she would be administering the medication within minutes and did not seek to create a misleading impression. In light of its findings in relation to Mrs Abramowicz's state of mind, the panel did not find that her actions would be seen as dishonest by the standards of ordinary decent people. Accordingly, the panel found this charge not proved.

Charge 3)

> "On 14th July 2022, incorrectly recorded and/or presigned the MAR Chart Signature Check Chart that you had completed the checks at the end of your shift at 1900 hours when you had finished your shift at 1200 hours."

This charge is found proved.

The panel first considered the MAR chart signature check chart and noted that the document recorded a signature at 1900 hrs. It next noted that the management report recorded that Mrs Abramowicz was sent home during her shift on 14 July 2022. The report recorded that she was: '*Sent home due to distress*.'

The panel was therefore satisfied from this evidence that Mrs Abramowicz did not complete her scheduled shift on that date.

The panel next considered the notes of the local disciplinary meeting. The panel noted the following exchange:

> *'KF: In relation to paperwork my understanding is you left the shift early but the paperwork was completed for the end of shift. Is that correct?*
>
> *LA: I normally work 07:00 – 19:00 but due to the stressful situation I was asked to go home, I have sheet to check and I went through before I left and signed any gaps that I saw. I was stressed and signed for the nurse check at 19:00 when it was 12:00.'*

The panel next considered the witness evidence of Ms Osbourne, where she stated that Mrs Abramowicz had been sent home early because she was upset and distressed. In her witness statement, Ms Osbourne states:

> *'The incident on the 14th of July occurred on the day I returned to work. We were gathering evidence on this day regarding the previous incident. We had called Lucy into a meeting inside of the office. I don't remember now what this meeting was regarding, but it wasn't the medication incident. Lucy was very upset on this day so it might have been to do with that. We asked her to go home, to take the day off and calm down to try and make her feel better.'*

The panel accepted Ms Osbourne's evidence which was consistent with Mrs Abramowicz's account.

The panel noted that the MAR Chart Signature Check Chart recorded a signature at 1900 hours, despite the evidence demonstrating that Mrs Abramowicz had left work at approximately 1200 hours. The panel also noted that the entry had subsequently been crossed through and counter-signed on 14 July 2022. The panel placed significant weight on this documentary evidence which showed that the MAR Chart Signature Check Chart had been incorrectly completed.

In light of all of the evidence, the panel was satisfied that Mrs Abramowicz did not remain on duty until 1900 hours and therefore could not have completed the MAR Chart Signature Check Chart at that time. The panel was also satisfied, based on Mrs Abramowicz's own admission and the documentary evidence, that the MAR Chart Signature Check Chart inaccurately recorded that the 1900-hour check had been completed. The panel therefore found charge 3 proved.

Charge 4)

> "Your actions at charge 3) was dishonest as you did not complete your checks at 1900 hours and you presigned the MAR Chart Signature Check Chart before carrying out the checks."

This charge is found NOT proved.

The panel first reminded itself of its finding in relation to charge 3 and considered whether Mrs Abramowicz's actions were dishonest.

The panel noted that in Ms Osbourne's witness statement, she stated:

'Later that day, we noticed that the end of shift chart had no missed signatures. This is where staff sign at the end of their shift to say that they have gone through their MAR charts and they are signing to say there are no missed signatures.'

The panel noted that in Mrs Abramowicz stated in the local disciplinary meeting notes:

LA:… I have sheet to check and I went through before I left and signed any gaps that I saw. I was stressed and signed for the nurse check at 19:00 when it was 12:00.'

The panel found that the evidence of Ms Osbourne supports Mrs Abramowicz's statement that she did the checks before signing.

The panel considered the local disciplinary meeting notes and noted Mrs Abramowicz response to the allegation:

'I normally work 07:00 – 19:00 but due to the stressful situation I was asked to go home, I have sheet to check and I went through before I left and signed any gaps that I saw. I was stressed and signed for the nurse check at 19:00 when it was 12:00.'

The panel was of the view that Mrs Abramowicz had clearly accepted responsibility for the inaccurate entry. The panel noted that she did not seek to deny making the entry and provided an explanation that she had completed it whilst distressed and before leaving her shift early at 12:00 hours, unexpectedly.

The panel next considered the witness evidence of Ms Osbourne, where she stated:

'We noticed that Lucy had signed 7:00 until 19:00, but she had left in the afternoon and gone home early. When I spoke to Lucy, again I think it was in an interview, she said that it was done in error. Lucy said it was a genuine error and when she left work, she was so used to writing 7-7 that she made a mistake. We have no evidence that Lucy had pre-signed this at the beginning of her shift. I do think that her reasoning made sense. She was very upset and highly flustered when she left. You do kind of go into autopilot in these situations. I was not convinced that Lucy had presigned the sheet. The signature check sheet exhibited is the relevant document.'

The panel found Ms Osbourne's evidence to be credible and accepted her evidence that such paperwork could be completed '*on autopilot.*' It noted that she accepted Mrs Abramowicz's explanation. The panel further noted the contextual circumstances surrounding Mrs Abramowicz's completion of the MAR Chart Signature Check Chart in that she was very upset and distressed at the time of the incident.

The panel was not satisfied that the evidence demonstrated that Mrs Abramowicz's actions were dishonest or that there was an intention by her to mislead others.

The panel determined that Mrs Abramowicz made the entry in genuine error whilst distressed and flustered. It was satisfied that in light of its findings about her state of mind, her actions would not be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Abramowicz's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Representations on misconduct

The NMC invited the panel to take the view that the facts found proved amount to misconduct.

The NMC made the following representations on misconduct:

The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct: '[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.'

As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively

'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired.'

And

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

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

The NMC identified the specific, relevant standards where it submitted that Mrs Abramowicz's actions amounted to misconduct: 8.5, 10.3, 11.1, 11.2, 19.1, 20.1, 20.2, 20.8, 25.1.

The NMC made the following further representations on misconduct:

We consider the misconduct serious because, failing to administer medication to Resident A, delegating the administration of the medication to a staff member who was not qualified nor experienced to do so, and failing to complete checks, placed residents at a real risk of significant harm. Furthermore, falsifying MAR charts to make it appear that residents had been given medication when they had not placed residents at a further risk of serious harm. Mrs Abramowicz was working as the Nurse in Charge at the Home when the incidents occurred and had a responsibility to ensure the safety of the residents, as well as colleagues.

The Home had a Management of Medication Policy which states as follows:
In Adult Care residential settings with permanent nursing services, medication will be managed and administered according to the following principles:
(a) The safety of the resident is at the forefront of all decision making
(b) The resident or representative will be involved with the decision-making process
(c) Best practices in relation to medication will be maintained
(d) Reduce the risks to colleagues involved with medication
(e) If there are any doubts in relation to medication instructions to seek advice or refer to an appropriate health professional
(f) Proper documentation is used and maintained

Mrs Abramowicz had a duty to uphold these principles, not only for the safety of the residents in her care but also as stated to Colleague A, who was placed in a position of practising outside the scope of their competence.'

Representations on impairment

The NMC made the following representations on impairment:

'The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will

help decide whether a professional's fitness to practise is impaired is:
"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

1. has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or
2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or
3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or
4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.

It is the submission of the NMC that points 1 to 4 can be answered in the affirmative in this case.

Impairment is a forward thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be

repeated.

We consider, however, that Mrs Abramowicz has displayed some insight. During a disciplinary meeting with the Home on 4 October 2022, she admitted to giving the medication to Colleague A to administer to Resident A. She said that she had been tending to another resident at the time who was at risk of falling, but that she recognized the risk that it posed to the resident. She acknowledged that Colleague A did not know the medication and that if Resident A had a reaction to the medication Colleague A would not have known what to do. Mrs Abramowicz admitted that in future if dealing with a stressful situation she would stop medication and take a minute before carrying on.

Mrs Abramowicz also admitted to the record keeping errors and failure to complete the appropriate checks, she reflected on what she would do differently in future. Mrs Abramowicz admitted that she had signed for the nurse check at 19:00 when it was 12:00. She had been asked to go home early that day, she said that she had been feeling stressed and that when completing the paperwork she signed any gaps that she saw.

In a telephone note to an NMC case officer dated 21 March 2023, she admitted the errors she had made. On 9 March 2023, Mrs Abramowicz also called to inform us that she was going to look for alternative employment and that she no longer wanted to be a nurse or carer due to the stress it has caused her.

Mrs Abramowicz has not undertaken relevant training in respect of the issues of concern, nor has she provided any reflective statements following on from the telephone calls to the NMC case officer in March 2023. She has since disengaged from the fitness to practice process.

We consider that there is a continuing risk to the public due to Mrs Abramowicz's lack of full insight and failure to undertake the relevant training to remediate the concerns and demonstrate strengthened practice.

In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery

Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

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

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

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

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

We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Mrs Abramowicz's conduct fell short of what would be expected of a registered nurse, and the public interest is engaged because falsification of records and not following correct medication administration procedures placed the residents at a real risk of potential harm. Nurses have a duty to uphold the standards of the profession, to act with honesty and integrity as well as to provide safe and effect

care when administering medication, to ensure public protection and preserve patient safety.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *These included: Roylance v General Medical Council (No 2) [2000] 1 A.C. 311, Nandi v General Medical Council [2004] EWHC 2317 (Admin), Cheatle v GMC [2009] EWHC 645*: *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council, Paula Grant [2011] EWHC 927 (Admin) and Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*
The panel also had regards to the terms of the Code.

The panel was of the view that Mrs Abramowicz's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Abramowicz's actions amounted to a breach of the Code. Specifically, the following sections of the Code:

> ***Practise effectively***
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
>
> ***10.1*** *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> ***10.3*** *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*

11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard*

Preserve safety

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

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

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

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

However, the panel found that the breaches of the code in this case were serious as Mrs Abramowicz's actions failed to preserve the safety of those in her care and put residents at risk of harm.

The panel found that in relation to charge 1a), whereby Mrs Abramowicz failed to administer medications to Resident A, this put Resident A at risk of physical harm as a result of not receiving the medications that they required.

The panel further noted that Mrs Abramowicz potted the medication and it was left on Resident A's side-table unattended, which compromised the safety of residents in the Home. The panel found that Mrs Abramowicz's actions could have caused physical harm to other residents within the Home, if this medication was taken mistakenly by a resident for whom it was not intended.

Furthermore, the panel found that in relation to charge 1b), by inappropriately delegating the administration of medication for Resident A to colleague A, Mrs Abramowicz's conduct placed colleague A in a compromising position by asking them to act outside of their scope of competence.

In relation to charge 1d), the panel considered that by pre-signing the MAR chart, Mrs Abramowicz did create a document which gave the misleading impression that the medication had been administered and had the missed tablets not been found, this impression would have continued. This placed Resident A at risk of harm.

The panel therefore found that in relation to charges 1a, b and d, Mrs Abramowicz's actions were sufficiently serious to amount to misconduct.

In relation to charge 3 the panel found that Mrs Abramowicz's actions did not amount to misconduct. It was mindful of its findings that Mrs Abramowicz had made a genuine error in her record keeping whilst distressed and flustered. It did not consider that this was sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

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

The panel first considered whether any of the limbs of the *Grant* test were engaged as a result of Mrs Abramowicz's past conduct. The panel was of the view that Mrs Abramowicz's misconduct in failing to administer medications to Resident A, inappropriately delegating the administration of medications for Resident A to Colleague C, and inaccurately completing documentation to indicate that medication had been given when it had not, placed Resident A at unwarranted risk of harm.

The panel also found that Mrs Abramowicz's misconduct constituted a breach of fundamental tenets of the nursing profession in that she failed to practise effectively and preserve safety. It determined that she failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that limbs a, b and c of the Grant test are engaged in respect of Mrs Abramowicz's past conduct. The panel noted that as dishonesty was not found, limb d of the *Grant* test was not engaged.

The panel next went on to consider whether Mrs Abramowicz's misconduct was capable of being addressed. The panel considered that Mrs Abramowicz's conduct does not appear to indicate deep-seated attitudinal concerns in light of the context in which it occurred. It

noted from the witness and documentary evidence that the Home had a fragmented management system and appeared to be under-staffed, and as a result of this and [PRIVATE], Mrs Abramowicz felt under stress. The panel was of the view that Mrs Abramowicz's misconduct could be addressed.

The panel then went on to consider whether the concerns have been addressed and remediated.

The panel determined with regard to insight, Mrs Abramowicz has not engaged with proceedings and has not provided the panel with any insight or given evidence of remediation. Whilst it acknowledged that she showed some limited insight into her actions in the internal investigation, it had limited evidence before it to show that Mrs Abramowicz has reflected, developed her insight into misconduct, or acknowledged how her actions could negatively impact on residents, her colleagues, the nursing profession and the wider public. Although she stated during the local disciplinary hearing that she would not act in a similar way again, the panel had no evidence before it to support this assertion. Accordingly, the panel determined that Mrs Abramowicz has not developed sufficient insight at this stage and the panel had nothing before it to demonstrate evidence of strengthened practice.

Furthermore, the panel noted that in Mrs Abramowicz's last contact with the NMC she stated that she had resigned from her role and does not wish to continue nursing.

In light of this, the panel was not satisfied that Mrs Abramowicz's misconduct has been remediated. Accordingly, the panel determined that there remains a risk of repetition.

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

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

The panel had regard to the serious nature of Mrs Abramowicz's misconduct and the public protection issues it had identified. It determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

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

Representations on sanction

The panel noted in the substantive meeting bundle that the NMC advised Mrs Abramowicz that it would consider the imposition of a striking-off order appropriate if it found her fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Abramowicz's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of engagement with the Fitness to Practise (FtP) process.
- Limited insight.

The panel also took into account the following mitigating features:

- Admissions at local level and to the NMC in the early stages of the investigation.

- Possible work [PRIVATE] factors in a busy environment and lack of support at the Home.

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

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that Mrs Abramowicz's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Abramowicz's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Abramowicz's registration would be appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and considered that the following factors applied:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*

- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case.

The panel accepted that Mrs Abramowicz is not currently working as a nurse and had indicated to the NMC that she may not return to practice, however it was of the view that a conditions of practice order is sufficient to protect patients and the wider public interest if she chooses to return to nursing practice. It determined that in this case, there are conditions that could be formulated which would protect residents during the period they are in effect.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

Whilst the panel noted that the NMC had sought a striking-off order, this was on the basis of allegations of dishonesty that the panel had found not proved. The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Abramowicz's case, given that it had not identified any attitudinal concerns.

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

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

1. You must limit your nursing practice to one single substantive employer, if that employer is an agency, all placements must be in a single location of a minimum period of three months.

2. You must not be the nurse in charge of any shift until such time as you have completed the Personal Development Plan (PDP) and have been assessed by a senior registered nurse as competent to undertake the role of Nurse in Charge.

3. You must not administer medication until have passed a competency-based assessment for the safe administration of medication with an assessor who will be a senior registered nurse.

4. You must work with your line manager or supervisor to create a personal development plan (PDP). This PDP should include appropriate training and reflection in relation to:

a) Medication administration.

b) Record keeping.

And detailed reflections on:

c) Understanding roles and responsibilities.

d) The importance of adherence to policies.

You must send a copy of your PDP to your case officer within 14 days of commencing or resuming any employment.

5. You must engage with your line manager or supervisor on a monthly basis to ensure you are making progress towards aims set out in your PDP.

6. You must send the NMC a report, 7 days in advance of an NMC hearing or meeting, from your line manager or supervisor which addresses your competency in the areas identified.

7. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your NMC case officer your employer's contact details.

8. You must keep the NMC informed about anywhere you are studying by:

a) Telling your NMC case officer within seven days of accepting any course of study.

b) Giving your NMC case officer the name and contact details of the organisation offering that course of study.

9. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.

b) Any employer you apply to for work (at the time of application).

c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

10. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Your line manager, mentor or supervisor.

b) Any current or future employer.

c) Any educational establishment.

d) Any other person(s) involved in your retraining and/or supervision required by these conditions.

11. You must tell your NMC case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.

b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

The period of this order is for 12 months with review. The panel considered that this time period would sufficiently protect the public whilst providing Mrs Abramowicz with the time

required to obtain employment and address the concerns identified, if she wishes to return to nursing practice.

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

This will be confirmed to Mrs Abramowicz in writing.

Interim order

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

Representations on interim order

The panel took account of the following representations made by the NMC:

'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 12 months, to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.