

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Hearing  
Monday 1 June 2026 – Friday 5 June 2026  
Monday 8 June 2026 – Friday 12 June 2026  
Monday 15 June 2026**

Virtual Hearing

**Name of Registrant:** Stephen John Manuel

**NMC PIN:** 18H0335O

**Part(s) of the register:** Registered Nurse – Sub part 1  
Adult Nursing – 21 August 2018

**Relevant Location:** Bournemouth

**Type of case:** Misconduct and Lack of Competence

**Panel members:** Catherine Devonport (Chair, registrant member)  
Jason Flannigan-Salmon (Registrant member)  
Colleen Sterling (Lay member)

**Legal Assessor:** Justin Gau (Monday 1 June 2026)  
Paul Housego (Tuesday 2 June – Monday 15 June 2026)

**Hearings Coordinator:** Yousrra Hassan

**Nursing and Midwifery Council:** Represented by Nawazish Choudhury, Case Presenter

**Mr Manuel:** Present and represented by Arthur Lo, instructed by the Royal College of Nursing (RCN)

**Facts proved:** Charges 1 & 2

**Facts not proved:** Charge 3

**Fitness to practise:** **Impaired**

**Sanction:**

**Conditions of Practice (18 months)**

**Interim order:**

**Interim Conditions of Practice (18 months)**

## Details of charge

'That you, a Registered Nurse:-

- 1) Between 19 January 2019 and 4 May 2021 failed to demonstrate the skills, knowledge and judgement required of a Band 5 nurse.
- 2) On 19 January 2019 in respect of Patient A who was noted to have a high potassium level at 14.49pm did not administer corrective medication to Patient A which had been prescribed at or around 14.50pm;
- 3) On 19 January 2019 incorrectly recorded in Patient A's Daily Nursing Record that their pressure areas were intact.
- 4) Your conduct at charge 3 was dishonest in that you had not assessed Patient A's pressure areas prior to making the aforesaid entry and by your conduct you intended to make it appear as though you had assessed Patient A's pressure areas.
- 5) On 19 January 2019 having documented at 12.30pm that Patient A's catheter was "thick with yellow pus" and having carried out a bladder washout
  - a) did not record Patient A's fluid input and output on a fluid balance chart;
  - b) did not take adequate steps to escalate Patient A's condition by
    - i) re-attempting to contact the urology department when there was no initial response after you had "bleeped" the urology team; or
    - ii) notifying the Ward Sister,

- 6) On 20 January 2019 did not carry out or record a set of observations or a NEWS assessment for Patient A at or around 09.40am when you recorded that they appeared “poorly”.
  
- 7) On 20 January 2019 having recorded Patient A as having a NEWS score of 11 at 10.30am
  - a) did not escalate the patient’s condition to
    - i. a Registrar or Consultant within 10 minutes; or
    - ii. a Critical Nurse Practitioner;
  
  - b) Did not complete an “SBAR” form;
  - c) Did not make entries in a fluid balance chart after 11am;
  - d) Did not use the sepsis screening tool;
  - e) Did not administer oxygen or did not record that supplementary oxygen was being administered.
  
- 8) Failed a medication competency assessment on:-
  - a) 27 July 2019;
  - b) 5 August 2019;
  - c) 4 October 2019;
  - d) 16 October 2019.
  
- 9) On 2 October 2019:-
  - a) failed to recognise that a diabetic patient required a referral to a diabetes specialist;
  - b) failed to arrange a review for a patient whose bladder retained 400ml of urine after catheter removal.
  
- 10) On 4 October 2019

- a) did not demonstrate that you knew the correct course of action to take upon discovery of a medication error;
- b) completed a drug form for the wrong patient.

11) Failed to achieve all competencies set out in a Performance Improvement Plan dated 3 July 2019 (and subsequently amended) by 16 October 2019.

12) On 4 May 2021

- a) did not check the name on Resident B's medication before administering it;
- b) administered medication prescribed for Resident B to Resident C.

### **Decision and reasons on application to amend the charge**

The panel heard an application made by Mr Choudhury, on behalf of the NMC, to amend the wording of the charges.

The proposed amendment was to amend the numbering of the charges. It was submitted by Mr Choudhury that the proposed amendment would provide clarity and more accurately reflect the evidence.

'That you, a Registered Nurse:-

1) Between 19 January 2019 and 4 May 2021 failed to demonstrate the skills, knowledge and judgement required of a Band 5 nurse **in the following ways.**

- a) On 19 January 2019 having documented at 12.30pm that Patient A's catheter was "thick with yellow pus" and having carried out a bladder washout:
  - i) did not record Patient A's fluid input and output on a fluid balance chart;
  - ii) did not take adequate steps to escalate Patient A's condition by

(1) re-attempting to contact the urology department when there was no initial response after you had “bleeped” the urology team; or

(2) notifying the Ward Sister.

- b) On 19 January 2019 in respect of Patient A who was noted to have a high potassium level at 14.49pm did not administer corrective medication to Patient A which had been prescribed at or around 14.50pm.
- c) On 20 January 2019 did not carry out or record a set of observations or a NEWS assessment for Patient A at or around 09.40am when you recorded that they appeared “poorly”.
- d) On 20 January 2019 having recorded Patient A as having a NEWS score of 11 at 10.30am:
  - i) did not escalate the patient’s condition to
    - (1) a Registrar or Consultant within 10 minutes; or
    - (2) a Critical Nurse Practitioner;
  - ii) Did not complete an “SBAR” form;
  - iii) Did not make entries in a fluid balance chart after 11am;
  - iv) Did not use the sepsis screening tool;
  - v) Did not administer oxygen or did not record that supplementary oxygen was being administered.
- e) Failed a medication competency assessment on:-

- i) 27 July 2019;
  - ii) 5 August 2019;
  - iii) 4 October 2019;
  - iv) 16 October 2019.
- f) On 2 October 2019:-
- i) failed to recognise that a diabetic patient required a referral to a diabetes specialist;
  - ii) failed to arrange a review for a patient whose bladder retained 400ml of urine after catheter removal.
- g) On 4 October 2019:-
- i) did not demonstrate that you knew the correct course of action to take upon discovery of a medication error;
  - ii) completed a drug form for the wrong patient.
- h) Failed to achieve all competencies set out in a Performance Improvement Plan dated 3 July 2019 (and subsequently amended) by 16 October 2019.
- i) On 4 May 2021:-
- i) did not check the name on Resident B's medication before administering it;
  - ii) administered medication prescribed for Resident B to Resident C.
- 2) On 19 January 2019 incorrectly recorded in Patient A's Daily Nursing Record that their pressure areas were intact.

3) Your conduct at charge 2 was dishonest in that you had not assessed Patient A's pressure areas prior to making the aforesaid entry and by your conduct you intended to make it appear as though you had assessed Patient A's pressure areas.

AND in light of the above your fitness to practise is impaired by reason of your misconduct in respect of Charges 1(a)-(d) ~~charges 2 and~~ **Charge 3** and your lack of competence or ~~misconduct in respect of the remaining charges.~~ **in respect of Charge 1(a)-(d) (if not misconduct) and 1(e)-(i) and (if Charge 3 is not proved) Charge 2.**

*For clarity the amendment results in the conclusion of the charge being as follows:*

AND in light of the above your fitness to practise is impaired:

by reason of your misconduct in respect of Charges 1(a)-(d) and Charge 3, and:

your lack of competence in respect of Charge 1(a)-(d) (if not misconduct) and 1(e)-(i) and (if Charge 3 is not proved) Charge 2.

On the first day of the hearing the panel was given advice by the Legal Assessor concerning the drafting of the hearing. He advised that the Charges would benefit from amendment by adding "in the following ways" at the end of the first sentence of Charge 1, and to amend the numbering of the subsequent charges so that they particularised the ways it was alleged your practice was impaired. Mr Choudhury, upon taking instructions from the NMC, informed the panel that the NMC agreed to add the words "in the following ways," and to the proposed renumbering but that it was not necessary to amend further, including as to the numbering of the charges. Mr Lo accepted that the amendment clarified matters. The panel decided to amend as suggested by the legal assessor. Having established the way the NMC was putting its case, the panel also decided, of its own volition, to amend the last paragraph of the Charge to make it clear which charges amounted to lack of competence, and which charges were alleged to be misconduct.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel 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. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

### **Decision and reasons on application for hearing to be held in private**

At the outset of the hearing, Mr Choudhury made a request that this case be held in private on the basis that proper exploration of your case involves matters in relation to your private and family life. The application was made pursuant to Rule 19 of the Rules.

Mr Lo indicated that he supported the application to the extent that any reference to your private and family life should be heard in private.

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 determined to go into private session in connection with your [PRIVATE] as and when such issues are raised in order to uphold your privacy.

### **Background**

Charges 1(a)-(h), 2 and 3 arose whilst you were employed as a Registered Nurse by [PRIVATE] (the Hospital) in January 2019. The allegations related to your clinical management of Patient A and concerns surrounding your overall professional competence

and failure to successfully complete a competency improvement plan. The second matter (Charge 1(i)) arose from an incident at [PRIVATE] (the Home), where it is alleged that you administered medication intended for one resident to another resident.

Some of the allegations relating to the Hospital concern events on 19 and 20 January 2019 involving Patient A. During the day shift on the 19 January 2019, you did not administer prescribed medication to treat the patient's high potassium level when it was prescribed by the doctor for the patient at approximately 15:00. Instead, at the end of your shift, at approximately 19:00, you informed the incoming night staff that Patient A required the medication. The medication was eventually administered by your colleague at approximately 20:00, resulting in a delay of around five hours from the time it should have been given.

Further concerns arose in relation to your clinical assessment and documentation for this patient. Although records from the previous night shift indicated that Patient A had a grade 1 sacral sore, you documented on 19 January 2019 that the patient's pressure areas were intact. When questioned by the Ward Sister, Kayley Thomson and Matron, Nicki Baker, you acknowledged that you had not in fact checked the patient's pressure areas. In addition, after observing pus in patient A's catheter, you carried out a bladder washout but failed to complete the required fluid balance chart following the procedure and you did not take adequate steps to escalate the patient's condition to the urology team or to the Ward Sister.

On the 20 January 2019 further concerns arose in relation to your management of patient A, who had become a deteriorating patient. You recorded a National Early Warning Score (NEWS) of 11, although it is alleged that the score should properly have been calculated as twelve. Irrespective of that discrepancy, both scores placed the patient within the highest risk category under the Trust's Deteriorating Patient Policy. The policy requires a series of actions to be undertaken, including escalation to a senior clinician, appropriate documentation, oxygen administration, completion of SBAR documentation, sepsis screening and maintenance of a fluid balance chart. Whilst you did escalate the matter to an FY1 junior doctor, it is alleged that the policy required escalation to a consultant.

Separate allegations relating to your professional competence arose, as set out in the charges. You failed competency assessments conducted on 27 July 2019, 5 August 2019, 4 October 2019, and 16 October 2019. Despite being placed on an improvement plan, it is alleged that you failed to complete and achieve the required competencies, including those relevant to your role.

You resigned your employment at the Hospital and later commenced work at the Home, a further issue arising on the 4 May 2021 when you accepted that you administered medication to the wrong resident.

### **Decision and reasons on facts**

At the outset of the hearing, the panel heard from Mr Lo, who informed the panel that you made full admissions to Charges 1 and 2. The admission to Charge 2 was on the basis that you had failed to check Patient A thoroughly, and so your entry was incorrect because a full examination should have been carried out. You denied that you had failed to carry out any examination at all. You did not accept that Patient A had a Grade 1 pressure sore at the time of your examination, as the subsequent examination recorded none. You denied Charge 3.

The panel therefore finds Charges 1 and 2 proved in their entirety, by way of your admissions.

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

- Edward Yarrow: Advanced Clinical Practitioner at the Hospital.
- Desiree Allarse: Band 5 Registered Nurse at the Hospital.

- Jodie Roberts Deputy Sister at the Hospital.
- Nicki Baker Matron at the Hospital.

In addition, you did not contest the evidence of other witnesses, and their evidence was admitted through their witness statements. They were Saneetha Thomas (a deputy sister at the Hospital), Sarah Fellows (a Practice Educator at the Hospital), Iuliana Cretu (a nurse at the Home) and Mandy Lewis (a Community Psychiatric Nurse).

The panel also heard evidence from you under affirmation.

The panel heard Mr Choudhury's lengthy submissions on facts relating to all the charges, and Mr Lo's shorter submissions, limited at this stage to Charge 3, the only charge you denied. These necessitated submissions concerning Charge 2, which was the factual allegation from which the dishonesty allegation of Charge 3 arose.

Mr Choudhury submitted that you have admitted all of the factual allegations, except the allegation of dishonesty, and that whilst you had sought to place reliance upon the context of the ward environment and staffing pressures on 19 January 2019, those wider circumstances did not detract from the admitted facts underpinning the charges.

Mr Choudhury submitted that significant weight should be attached to the contemporaneous documentary evidence. Referring to the guidance on witness credibility contained within DMA-6, Mr Choudhury highlighted that memories naturally fade over time and that contemporaneous records are often the most reliable evidence of events. He relied upon the authorities of *R. (on the application of Dutta) v General Medical Council*, 2020 WL 04207724 (2020) and *Byrne v General Medical Council*, 2021 WL 03493373 (2021), submitting that where witness evidence accords with contemporaneous documentation, considerable weight should be attached to that evidence.

Mr Choudhury submitted that the panel had the benefit of a substantial body of contemporaneous documentation created at, or shortly after, the relevant events. This included Patient A's medical records, the Trust's Deteriorating Patient Policy in force at the relevant time, the Datix incident report, local investigation records, and numerous other documentary exhibits. The panel also had before it records of local interviews conducted in mid-April 2019 with Edward Yarrow, yourself, Jodie Roberts, Desiree Allarse, and Hollie Lawrence who was a bank healthcare assistant and a student nurse (from whom there was no NMC witness statement), all of whom were interviewed only two to three months after the incidents occurred. When viewed alongside the witness statements and oral evidence, Mr Choudhury submitted that the documentary evidence provided a consistent and compelling account.

Mr Choudhury submitted that the allegations concerning Patient A occurred on 19 and 20 January 2019, only a few months after you had qualified as a UK nurse in August 2018. You commenced employment at the Hospital in August 2017 and had therefore been working within the Trust's systems and policies for approximately eighteen months by the time of the incident. He submitted that this was not a case where you were unfamiliar with local procedures; rather, it was a case where you had failed to follow clear and established policies concerning medication administration, the management of deteriorating patients, escalation procedures, and the achievement of required competencies.

Mr Choudhury further submitted that the oral evidence from the NMC witnesses was credible, reliable and consistent. Mr Choudhury submitted that there were no material inconsistencies between the witness's oral evidence, witness statements, or the contemporaneous records, and that their evidence should therefore be regarded as reliable.

Mr Choudhury invited the panel to draw both direct and indirect inferences from the documentary and witness evidence. He submitted that the evidence demonstrated that you had failed to act promptly when you knew, or ought to have known, the importance of doing so. You had failed to appreciate the seriousness of Patient A's deteriorating

condition, had not followed clear and unambiguous instructions contained within the Trust's policies, and had failed to take proper accountability for your own actions. Instead, Mr Choudhury submitted, you had sought to place responsibility on others rather than accepting responsibility for your own clinical practice.

Mr Choudhury referred to the witness evidence of Sarah Fellows and Nicki Baker, both of whom described you in positive personal terms. However, Mr Choudhury submitted that kindness alone could not excuse failures in professional practice.

Mr Choudhury submitted that you were fully aware of the escalation processes. You knew how to contact the urology team, having attempted to bleep them at approximately 12:30 on 19 January 2019. Your difficulty, therefore, was not one of understanding the system but of failing to appreciate when and how to escalate matters appropriately.

Mr Choudhury referred the panel to the evidence concerning your role and responsibilities as a Registered Nurse. He submitted that the evidence of Saneetha Thomas and Sarah Fellows established that your duties included administering medication, providing patient care, escalating concerns to senior staff, keeping the nurse in charge informed, overseeing the care of allocated patients, completing care plans, prioritising workload, and recognising and responding appropriately to deteriorating patients.

Mr Choudhury further submitted that a consistent theme emerging from the evidence of your colleagues was concern regarding your ability to prioritise your workload effectively. Saneetha Thomas described you as being "laid back" and requiring frequent reminders about your responsibilities. In your local interview, you accepted that you were not good at prioritising your workload. Similarly, Jodie Roberts stated that you struggled to organise and prioritise your workflow, whilst Saneetha Thomas commented that you often made excuses for not completing tasks, appeared too relaxed in your approach, and required encouragement to work more effectively. In addition, Nicki Baker stated that you required prompting during medication rounds.

Mr Choudhury placed reliance on the Trust's Deteriorating Adult Patient Policy, submitting that you were familiar with its requirements. He referred the panel to the flowchart within the policy, which made clear that a NEWS score of 7 or above required urgent escalation. Given your experience in completing NEWS assessments and the equivalent guidance contained within Patient A's records, Mr Choudhury submitted that you knew, or ought to have known, that escalation was mandatory but failed to do so.

Mr Choudhury submitted that the evidence did not support the suggestion that language barriers or a lack of support had contributed to the events. He noted that witnesses, including Jodie Roberts and Nicki Baker, had raised no concerns regarding your ability to communicate effectively and he submitted that the real issue was your overly relaxed approach to seeking assistance and escalating concerns when required.

In relation to Charge 3, the dishonesty allegation, Mr Choudhury submitted that the issue was not simply an incomplete clinical record. By recording "PA intact", he submitted that you had indicated that you had assessed Patient A's pressure areas, when you later accepted that you had not done so. Mr Choudhury submitted that the contemporaneous records, together with your own evidence, supported the allegation of dishonesty.

Mr Choudhury stressed that you had signed the notes of your interview with Edward Jarrow the day of the interview, and those notes attributed to you the statement that you had not checked Patient A's pressure areas. The letter to you from the matron, Nicki Baker, restricting your duties contained a similar statement to which you did not object. Mr Choudhury submitted that your evidence, that you had checked but not properly, was a later construct to deflect the dishonesty charge. He submitted that your evidence, [PRIVATE] and that English was not your first language, did not undermine the clear evidence of Edward Yarrow and of Nicki Baker. Nicki Baker was very clear about her recollection even 7 years on.

The panel heard the submissions from Mr Lo in relation to the facts.

Mr Lo submitted that the factual allegations had been admitted but submitted that the wider context in which the events occurred was an important consideration for the panel in its evaluation of Charge 2, which was the basis of Charge 3. He reserved his submissions on the competence allegations for the next stages of misconduct and impairment. He would be submitting that the matters set out in Charge 1 were competence issues and not misconduct, and that your fitness to practise was not currently impaired.

In relation to Charge 2 Mr Lo submitted that you were still relatively inexperienced in the role of a Registered Nurse, in a highly demanding and pressured ward and that the demands placed upon you on 19 and 20 January 2019 should be considered.

Mr Lo submitted that although you had spent a considerable period working within the Trust before qualifying, much of that time had been as a pre-registration nurse, performing duties broadly equivalent to those of a healthcare assistant and primarily providing direct personal care. Whilst you had been administering medication during your training, the responsibilities associated with independently managing a patient allocation, prioritising competing demands and organising your own workload were relatively new to you at the time of the incident.

Mr Lo submitted that staffing levels and workload were contributing factors. He referred the panel to the evidence of Edward Yarrow, who stated that the ward was operating with one Registered nurse and one healthcare assistant fewer than expected. Whilst Jodie Roberts initially suggested that the ward was not understaffed, she accepted during her oral evidence that Mr Yarrow's account was likely to be the more accurate.

Similarly, Mr Lo submitted that although the workload on the ward on 19 and 20 January 2019 was described as "normal" and "not busier than usual", he submitted that this simply reflected the inherently demanding nature of an understaffed acute surgical ward. Mr Lo referred to the evidence of Ms Allarse and Ms Roberts, both of whom accepted that the ward was busy by its ordinary standards. He submitted that even if the ward was not

exceptionally busy, your workload would nevertheless have been substantial, and this was a relevant factor when considering your actions.

Mr Lo also submitted that you did not feel adequately supported by senior colleagues. He referred to your evidence that you had not been issued with a bleeper and did not fully appreciate that you could seek assistance from Ms Roberts or other senior staff.

Addressing the allegation concerning Patient A's pressure areas, Mr Lo submitted that you accepted that you had not carried out a sufficiently thorough assessment but disputed the suggestion that you had not checked the patient at all. Your evidence was that you had turned the patient onto his side, observed that the areas were red but not broken, and noted that the leg ulcer appeared to be healing. Mr Lo submitted that you had not conducted a comprehensive assessment rather than having omitted the assessment entirely. He submitted that this account was broadly consistent with Ms Allarse's evidence as to the manner in which such checks were commonly performed, and drew attention to the fact that Ms Allarse's examination of Patient A on the subsequent night shift was that there was no pressure sore, and to the evidence of Ms Baker that Grade 1 pressure sores, properly attended to, could resolve swiftly as they resulted from constricted blood flow, and frequent turning of the patient could resolve the condition in a short time. Accordingly, your acceptance of the charge was not on the basis that there was a pressure sore which you had failed to record, but that you had recorded there was none after carrying a cursory rather than a proper examination.

In relation to the allegation of dishonesty, Mr Lo relied upon the principles established in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67* and submitted that your actions amounted to negligence or mistake rather than deliberate dishonesty. He submitted that there was a clear distinction between an inaccurate clinical record and a conscious attempt to mislead. You accepted that your documentation was incorrect, but Mr Lo submitted that there was no evidence that you intended to create a false record.

Mr Lo further submitted that your conduct following the incident supported the conclusion that you had not acted dishonestly. During the initial meeting with Ms Baker and the Ward Sister, when confronted with the documentation recording "PA intact", you openly accepted that you had not completed a full inspection of the patient's pressure areas. Had you genuinely intended to conceal your actions, Mr Lo submitted, it would have been open to you to maintain that you had carried out the assessment. Instead, your willingness to acknowledge your shortcomings was inconsistent with any deliberate intention to deceive.

Accordingly, whilst accepting your assessment and documentation fell below the required standard, Mr Lo invited the panel to conclude that your actions arose from error and inexperience rather than dishonesty.

Before making any findings on the facts, the panel heard and accepted the advice of the Legal Assessor. The Legal Assessor referred the panel to the authorities of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*, at paragraph 74, *Khan v General Medical Council (Rev 1) [2021] EWHC 374 (Admin)*, and *R (Dutta) v General Medical Council [2020] EWHC 1974 (Admin)*, in particular the observations at paragraph 35 concerning the assessment of witness credibility and the importance of contemporaneous documentary evidence.

The panel considered the witness and documentary evidence provided by both the NMC and by you.

The panel then considered the circumstances of Charge 2 and the disputed Charge 3 and made the following findings.

## **Charge 2**

“On 19 January 2019 incorrectly recorded in Patient A’s Daily Nursing Record that their pressure areas were intact.”

**This charge was found proved on your admission.**

However, the panel made findings of fact about the extent of your admission as a necessary precursor to its consideration of Charge 3.

In reaching its decision, the panel placed significant weight on the contemporaneous documentary evidence and the consistent evidence of the witnesses who were involved in the local investigation. In particular, the panel found the evidence of Ms Baker, Matron, to be clear, credible and reliable. Ms Baker's written statement, oral evidence, and the records of the local investigation were all consistent in recording that, when questioned about the entry stating that Patient A's pressure areas were intact, you admitted that you had not checked the patient's pressure areas. Her recollection was fresh in her mind despite the passage of 7 years.

The panel also considered the evidence of Mr Yarrow, who conducted the local investigation in April 2019, only a short time after the incident. His evidence was similarly that you had accepted that you had not carried out the assessment, not that you had done so in a cursory way that was not thorough. The panel was satisfied that both witnesses gave an accurate account of those discussions and attached considerable weight to their evidence, given its consistency with the contemporaneous records.

You accepted during these proceedings that you had not carried out a thorough assessment of Patient A's pressure areas. You maintained, however, that you had undertaken a limited visual inspection by turning the patient onto one side and observing redness, but that you had not examined the patient fully. The panel carefully considered this explanation, together with your submission that, at the time of the incident, you were [PRIVATE] English was not your first language.

However, the panel was not persuaded that these factors undermined the reliability of the contemporaneous evidence. It noted that there was no reference during the local investigation to you having checked the patient "partially" or "not thoroughly". Rather, the

consistent evidence of both Ms Baker and Mr Yarrow was that you admitted that you had not checked the pressure areas. The panel was also satisfied that Ms Baker had specifically asked you whether you had checked the patient's pressure areas and that her recollection of your response remained clear and consistent throughout her evidence.

Accordingly, the panel did not consider your explanation for not qualifying your admission to either Mr Yarrow or Ms Baker to be credible. [PRIVATE] and that English is not your first language, the difference between not checking at all and checking in an inadequate way is significant and not a matter of linguistic nuance. It was not until much later that you provided this explanation.

The panel accepted that Patient A was subject to regular two-hourly repositioning. Ms Baker stated that any Grade 1 pressure sore damage, such as redness, could quickly improve with appropriate care. However, the issue before the panel was not the severity or otherwise of the area of pressure damage but whether you had recorded that the patient's pressure areas were intact without assessing the sacral area at all.

Having considered all of the evidence, the panel concluded that, on the balance of probabilities, that you had not assessed Patient A's pressure areas before making the entry in the nursing records.

Accordingly, the entry recording that the pressure areas were intact was inaccurate. Given your admission and the clear and consistent contemporaneous evidence, the panel was satisfied that Charge 2 was proved on the basis that on 19 January 2019 you had not checked Patient A's pressure areas at all.

### **Charge 3)**

“Your conduct at charge 2 was dishonest in that you had not assessed Patient A's pressure areas prior to making the aforesaid entry and by your conduct you

intended to make it appear as though you had assessed Patient A's pressure areas."

**This charge is found NOT proved.**

In considering this charge, the panel took into account its findings in relation to Charge 2, together with the contemporaneous records and the consistent evidence of Ms Baker and Mr Yarrow. The panel was satisfied, on the balance of probabilities, that you had admitted during the local investigation that you had not assessed Patient A's pressure areas before recording that they were intact.

The panel also considered the wider context of the incident, including that you started work in the Hospital in August 2017 as an international nurse (nurse not trained or qualified within the UK). You worked as an HCA and were supported to undertake the required OSCE (objective, structured, clinical examination) which is designed to assess clinical skills, professional skills and professional judgement of international nurse recruits. You gained your UK nursing qualification in August 2018. You commenced work on an acute surgical ward which was understaffed and inherently busy.

Creating a false entry in a medical record is usually indicative of dishonesty. However, the *Ivey* test requires the panel to consider what the well-informed member of the public would make of it.

You volunteered the fact that on 19 January 2019 you had not checked the pressure areas of Patient A, to both Mr Yarrow and to Ms Baker. The episode has to be viewed in the context of the many competence issues set out in Charge 1, which included a failure, or inability, to pass a series of nursing competency assessments extending over a lengthy period, from 27 July 2019 until 16 October 2019. From these dates it is apparent that your competence level at the time (19 January 2019) was concerning as a highly detailed performance improvement plan followed, but your competency levels did not improve to a

satisfactory level. The panel noted that the competency issue at 1(i) at the Home was in 2021, and so over 2 years later.

The panel noted that you had been candid about the matter at the time, when you could have concealed it by denial, and that you derived no advantage at the time from the incorrect entry.

Overall, the panel considered that the well-informed member of the public would consider this far more likely to be another example of incompetence and not a dishonest action by you.

For these reasons the panel found Charge 3 NOT proved.

While it is not a reason for the finding, and while being clear that matters of sanction are for the panel only, the panel was confused by the NMC's sanction bid of a condition of practice order for 12 months which would not have addressed dishonesty. This seemed to the panel to indicate that the NMC was itself unsure that this was dishonesty.

The panel heard live evidence from the following witness called on behalf of Mr Lo:

- Anthony Mifa: Branch Manager, Blissful Healthcare Agency

### **Submissions on misconduct**

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

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

Mr Choudhury identified the specific, relevant standards where he submitted that your actions amounted to misconduct.

Mr Choudhury submitted that the conduct alleged at Charges 1(a)–1(d) amounted not merely to a lack of competence but crossed the threshold into misconduct. He invited the panel to find that each of the matters alleged at Charges 1(a), 1(b), 1(c) and 1(d) concerned highly important and significant clinical responsibilities. These were not trivial tasks or administrative oversights. Rather, they were mandatory actions which you were required to undertake in order to ensure Patient A's safety.

Mr Choudhury submitted that the conduct in this case was of such seriousness that it crossed the threshold from incompetence into misconduct.

Mr Choudhury characterised Charges 1(a)–1(d) as a catalogue of failures occurring over a period of approximately two days. He submitted that, taken individually and cumulatively, those failures amounted to gross negligence. The failures related to matters of urgency and clinical significance, requiring immediate action and prioritisation. He submitted that you ought to have prioritised Patient A's care over competing demands and that the consequences of your omissions were potentially severe. Mr Choudhury submitted that there was a five-hour delay in ensuring that Patient A received prescribed medication. He submitted that this delay alone could support a finding that your conduct was grossly negligent. Whilst you had informed Ms Allarse that medication was required, you failed to communicate the urgency of the situation or the time by which the medication was needed.

Mr Choudhury further relied upon the evidence relating to the failure to complete the sepsis screening tool on 20 January. He submitted that the sepsis pathway and

associated documentation set out clear and mandatory requirements with which you were familiar and which you knew you were required to follow. He submitted that you were aware of the appropriate escalation procedures, including how to contact the urology team and escalate concerns to senior medical staff where necessary. Your knowledge of those procedures, together with the relevant policies and escalation flowcharts, demonstrated that these were not matters beyond your competence or understanding. Rather, they were established procedures in which you had received training and which you knew were expected of you in the circumstances. Mr Choudhury submitted that your failure to follow those procedures was therefore not indicative of a lack of competence but instead amounted to a serious departure from fundamental professional standards, such as to constitute gross negligence.

Mr Choudhury submitted that your explanations, namely that you were a newly qualified nurse and busy during the relevant shifts, did not adequately explain or diminish the seriousness of the omissions. He further relied on the evidence of Ms Roberts, who stated that you did not escalate your concerns to her whilst she was the nurse in charge, nor did you seek assistance despite opportunities to do so and being asked whether you required support. Mr Choudhury noted that Ms Roberts was shocked when she later discovered that the concerns had not been escalated and that the medication had not been administered as required. He submitted that her reaction demonstrated the seriousness with which an experienced nurse viewed your omissions.

Mr Choudhury submitted that the failings were serious and had the potential to compromise patient safety.

Mr Choudhury submitted that your conduct represented breaches of several fundamental provisions of the NMC Code, including paragraphs 1.1, 1.4, 8.5, 13.2,13.3, 16.2 and 20.1. He submitted that these provisions go to the heart of a nurse's professional obligations to prioritise people, practise effectively, preserve safety and promote professionalism and trust. Given your training, knowledge and understanding of what was required of you, Mr Choudhury submitted that the failings could not properly be characterised as a lack of

competence. Rather, they were serious departures from fundamental professional standards and therefore amounted to misconduct.

Accordingly, Mr Choudhury invited the panel to conclude that Charges 1(a)–1(d) crossed the threshold into misconduct. He submitted that any finding to the contrary would fail to reflect the gravity of your omissions and the serious risk posed to Patient A.

Mr Lo submitted that the key issue was whether the proven failings were sufficiently serious to amount to misconduct, rather than merely demonstrating a lack of competence.

Mr Lo submitted that the evidence did not establish that your failings created a sufficiently serious risk of harm to justify a finding of misconduct. He noted that, whilst there had undoubtedly been errors, the evidence did not demonstrate that those errors resulted in actual serious harm to Patient A. He referred to the evidence relating to the administration of medication and submitted that, notwithstanding the delay, Patient A did not suffer the most serious adverse outcome. He submitted that the assessment of misconduct should be based on the evidence before the panel and not on speculation as to what might have occurred.

In relation to Charges 1(a) and 1(b), concerning the failure to record fluid input and output, Mr Lo questioned whether there was evidence demonstrating that those omissions created a serious risk of harm. Similarly, in relation to the catheter-related concerns, he submitted that whilst there was evidence of pus being present and that Patient A subsequently became septic, there was insufficient evidence establishing the extent to which your actions or omissions materially increased the risk of harm.

Mr Lo referred to the evidence of witnesses who had spoken about the potential consequences of the failures. He noted that Ms Allarse had referred to elevated potassium levels and the potential impact on cardiac function, whilst Ms Baker had spoken of a risk of cardiac arrest. However, he submitted that neither witness was able to provide evidence as to the degree of risk involved or the likelihood of those outcomes occurring. He

submitted that there was no clear evidence demonstrating that the risks would have been obvious to you or that the failings created an imminent danger to Patient A.

Turning to the failure to undertake a NEWS assessment and the subsequent failure to escalate appropriately following a NEWS score of 11, Mr Lo submitted that there was insufficient evidence to demonstrate the extent to which Patient A was placed at immediate or serious risk. He submitted that, whilst escalation should have occurred, the evidence did not establish how the risk of harm was increased by your omissions. He further noted that other healthcare professionals involved in Patient A's care also had responsibilities to escalate concerns, which was relevant when assessing the seriousness of your conduct.

Mr Lo submitted that, whilst you had failed to comply with Trust policies and procedures in relation to the completion of the sepsis screening tool and the provision of supplementary oxygen, the NMC had not adduced sufficient evidence to establish that those omissions placed Patient A at a serious risk of harm. He submitted that there was no medical evidence before the panel explaining the extent of the danger arising from those failures, nor any evidence enabling the panel to assess the degree to which your actions increased the risk to Patient A. In the absence of such evidence, Mr Lo submitted that the failings were more properly characterised as deficiencies in professional performance indicative of a lack of competence, rather than conduct sufficiently serious to amount to misconduct.

Mr Lo also relied upon factors relevant to culpability. He submitted that, at the material time, you were an inexperienced nurse working within a busy ward environment and faced additional challenges arising from language barriers. He referred to your evidence concerning your reluctance to seek assistance and submitted that these contextual factors were relevant when assessing the extent of your personal culpability. Whilst they did not excuse the failings, he submitted that they provided important context and weighed against a finding that your conduct was sufficiently serious to amount to misconduct.

Mr Lo therefore invited the panel to find that the proven facts were indicative of a lack of competence rather than misconduct.

Before making any findings on misconduct, the panel heard and accepted the Legal Assessor's advice. The Legal Assessor referred the panel to the authorities in *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* [1999] UKPC 16, *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin), and FTP-2a.

### **Decision and reasons on misconduct**

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

The panel decided that the matters in charges 1(a) and 1(b) were matters of lack of competence, and not misconduct.

The panel decided that your actions in relation to charges 1(c) and 1(d) did fall significantly short of the standards expected of a Registered Nurse and met the requirements of misconduct.

#### **Charge 1(a)(i):**

In considering whether Charge 1(a)(i) amounted to misconduct, the panel carefully considered the seriousness of the omission and the surrounding circumstances. The panel saw the fluid balance chart for the day in question. The chart showed that nothing was recorded by you from 12:00 until 20:00 when the night staff took over Patient A's care. The panel accepted the evidence that the completion of fluid balance charts is a fundamental aspect of nursing care. During your local interview with Mr Yarrow, you confirmed that you understood the importance of fluid balance monitoring. The panel also took account of the

evidence of Ms Roberts, who described the bladder washout as a relatively straightforward nursing task, and of Ms Baker, who stated that fluid balance monitoring should ordinarily be undertaken hourly to ensure that the patient is not overloaded or dehydrated and that you would have learned this when doing your OSCE.

Notwithstanding the importance of fluid balance monitoring, the panel was not persuaded that the omission in this instance was sufficiently serious to amount to misconduct. The panel accepted your explanation that you should have completed the fluid balance chart but forgot to do so during what you described as a particularly busy shift. The panel found no evidence that the omission was deliberate or reckless. Rather, it considered the failing to be indicative of poor practice and inadequate management of Patient A's care at the time.

Whilst the panel recognised that the omission may have amounted to negligence and reflected a lack of the skill, judgement or organisation expected of a Band 5 nurse, it did not consider that the conduct represented such a serious departure from the standards expected of a Registered Nurse so as to amount to gross negligence and so misconduct. The panel therefore concluded that Charge 1a(i) was more appropriately characterised as poor professional practice and a lack of competence, rather than misconduct.

#### **Charge 1(a)(ii)(1):**

In considering whether Charge 1a(ii)(1) amounted to misconduct, the panel accepted the evidence that a Registered Nurse is responsible for appropriately escalating concerns regarding the condition of patients allocated to them on a shift. The panel had regard to the evidence of Ms Fellows regarding the standards expected of a Registered Nurse and accepted that, following the absence of a response from the urology team, further attempts at escalation ought to have been made.

However, the panel was not satisfied that this failing, viewed in its particular context, was sufficiently serious to amount to misconduct. Whilst you failed to re-attempt contact with

the urology department after receiving no response to your initial bleep, the panel did not find that this omission was deliberate, reckless, or a conscious disregard for Patient A's safety. Rather, it considered the failing to be an example of poor professional practice and a lapse in clinical judgement. Although you fell below the standard expected of a Band 5 nurse by not pursuing the escalation further, the panel concluded that the conduct did not represent such a serious departure from professional standards so as to be characterised as gross misconduct. Accordingly, the panel determined that this charge was more appropriately characterised as poor practice and a lack of competence rather than misconduct.

**Charge 1(a)(ii)(2):**

In considering whether Charge 1a(ii)(2) amounted to misconduct, the panel had regard to the evidence of Ms Roberts, who stated that she became aware of the pus in Patient A's catheter through another nurse and not from yourself. The panel accepted that, as the nurse allocated to Patient A, you had a responsibility to communicate significant clinical concerns to the Ward Sister and to ensure that relevant information was appropriately escalated. Effective communication with colleagues is a fundamental aspect of safe nursing practice.

The panel found that you failed to inform the Ward Sister of the condition of Patient A's catheter and that there had also been a delay in carrying out the bladder washout. At your local interview with Mr Yarrow, he asked why you did not escalate when you were not called back you stated that you thought everyone was aware of the catheter content. The panel considered these omissions to be serious shortcomings in the management of Patient A's care. It accepted that the presence of pus and blood in the catheter was a concerning clinical finding and could potentially indicate infection or sepsis. However, the panel had evidence that pus in the catheter was not immediately life-threatening or that the omission, viewed in isolation, amounted to such a serious departure from professional standards sufficient to constitute gross negligence as so misconduct.

Whilst your failure to communicate this information to the Ward Sister represented extremely poor practice and fell below the standard expected of a Registered Nurse, the panel concluded that it was more appropriately characterised as a deficiency in professional performance and clinical judgement rather than misconduct.

**Charge 1(b):**

In considering whether Charge 1b amounted to misconduct, the panel recognised the seriousness of the failure to administer prescribed corrective medication to Patient A following the identification of a very high potassium level of 7.1. The panel accepted the evidence that administering the medication was a priority and that prompt treatment was extremely important. It also noted the evidence of Ms Roberts, who stated that a nurse faced with such a situation ought to have prioritised the administration of the medication above other tasks.

The panel further considered the evidence of Ms Allarse, like you an overseas nurse who started at the Hospital at about the same time as you did. She explained that she understood the importance of the medication and was shocked to learn that it had not been administered promptly when you were told by a doctor that they had prescribed the medication at 15:00 during your day shift. The panel found it particularly concerning that, during handover, you informed Ms Allarse that the medication had not been given but failed to communicate that it had been prescribed approximately five hours earlier. The panel considered this to be a significant failure in communication and clinical judgement. Ms Allarse said that as the potassium level was so high the first thing she did was to give a hyperkalemia medication to Patient A. Given the danger to the heart of raised potassium, it is important for this medication to be given as soon as possible. In your local interview with Mr Yarrow, you said the reason that you had not given the medication to Patient A was that he wanted to finish eating his dinner. You also said that there were other patients with high NEWS scores within your bay, requiring your attention. You failed to appreciate the significance of a high potassium level as Patient A did not present as unwell. Sister Roberts who was in charge on this shift said that if you are unable to

administer medication you are expected to record this in the notes, she also said that you had not informed her of Patient A's high potassium and how it was important that all staff on the ward were aware of it because of the danger of cardiac arrest to Patient A.

However, the panel also accepted that there was no evidence that you deliberately or recklessly withheld the medication or consciously disregarded Patient A's welfare. The panel was satisfied that, at the time, you did not fully appreciate the urgency and significance of the medication being administered.

Accordingly, whilst the panel regarded the charge as a serious example of poor professional practice, it concluded that it did not amount to misconduct. Rather, it was indicative of your failure to demonstrate the skills, knowledge and judgement expected of a Band 5 nurse.

#### **Charge 1(c):**

In considering whether Charge 1(c) amounted to misconduct, the panel attached significant weight to the fact that you had personally recorded in the nursing notes at approximately 09:40 that Patient A appeared "poorly". The panel accepted that the entry was in your handwriting and was therefore satisfied that you had identified a deterioration in Patient A's condition. Despite recognising that the patient was unwell, you failed to carry out or record a set of observations or undertake a NEWS assessment at that time.

The panel considered this omission to be particularly serious. Recording observations and undertaking a NEWS assessment are fundamental nursing responsibilities and are essential tools for identifying deterioration and determining whether escalation is required. The panel heard evidence that you had received training in NEWS score and in management of deteriorating patients and therefore you should have known the responses required. The panel noted that you were concerned enough about Patient A's condition to escalate the matter to the Urology FY1 doctor (junior doctor), yet you failed to undertake the basic observations that would have informed and supported that escalation.

Whilst the panel noted evidence that Hollie Lawrence, a healthcare assistant and student nurse, may have been involved in taking observations, there was no evidence that these had been recorded. The panel was satisfied that responsibility for ensuring observations were undertaken and appropriately recorded remained with you as the allocated Registered Nurse.

The panel further noted that the first recorded observations did not appear until approximately 10:30, despite your documenting concerns regarding the patient's condition nearly an hour earlier. The nursing records suggested that observations may have been taken prior to that time; however, there is no record on Patient A's NEWS chart. The panel considered that, as a Registered Nurse, you are responsible for not only ensuring that observations were carried out but also for ensuring that they were properly documented.

The panel also had regard to your training and knowledge. It accepted that you had received training relating to sepsis recognition, NEWS scores and escalation protocols and therefore understood the purpose and importance of undertaking observations when a patient appeared unwell. At local interview you told Mr Yarrow that the reason for you not recording the observations was that you were more concerned with taking physical care of Patient A, being with him and looking after him. Mr Yarrow said that he didn't think you understood the urgent priority of recording Patient A's vital signs.

Taking all of these factors into account, the panel concluded that the omission represented a serious departure from the standards expected of a Registered Nurse. The failure to undertake and record basic observations in circumstances where you had recognised that Patient A appeared poorly undermined patient safety and fell significantly below fundamental nursing standards, such as to be properly considered gross negligence. You were aware the patient was very unwell, you knew what should be done in consequence, but you failed to take any of the necessary steps. This was a reckless disregard of the needs of the patient. The panel therefore determined that Charge 1c amounted to misconduct.

### **Charge 1(d)(i)(1) & (2):**

The panel considered these together. In considering Charge 1d(i)(1) and (2), the panel considered that your failure to escalate Patient A's condition to a Registrar or Consultant within 10 minutes, and your failure to escalate to a Critical Nurse Practitioner, amounted to misconduct as it was gross negligence.

The panel attached significant weight to the fact that you recorded a NEWS score of 11 at 10:30. It accepted the evidence of Mr Yarrow that a NEWS score of 11 is exceptionally high and indicative of a patient who is acutely unwell and requires urgent escalation. The panel also had regard to the Trust's NEWS escalation policy, which required patients with a NEWS score of 7 or above to be escalated to a Registrar or Consultant, with a NEWS score of 11 necessitating immediate senior review. The policy further required escalation to the Critical Care Outreach Team. In your local interview you told Mr Yarrow that the reason that you did not escalate was that you were new and did not know the policy. You also said that you had told a junior doctor (FY1) of Patient A's condition.

The panel was satisfied that you were fully aware of these requirements. It noted the evidence that all nursing staff received NEWS and escalation training and that, in your oral evidence, you accepted that you had completed many NEWS assessments during your nursing practice. The panel therefore rejected any suggestion that you were unfamiliar with the escalation process or unaware of the significance of the score recorded. Whilst Ms Lawrence gave evidence that you were a relatively new nurse, the panel was satisfied that you had received the relevant training and understood the importance of escalating a patient with such a high NEWS score.

The panel noted that, despite recording the NEWS score, you failed to escalate the matter to the appropriate level of seniority. The evidence demonstrated that you neither contacted a Registrar or Consultant within the required timeframe nor contacted the Critical Care Outreach Team. The panel had regard to the evidence that it was the medical team, rather than yourself, who subsequently escalated concerns regarding Patient A's condition. In the

panel's view, your inaction represented a significant failure to respond appropriately to a patient exhibiting clear signs of clinical deterioration.

The panel considered this failing to be fundamentally different from a mere lapse in practice or an error arising from inexperience. You knew the significance of the NEWS score, had received the relevant training, understood the escalation requirements, and nevertheless failed to take the action required by Trust policy. Given the seriousness of Patient A's condition, the high NEWS score, and the clear escalation requirements, the panel concluded that your omissions constituted a serious departure from the standards expected of a Registered Nurse such as to amount to a reckless disregard for the patient's urgent needs and so to amount to gross negligence. Accordingly, the panel determined that Charges 1d(i)(1) and 1d(i)(2) amounted to misconduct.

**Charge 1(d)(ii):**

In considering whether Charge 1d(ii) amounted to misconduct, the panel had regard to the Trust's NEWS escalation policy, which expressly required the use of an SBAR form whenever a Registered Nurse was escalating a deteriorating patient with a medium or high-risk NEWS score to medical staff or the Outreach Team. The panel noted the documentary evidence within the policy which stated that an SBAR "must be used" in such circumstances. The purpose of the SBAR tool was to provide a structured method of communication, ensuring that relevant clinical information was clearly conveyed to both medical and nursing staff and enabling an appropriate plan of care to be formulated.

The panel found that you failed to complete an SBAR form despite recording a NEWS score of 11. A NEWS score of 11 indicated a significantly deteriorating patient who required urgent escalation. The panel also noted that there was no evidence within the nursing records to indicate that an SBAR had been completed or that the required information had otherwise been communicated in a structured manner.

The panel considered that the omission was serious. Given your training, knowledge of the NEWS escalation process, and the mandatory nature of the policy requirement, you knew of the importance of completing the SBAR form. The panel was satisfied that the failure deprived other healthcare professionals of an important communication tool designed to support timely clinical decision-making and patient safety.

Taking all the circumstances into account, the panel concluded that your failure to complete an SBAR form in the context of a NEWS score of 11 represented a serious departure from expected professional standards such as to amount to gross negligence. Accordingly, the panel determined that Charge 1d(ii) amounted to misconduct.

**Charge 1(d)(iii) & (iv):**

The panel considered Charges 1d(iii) and 1d(iv) together. The panel attached particular weight to the clinical context in which these omissions occurred. Patient A had been assessed as having a NEWS score of 11, indicating a severely deteriorating patient requiring urgent assessment, monitoring and escalation. Mr Yarrow's evidence was that any patient with a NEWS score of 5 or more, or 3 in a single parameter should also have a fluid balance chart and a Sepsis screen completed as per the NEWS protocol and as documented on the reverse of the NEWS chart. The panel noted that the sepsis screening tool was specifically designed to facilitate the early identification and treatment of sepsis and formed an integral part of the Trust's escalation procedures.

The panel was satisfied that you had received training in NEWS assessments, sepsis recognition and escalation protocols and therefore understood both the purpose and the importance of the sepsis screening tool and the circumstances in which it should be used. Despite recognising that Patient A was deteriorating and recording a NEWS score of 11, you failed to complete the screening tool and failed to continue documenting fluid balance measurements after 11:00.

The panel considered that these omissions demonstrated a deeply concerning disregard for fundamental aspects of nursing care at a time when Patient A required enhanced monitoring and assessment. The failure to utilise the sepsis screening tool undermined the mechanisms designed to identify and respond promptly to a potentially life-threatening condition, whilst the failure to maintain accurate fluid balance records deprived the clinical team of important information regarding the patient's condition.

Taking all of the circumstances into account, the panel concluded that your conduct represented such a serious departure from the standards expected of a Registered Nurse that it amounted to gross negligence. The panel therefore determined that Charges 1d(iii) and 1d(iv) amounted to misconduct.

**Charge 1(d)(v):**

In considering whether Charge 1d(v) amounted to misconduct, the panel attached significant weight to the evidence concerning Patient A's oxygen saturation levels and your response to those observations. The panel noted the evidence of Mr Yarrow, who stated that Patient A's oxygen saturation level was recorded as 84% at 10:30 by you, a level which was significantly below the normal range of above 95% and indicative of a seriously unwell patient. Mr Yarrow's evidence was that supplementary oxygen should have been administered in response to such a reading as a matter of urgency and that this need ought to have been apparent when you had earlier documented that Patient A appeared "poorly", cold and clammy. The medical notes make clear that when supplementary oxygen was provided later, it was at a high level because the patient's blood was, so oxygen depleted, indicative of a highly unwell patient in urgent need of treatment. You failed to take the appropriate, or any, action despite noting that the patient was severely unwell.

The panel considered your explanations regarding oxygen administration. It noted that during the investigation you stated that you could not recall whether oxygen had been administered but believed that the patient had an oxygen mask on. On reviewing Patient

A's NEWS chart, the panel noted that you had documented that the patient was breathing air and not on oxygen. Similarly, Mr Yarrow recorded that during interview you stated that you knew the patient had oxygen because the patient was looking unwell. However, the panel found no documentary evidence within the nursing records, observation charts or other contemporaneous records to demonstrate that supplementary oxygen had in fact been administered by you or that its administration had been recorded.

The panel accepted Mr Yarrow's evidence that, had the supplementary oxygen been administered and documented, Patient A's NEWS score would have increased from 12 (you had incorrectly recorded it as 11) to 14, thereby indicating an even greater level of clinical concern and requiring urgent escalation. The panel considered that recognising the need for oxygen in a patient with oxygen saturations of 84% did not require specialist knowledge or advanced training. Rather, it was a fundamental aspect of nursing care which any Registered Nurse would be expected to appreciate. The panel was satisfied that you knew, or ought to have known, the seriousness of Patient A's condition and the need for appropriate intervention.

The panel concluded that the failure either to administer supplementary oxygen or to record that it had been administered constituted a serious departure from the standards expected of a Registered Nurse. Given the severity of Patient A's clinical condition, the significantly abnormal oxygen saturation levels, and your failure to take or document appropriate action, the panel determined that Charge 1d(v) amounted to gross negligence and so amounted to misconduct.

In summary, in reaching its decisions, the panel concluded that the failings within Charge 1a and Charge 1b, whilst serious and reflective of poor professional practice, remained matters of incompetence and did not cross the threshold of gross negligence required for a finding of misconduct.

The panel determined that the conduct underpinning Charges 1c and 1d amounted to a serious departure from the standards expected of a Registered Nurse such as to amount

to gross negligence. This is because your patient was presenting as severely unwell, you knew what needed to be done, but failed to take no or any appropriate action. This was a reckless disregard of the needs of the patient, of which you were aware, when you knew what needed to be done. Accordingly, the panel found that those matters crossed the threshold from incompetence into misconduct.

### **Submissions on impairment**

Mr Choudhury moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Choudhury submitted the concerns in relation to your lack of competence remain highly relevant, alongside the misconduct findings that have been proved. Whilst the NMC acknowledges that the underlying events occurred in 2019 and that the panel should give significant weight to the passage of time, he submitted that the mere passage of time does not resolve the concerns identified in this case.

Mr Choudhury accepted that you have undertaken a considerable amount of training and education since the events in question and that positive testimonials have been provided regarding your current practice as a nurse. However, he invited the panel to consider the nature and relevance of that evidence. In particular, he noted that many of the courses completed were online and did not directly address the key clinical concerns arising from this case. He further submitted that your current practice has largely been confined to care home settings, which are generally lower-risk environments than acute hospital wards, and therefore do not provide an equivalent opportunity to demonstrate competence in managing deteriorating patients.

Mr Choudhury submitted that the NMC accepts that your remorse, apology and insight were genuine.

Mr Choudhury submitted that a significant aspect of your case has been your wish to return to hospital practice to redeem yourself. However, you have been unable to secure such employment because of these ongoing NMC proceedings. Mr Choudhury submitted that this explanation should be treated with caution. He submitted that you are unable to provide clear details of recent applications or rejections and have produced no documentary evidence demonstrating that hospitals had declined to progress your applications because of the NMC referral. Whilst experienced panels may recognise that regulatory proceedings can sometimes create practical difficulties for registrants seeking employment, he submitted that this case is distinguishable because no interim order has ever been imposed. In those circumstances, he submitted that there is insufficient evidence to conclude that the referral to the NMC has prevented you from obtaining hospital employment and thereby prevented you from demonstrating strengthened practice.

Mr Choudhury further submitted that your clinical experience since 2021 demonstrates only limited progression beyond basic nursing functions. While noting the value of your current nursing practice, he also noted that you described your role as predominantly involving assisting residents with activities of daily living, medication administration (excluding intravenous medication), personal care, meal provision, wound care, NEWS scoring and fluid balance monitoring. However, he submitted that you have not been exposed to, or tested in, situations comparable to those that arose in relation to Patient A. In particular, you have not demonstrated competence in managing a seriously deteriorating patient, such as one presenting with a NEWS score of 7 or above or a critically elevated potassium level. Mr Choudhury submitted that the panel should carefully consider what assurance it can have that you would now recognise, assess and respond appropriately to a comparable clinical situation, should one arise in practice today.

Mr Choudhury submitted that while your testimonials are generally positive and consistent with observations made by NMC witnesses regarding your character and work ethic, there is a notable absence of evidence from clinical supervisors or managers within the various care homes where you have worked over the last five years. He submitted that such evidence would have been particularly valuable in assessing whether the concerns identified in this case have been fully addressed.

Turning to the misconduct findings, Mr Choudhury submitted that the proved charges involved a series of actions and omissions which represented serious departures from the standards expected of a Registered Nurse and fundamental breaches of the Code. He submitted that the misconduct engaged core tenets of the nursing profession, namely the duty to safeguard patients and maintain public trust.

Mr Choudhury submitted that limbs a, b and c of the Dame Janet Smith's impairment test are engaged. He submitted that Patient A was placed at risk because of your misconduct and that there remains a risk of repetition because you have not been tested in a clinical environment comparable to that in which the original concerns arose. Given the absence of evidence demonstrating safe practice in an acute hospital setting or experience managing a similarly deteriorating patient, he submitted that the panel cannot be satisfied that the risk has been fully remediated. Accordingly, he invited the panel to find that your fitness to practise remains impaired on both public protection and public interest grounds.

Mr Lo reminded the panel that impairment has no statutory or regulatory definition and is ultimately a matter for the panel's professional judgement. Referring to the principles set out in *Cohen v GMC* [2008] EWHC 581 (Admin), he submitted that the panel should consider whether the conduct that gave rise to the charges was remediable, whether it has in fact been remedied, and whether it is highly unlikely to be repeated. Accordingly, despite the seriousness of the failings identified in 2019 and 2021, he submitted that the panel should not approach the matter on the basis that a finding of impairment must automatically follow from the findings of misconduct and lack of competence.

Addressing the misconduct findings relating to Charges 1(c) and 1(d), Mr Lo submitted that you have demonstrated substantial insight into your failings. He referred the panel to your reflective pieces, which he submitted show a clear understanding of the significance of a NEWS score indicating severe physiological deterioration, the need for immediate escalation, and the risks associated with failing to recognise and respond appropriately to a deteriorating patient. He submitted that you now understand the importance of structured communication through SBAR, the role of accurate fluid balance monitoring, and the need for timely observation, assessment and escalation.

Mr Lo further submitted that you have demonstrated meaningful insight into the factors that contributed to your errors at the time, [PRIVATE] workload pressures. He noted that you accepted personal responsibility for managing those pressures and gave evidence that you would now seek support from senior colleagues [PRIVATE].

In support of remediation, Mr Lo submitted that you had undertaken extensive training in areas relevant to the concerns identified by the panel, including deteriorating patients, sepsis recognition, escalation, medication management and record keeping. He submitted that you have not merely completed training courses but have actively incorporated the learning into your day-to-day practice. He submitted that you have practised safely and without incident for approximately five years since the events in question and that there is no evidence of any recurrence of similar concerns during that period. In his submission, this demonstrated that the risk to patients is now low.

Mr Lo submitted that your insight and remediation extended beyond patient safety considerations. He submitted that you fully accept that your conduct had the potential to undermine public confidence in the nursing profession and recognise the breaches of the NMC Code relating to prioritising people, practising safely, preserving safety, and promoting professionalism and trust. He submitted that you have accepted responsibility for your actions, expressed genuine remorse, and demonstrated a clear understanding of the wider impact of your failings on patients, families, colleagues and public confidence in the profession.

Mr Lo submitted that you have shown insight into each area of concern and have developed the necessary knowledge and skills to address them. In relation to the delayed administration of medication for severe hyperkalaemia, he submitted that you now understand the urgency of such situations, the potentially life-threatening consequences of delay, and the need for prompt treatment and escalation. Similarly, in relation to the documentation concerns, you have demonstrated that accurate and contemporaneous record keeping of clinical intervention is fundamental to effective patient care. He submitted that you now understand the risks associated with inadequate documentation and have implemented safeguards in your current practice to ensure records are accurate, complete and contemporaneous.

Overall, Mr Lo submitted that you have demonstrated substantial insight into the causes and consequences of your failings, have undertaken significant remediation, have maintained safe practice over a prolonged period, and have developed effective strategies to prevent recurrence. He submitted that the deficiencies which characterised your early practice have been remedied and that the risk of repetition is low. Accordingly, he invited the panel to conclude that your fitness to practise is no longer impaired on either public protection or public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *CHRE v NMC and Grant [2011] EWHC 927 (Admin)*, *Cohen v GMC [2008] EWHC 581 (Admin)*, *NMC v Persand [2023] EWHC 3356 (Admin)*, and *R (Sheikh) v GDC [2007] EWHC 2972 (Admin)*, together with the NMC's guidance on impairment (*DMA-1*) and *FTP-16(a) and FTP-16(c)*.

### **Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct or lack of competence, your 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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/ 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) *(n/a)*

The panel found that these three limbs are engaged, looking forward.

The panel found that Patient A was put at risk as a result of your misconduct. Your misconduct had breached a fundamental tenet of the nursing profession by failing to act without delay when you knew that a patient was seriously unwell and urgent action was needed so bringing the nursing reputation into disrepute.

The panel also found that your fitness to practice is currently impaired by reason of lack of competence.

The panel found that you have demonstrated a good level of insight into the concerns identified in this case. Through your reflective pieces and oral evidence, you were able to recognise and articulate the nature of your failings, the risks arising from them, and the potential impact on patient safety, colleagues, and public confidence in the profession. You also demonstrated an understanding of the professional standards expected of a Registered Nurse and were able to explain the steps you would now take if faced with similar situations. The panel accepted that you have shown genuine remorse for your actions and omissions.

The panel accepted that you are a kind and caring nurse. The panel was provided with details of the many training courses you had undertaken over the past years. This included many RCN courses and the mandatory training courses provided by the nursing agency where you have been working over the past 5 years on an ad hoc basis.

Mr Mifa, the branch manager of the agency, confirmed that all of the training he provided was tailored to suit the requirements of his clients, these were residential and Nursing homes, where your nursing practice focused on basic nursing care, supporting activities of daily living, wound care and medication administration.

Mr Mifa also stated that there had been no issues raised by any of the homes where you had worked as an agency nurse. Mr Mifa secured your shifts at a number of nursing homes and reported that on starting a new placement you would be expected to undertake a shadow shift where the home would assess your skills.

However, the panel was not provided with any independent verification of the content or outcomes of these assessments or the seniority of the person assessing you. Mr Mifa is not a Registered Nurse and therefore could not speak to this.

The panel noted that the majority of the training you undertook was conducted online and as such the panel had no evidence before it to show that this training was being put into practice safely and effectively.

The panel noted that there is limited evidence of this training having been tested or demonstrated in a clinical environment comparable to that in which the original concerns arose.

The panel was satisfied that the misconduct and lack of competence in this case are capable of being addressed, as they do not arise from attitudinal concerns or deep-seated behavioural issues. Rather, the concerns relate to clinical practice, knowledge, judgement and decision-making, which are capable of remediation through training, reflection and strengthened practice.

The panel therefore carefully considered the evidence before it in determining whether you have taken sufficient steps to strengthen your practice. The panel took into account the reflective pieces provided by you, the training courses you have undertaken, and the oral evidence relating to your current practice. The panel noted that you have undertaken training in relevant areas, including catheter care, medication administration, patient escalation and the recognition of deteriorating patients. However, whilst the panel was satisfied that some remediation has taken place, it concluded that the concerns have only been partially remedied. Although you have undertaken training and demonstrated an understanding of the lessons learned, much of this training has been completed online and there has been limited opportunity for you to demonstrate these skills in practice within an acute hospital environment comparable to that in which the concerns arose and to which you wish to return.

The panel also noted the absence of continuous, or any, employment in a hospital environment and the lack of evidence from any senior clinical supervisor who had been able to assess your overall competence across all areas relevant to this case. Accordingly, whilst the panel accepted that you have made progress and undertaken meaningful remediation, it is not satisfied that the concerns have been fully remedied. In those circumstances and given that you have not demonstrated competence in a clinical setting comparable to an acute hospital ward, the panel was not persuaded that the risk of repetition is highly unlikely.

For these reasons the panel is of the view that there remains a risk of repetition, given your expressed wish to return to a hospital environment. You have undertaken training, reflected upon your failings and have administered medication within a care home setting for the past five years, but the panel is not satisfied that the concerns identified in this case have been fully remediated as the work you have been doing bears little relation to the work you were doing when the issues resulting in the charges (about the Hospital) arose. The panel noted that it had not been provided with evidence demonstrating that your competencies have been comprehensively assessed in a practical way across all of the areas relevant to the charges. In particular, the panel considered that medication

administration within a care home environment differs materially from medication management within an acute hospital setting.

The panel noted the absence of references from a care home manager, clinical lead, nurse manager or other senior nursing professional able to provide an overarching assessment of your competence based on observation of you in the care home setting, together with the lack of sustained, or any, employment in an acute hospital setting. In those circumstances, the panel was not persuaded that the likelihood of repetition is highly unlikely. The panel considered that, were similar failings to recur, patients could be placed at unwarranted risk of harm and public confidence in the nursing profession could be undermined. The panel therefore decided that a finding of current 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 considered that a finding of current impairment was not also required on public interest grounds. It is not enough that a member of the public might have a generalised concern. There was a finding of current impairment on competency grounds and nothing in the case went above, or beyond, the need to ensure the safety of the public by reason of those competency concerns, dealt with above. The misconduct charges found proved were examples of gross negligence, and the finding of current impairment by reason of those professional competence issues deals with that concern. The panel considered that the finding of current impairment on the grounds of lack of competence was sufficient to maintain public confidence in the profession and declare and uphold professional standards.

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

## **Sanction**

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

## **Submissions on sanction**

Mr Choudhury informed the panel that in the Notice of Hearing, dated 30 April 2026, the NMC advised you that it would seek the imposition of a conditions of practice order for 18 months if the panel found your fitness to practise currently impaired.

Mr Choudhury submitted that a warning or caution would be insufficient, as it would not reflect the seriousness of the case, particularly given Patient A's vulnerability, the risk of harm, and the panel's findings of gross negligence in relation to charges 1(c) and 1(d).

However, Mr Choudhury submitted that suspension or striking off would be disproportionate. He emphasised the mitigating factors, including your genuine remorse, insight, and evidence of strengthened practice. He invited the panel to impose conditions of practice order, as it would be appropriate, proportionate, workable, and sufficient to address the identified public protection concerns.

The panel also bore in mind Mr Lo's submissions that, in accordance with the Sanctions Guidance, the purpose of a sanction is not to punish a registrant but to protect the public. He reminded the panel that any sanction imposed must be proportionate to the facts found proved and the impairment identified.

He acknowledged that you had made serious errors which had the potential to place Patient A at an increased risk of harm. However, he emphasised the significant mitigating factors present in the case. He submitted that you have demonstrated genuine remorse, accepted responsibility for your actions throughout the proceedings, and had taken meaningful steps to strengthen your practice.

Mr Lo submitted that you have worked for five years in your current workplace without any reported incidents. In those circumstances, he submitted that while taking no action or imposing a warning would be insufficient to address the risks identified, a suspension order or striking-off order would be wholly disproportionate. He informed the panel that the conditions proposed by the NMC would be workable and would protect the public and address the concerns identified in the case.

### **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. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The panel found that your delayed response to a deteriorating patient amounted to gross negligence.
- Patient A was a vulnerable patient, and your actions placed them at a risk of harm.

The panel also took into account the following mitigating features:

- You demonstrated genuine remorse for the failings identified.
- You demonstrated insight, including a clear understanding of the omissions, the reasons they occurred, and the risks they created.
- You provided evidence of steps taken to strengthen and develop practice.
- You have practised for five years since the last incident without any reported concerns or further incidents.

The panel first considered whether to take no action but concluded that this would be inappropriate as this would leave the competency issues unaddressed. 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 found that there is a risk to patient and public safety and so a caution order was not appropriate. The panel therefore determined that a sanction that does not restrict your practise would not protect the public.

The panel next considered whether placing conditions of practice on your 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 had regard to the following factors:

- *'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*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *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 considered that your case met these parameters (save that relating to health which did not apply). The panel had regard to the fact that these incidents happened a long time ago and that since 2021 you have practised without incident, albeit in a different setting. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to continue to practise as a nurse until you are able to demonstrate that you are safe to practise unrestricted.

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 you would be willing to comply with conditions of practice.

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

The panel considered that the order should be of 18 months' duration so as to give you time to meet the conditions. If you are able to be assessed as competent before the 18 months elapses it will be open to you to apply for an early review of this order.

The panel was of the view that imposing either a Suspension Order or a Striking-Off Order would be disproportionate and would not be a reasonable response to the circumstances of your case. The panel considered that the concerns identified relate to competency issues that are capable of being addressed through targeted remediation and conditions of practice. A suspension order would not address those concerns and would be more restrictive than necessary. In light of this, the panel concluded that a suspension order would not be appropriate or proportionate. Having reached that conclusion, the panel was satisfied that a striking-off order, being the most restrictive sanction available, would be wholly disproportionate.

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

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

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

1. By the 14 September 2026 you must develop and inform the NMC of a Personal Development Plan ('PDP') in the following areas:
  - a) Medication Knowledge and Administration;
  - b) Record Keeping;
  - c) Recognising, Escalating and managing Deteriorating Patients;
  - d) Patient Assessment

2. To conclude the PDP, you must pass a Competency Based Assessment, having notified the NMC in advance of the basis of assessment and the identity of the assessor.
3. You must meet and document with a supervisor, line manager or mentor (who must be a Registered Nurse) monthly to discuss your performance and PDP in relation to:
  - a) Medication Knowledge and Administration;
  - b) Record Keeping
  - c) Recognising and Escalating Deteriorating Patients;
  - d) Patient Assessment
4. 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 for a minimum period of three months, or at a nursing home or care home where you have already worked for an aggregate of three months through that agency.
5. You must not be the Nurse in Charge of any shift in a hospital environment, until such time as you have completed the Personal Development Plan and have been assessed by a practice educator (or equivalent) as competent to undertake a Band 5 position, as the nurse in charge.
6. You must ensure that you are supervised by another substantive Registered Nurse any time you are working. They do not need to watch you continuously, but they must be able to oversee your practice.

7. Seven days in advance of the next NMC hearing or meeting you must send the NMC a report in relation to your progress on your PDP from either:
  - a) a line manager
  - b) a Mentor or Supervisor
  
8. You must keep us informed about anywhere you are working by:
  - a) Telling your case officer within seven days of accepting or leaving any employment.
  - b) Giving your case officer your employer's contact details.
  
9. You must keep us informed about anywhere you are studying by:
  - a) Telling your case officer within seven days of accepting any course of study.
  - b) Giving your case officer the name and contact details of the organisation offering that course of study.
  
10. You must immediately give a copy of these conditions to:
  - a) Any organisation or person you work for.
  - b) Any employers you apply to for work (at the time of application).
  - c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
  
11. You must tell your case officer, within seven days of your becoming aware of:
  - a) Any clinical incident you are involved in.
  - b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

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

a) Any current or future employer.

b) Any educational establishment.

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

The period of this order is 18 months.

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

### **Interim order**

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

### **Submissions on interim order**

The panel took account of the submissions made by Mr Choudhury. He submitted that an interim order is necessary.

The panel also took into account the submissions of Mr Lo.

The panel accepted the advice of the legal assessor.

This will be confirmed to you in writing.

### **Decision and reasons on interim order**

The panel was satisfied that an interim order is necessary for the protection of the public. 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 18 months.

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

That concludes this determination.