

Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 August 2026 – Tuesday, 18 August 2026
Monday, 26 October 2026

Virtual Hearing

Name of Registrant:	Rachael Anne Delaney
NMC PIN:	22H1085E
Part(s) of the register:	Registered Nurse - Adult (RNA) 3 October 2023
Relevant Location:	Bradford
Type of case:	Misconduct/Lack of competence
Panel members:	Rachel Merelie (Chair, Lay member) Hazel Walsh (Registrant member) Margaret Stoddart (Lay member)
Legal Assessor:	Graeme Henderson (10 August 2026 – 14 August 2026) Alain Gogerty (17 August 2026 – 18 August 2026) Giovanna Palmiera (26 October 2026)
Hearings Coordinator:	Teige Gardner
Nursing and Midwifery Council:	Represented by Benjamin D'Alton (10 August 2026) and Giedrius Kabasinskas (11 August 2026 – 18 August 2026 & 26 October 2026), Case Presenter
Ms Delaney:	Present and represented by James Wilkinson (10 August 2026 – 18 August 2026 & 26 October 2026), (Unison)
Facts proved by way of admission:	Charges 2, 3, 4, 5, 6, 7, 8 and 11(c)(ii)
Facts proved:	Charges 1, 9, 11(a), 11(b) and 11(c)(i)
Facts not proved:	Charges 10, 12 and 13

Fitness to practise:

Impaired

Sanction:

Conditions of practice order (12 months)

Interim order:

**Interim conditions of practice order
(18 months)**

Application for an adjournment

At the outset of the hearing, the panel heard an application for an adjournment from Mr D'Alton, on behalf of the Nursing and Midwifery Council (NMC). He submitted that the original case presenter for this case has fallen unexpectedly ill and will be unable to present this case. He informed the panel that a new case presenter has been found to present this case, but they will need the rest of the day to prepare for the case. He submitted that the case presenter needs this time to familiarise himself with the case and therefore an adjournment until tomorrow morning is required.

Mr Wilkinson did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel took into consideration the circumstances surrounding the adjournment application. It noted that the original case presenter was unexpectedly unwell, and another case presenter has been found to cover this case. The panel accepted Mr D'Alton's submission that the new case presenter will need time to prepare to present this case. The panel was of the view that adjourning this case would not cause any unfairness to you. Therefore, the panel accepted the application and determined to adjourn this case until Tuesday 11 August 2026.

Details of charge (as amended)

That you, a registered nurse, whilst employed by Bradford District Care NHS Foundation Trust (the 'Trust') as a band 5 nurse:

1. Between 12 December 2023 and 12 August 2024, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in the following areas:
 - a) Medication administration,
 - b) Record keeping,
 - c) Patient safety

As set out in, but not limited to, charges 2 to 10.

2. On 27 December 2023, you used the wound template when you should have used:
 - a) The pressure ulcer template;
 - b) Leg ulcer template.
3. On 27 February 2024 failed to complete:
 - a) Any or adequate information regarding a pressure ulcer.
 - b) A full initial visit template;
 - c) Pressure ulcer assessment;
 - d) Fire risk assessment;
 - e) Follow up care plans.
4. On 29 December 2023, you administered Tinzaparin medication to an unknown patient outside the two-hour safe window due to not adequately checking the patient records,
5. On 29 December 2023, incorrectly documented blood glucose levels and/or failed to respond appropriately or at all to blood glucose levels being below 5mmols.
6. On 29 December 2023, ended care plans for blood and urine tests without documenting reasons or carrying out interventions.
7. On 22 February 2024, documented that you had administered 18 units of insulin to Patient A when 16 units should have been administered.
8. On 27 February 2024, failed to administer insulin to Patient B because you did not scroll down to the patient's entry on your ledger.
9. On 28 February 2024, administered insulin to Patient A who was not part of the district nursing case load and/or failed to make records of your visit to this resident.

10. On 29 April 2024, unsafely broke the skin of Patient C when popping blisters.

11. Acted outside the scope of your competence, in that you:

- a) On or around 11 April 2024, applied a compression bandage to Patient D when you had not been signed off as competent to do so;
- b) On 29 April 2024, undertook dopplers on Patient C when you had not been trained to do so and/or incorrectly calculated the results;
- c) On 3 June 2024:
 - i. Changed Patient E's catheter without clinical justification and/or when it was outside of your scope of competence;
 - ii. Failed to record any clinical justification in Patient E's notes for changing the patient's catheter.

12. On 8 June 2024, amended the patient notes at charge 11.cii. to indicate that Patient E's catheter was bypassing when it was not.

13. Your conduct at charge 12 was dishonest, in that you intended to create the misleading impression that the catheter was bypassing when it was not.

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence at charges 1-10 and/or misconduct at charges 11-13.

Decision and reasons on application to amend the charge

When the hearing resumed on the second day, the panel heard an application from Mr Kabaniskas, on behalf of the NMC, to amend the wording of charge 3.

The proposed amendment was to change the date of the charge. It was submitted by Mr Kabaniskas that the proposed amendment would provide clarity and more accurately reflect the evidence. He submitted that this would not be unfair to you, as the

mischief of the charge remains the same, only the date needs to be amended to match the evidence.

14. On 27 ~~December 2023~~ February 2024 failed to complete:

- f) Any or adequate information regarding a pressure ulcer.
- g) A full initial visit template;
- h) Pressure ulcer assessment;
- i) Fire risk assessment;
- j) Follow up care plans.

Mr Wilkinson did not oppose this application.

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

Mr Wilkinson made a request that this case be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Kabasinkas did not oppose this application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may

hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session [PRIVATE].

Decision and reasons on application to amend the charge

Prior to final submissions, the panel heard an application made by Mr Kabaniskas, on behalf of the NMC, to amend the wording of charge 1.

The proposed amendment was to change the charge to refer to charges 2 to 10, instead of 2 to 12. It was submitted by Mr Kabaniskas that the proposed amendment would provide clarity and more accurately reflect the charges that relate to lack of competence. He submitted that this would not be unfair to you, as the mischief of the charge remains the same, only the charges referred to need to be amended to match the lack of competence charges.

1. Between 12 December 2023 and 12 August 2024, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in the following areas:
 - d) Medication administration,
 - e) Record keeping,
 - f) Patient safety

As set out in, but not limited to, charges 2 to 42 10.

Mr Wilkinson did not oppose this application.

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.

Background

You commenced employment with Bradford District Care NHS Foundation Trust (“the Trust”) on 16 October 2023 as a Band 5 Community Staff Nurse, within the Bingley District Nursing Team. This was your first role as a registered nurse, having qualified from the University of Bradford in September 2023.

In common with all new staff you entered a six month probationary period (subsequently extended to nine months). As a newly qualified nurse, you also entered the Trust’s twelve month preceptorship programme, which is a structured period of support for your transition as a newly qualified nurse.

As a District Nurse, you primarily visited housebound patients and nursing homes to deliver interventions such as wound management, medication administration, catheter care, bowel care and palliative care. You also ran clinics for non-housebound patients. Documentation is captured in patient-held notes and electronically on SystmOne.

You were referred to the NMC on 14 August 2024 from the Trust. The concerns alleged are in relation to medication errors, working outside of your scope of practice and unsafe practices.

It is alleged that on one occasion, you did not correctly check records and then administered Tinzaparin outside of the two-hour window for safe administration.

It is alleged that on another occasion, you administered insulin to a care home resident who was not on your District Nurse (DN) caseload. It is alleged that the patient concerned had been referred to the unplanned care team, who had also visited this patient. Additionally, it is further alleged that you did not maintain

contemporaneous record keeping on System One and this could have potentially led to patient harm.

It is also alleged that you had not visited a patient requiring insulin which was on your scheduled list of visits, and a patient visit was subsequently missed.

It is alleged that you applied compression bandages to a patient when you had not been signed off as competent to do so.

It is also alleged that you had worked outside your scope of practice by changing a catheter for a patient who was at risk of urinary sepsis and who had a specific care plan detailed in their records. It is alleged that as a result of this, the patient was put at a further risk of infection. It is alleged that there was no good reason, justification or rationale for such clinical intervention by you nor was there a clinical rationale documented. It is also alleged that, while on annual leave, you subsequently accessed the patients records and amended them to record that the catheter was bypassing.

It is alleged that you had not been signed off to carry out doppler assessments but had undertaken this task. It is alleged that as a result you had incorrectly calculated doppler results which could have caused patient harm.

In relation to unsafe practice, it is alleged that you broke the skin of a patient in the form of popping a blister. This was reported by the patient themselves and to a senior staff nurse. Your alleged actions could have caused patient delayed wound healing, risked infection and delayed chemotherapy treatment.

Decision and reasons on facts

At the outset of the hearing, following the charges being read, the panel heard from Mr Wilkinson, who informed the panel that you admitted to charges 2, 3, 4, 5, 6, 7, 8 and 11(c)(ii).

The panel therefore finds charges 2, 3, 4, 5, 6, 7, 8 and 11(c)(ii) proved, by way of your admissions.

You did not admit current impairment.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kabasinkas on behalf of the NMC and by Mr Wilkinson, on your behalf.

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

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

- Kelly Golding: District Nurse and your Line Manager and Preceptor at the Trust
- Carla Smith: Registered Nurse and Operational Manager at the Trust
- Laura Grimshaw: District Nurse at the Trust

The panel also heard evidence from you under oath.

The panel heard and accepted the advice of the Legal Assessor who referred to a number of authorities including *El Karout v NMC* [2019] EWHC 28 (Admin).

In that case the Court was critical of the use, by the NMC of hearsay evidence which involved witnesses who spoke to a local investigation but declined to provide witness statements to the NMC. There was no record of what these witnesses actually said. In

the circumstances the Court express concerns regarding the admissibility of the evidence.

The legal assessor also referred to the case of *Dutta v GMC* [2013] EWHC 132 (Admin) which made it clear that the starting point in determining facts was to consider contemporary documents and agreed evidence, before considering live evidence.

The panel considered the witness and documentary evidence provided by both the NMC and you. The panel first considered each of the disputed charges relating to lack of competence referred to in charge 1, namely charges 9 and 10. It then considered charge 1, before considering the charges relating to misconduct in 11 to 13. The panel made the following findings.

Charge 9

“On 28 February 2024, administered insulin to Patient A who was not part of the district nursing case load and/or failed to make records of your visit to this resident..”

This charge is found proved.

In reaching this decision, the panel took into account your oral and documentary evidence, the patient records and the oral and documentary evidence from Ms Golding and Ms Smith. Although the administration of insulin was allocated to the district nursing team it was assigned to the unplanned district nursing team and not your team (the district nursing team).

The panel was satisfied that that you had administered insulin to Patient A you accepted that you had done so in both your written and oral evidence. The panel further noted the witness statements from Ms Golding and Ms Smith which also confirm that you had given Patient A insulin, who was not part of the planned district nursing case load.

In Ms Golding’s witness statement, she stated:

'Ms Delaney was in a care home visiting a patient. Ms Delaney was then approached by the carers and the family to administer insulin to a patient with dementia that had been discharged from hospital. Insulin administration is always allocated by a coordinator. When a patient has been in hospital, the hospital then sends a referral, which the unplanned community nursing team generally pick up for the same day visits. This had already been given to a nurse from the unplanned team. Ms Delaney failed to check this with myself as the coordinator for the day, nor did she check the hospital referral for any dose changes. Instructions should only come from a prescribing professional for administration of medication, not from family.'

Ms Golding and Ms Smith confirmed that Patient A was not part of the planned district nursing case load during their oral evidence. The panel noted your written and oral evidence that you were, at this time, unaware that if a patient was admitted to Hospital they are no longer on the planned district nursing case load.

However, the panel determined that Patient A had been administered insulin by you and they were not part of the district nursing case load.

The panel then considered whether you failed to make records of your visit to Patient A. The panel was satisfied that, having administered insulin you were under a duty to record the same. The panel took into account your oral and documentary evidence. In your oral evidence, you said that you had booked an appointment to administer insulin to Patient A on your ledger thinking that the coordinator had forgotten to do so. This entry into the ledger was made at 09:45, which suggests you had connectivity at this point. However, the patient notes on SystmOne were not completed until 10:50 and it is unclear why you did not update the notes at the first opportunity.

The panel further noted your written statement, in which you state:

“I went to the residential side where Patient A’s room was allocated and gathered the relevant equipment and the green folder which included the diabetic management plan documentation.”

The panel noted that in the incident report, dated 3 March 2024, and during your oral evidence, you said you had recorded your administration of insulin to Patient A in the green folder.

The NMC’s case was partly founded on the fact that there is documentation to the effect that the Unplanned team visited Patient A and was told by Patient A’s relatives that you had administered Insulin. However, the NMC did not provide any evidence to contradict your assertion that you completed all of the physical paperwork (the green folder) in the Home. In your probation report it was noted that ‘...*the handheld documentation had been completed but the SystemOne record had not been updated*’.

In light of the above, the panel determined that you had made a record of your visit to Patient A. Therefore, this charge is not proved in relation to this element.

In summary, the panel concluded that this charge is found proved only in that on 28 February 2024, you administered insulin to Patient A who was not part of the district nursing case load.

Charge 10)

“On 29 April 2024, unsafely broke the skin of Patient C when popping blisters.”

This charge is found not proved.

In reaching this decision, the panel took into account Patient C’s patient records, your oral and documentary evidence, the email from the senior community staff nurse to Ms Golding and the oral and documentary evidence of Ms Golding and Ms Smith.

The panel noted Patient C's patient records, which set out a timeline of events. It noted that on 29 April 2024 you did a home visit for Patient C. In your record of this visit, entered the following morning, you wrote:

'...blister popped whilst removing the old dressing, drained the fluid, patients request due to discomfort.'

Ms Golding and Ms Smith, during their oral evidence, stated that it was uncommon for blisters to pop as a result of the removal of a dressing, as it was the absorbent part of the dressing that touches the blister. However, both witnesses conceded that it is not impossible that blisters could pop as a result of changing a dressing.

The panel noted other evidence, namely the file note from 7 June 2024 that contained notes from your meeting regarding this incident with Ms Golding. In these file notes, it states that it had been reported that you had '*actively popped blisters*', which you denied categorically. In all your responses to the charges, you deny popping the blisters and say you would never do this.

In your response to the probation review, on 19 July 2024, you state:

'Blisters: This is incorrect and untrue information. I have never popped a water blister and have the clinical knowledge not to do so. This I find absurd and targeted. When I visited the patient himself and his wife wanted to pop the blister themselves and I advised against this. I stated that having the fluid will aid the healing of the tissue underneath and stop any infection. He seemed to be happy with this. ... When I was removing the dressing it was leaking so I reached for the sterile green tray for the liquid to drain into. The blisters appeared to have burst when the dressings were being removed if not before this.'

Your oral evidence supported this account.

The principal evidence relied on by the NMC was an email from a Senior Community Staff Nurse to Ms Golding dated 6 June 2024. It is said in that email that Patient C

alleged, during the course of a telephone call, between her and Patient C in May 2024, that you popped the blisters on his feet. There is no record of what Patient C said precisely. No incident report exists. There was no follow up enquiry, with Patient C, by either the Trust or the NMC. The Senior Community Staff Nurse did not give evidence.

The panel had serious concerns over whether this imprecise tertiary hearsay evidence was admissible. In any event it could attach no weight to this evidence. Given the passage of time between 29 April 2024 and 6 June 2024 it is not clear when Patient C said the incident happened, nor precisely when the telephone call took place. Although Patient C claimed to have identified you as the nurse involved, you were not the only nurse who visited Patient C. The email of 6 June 2024 contains the Senior Community Staff Nurse's conclusion of what was said but no actual details of the nature of the telephone call, between her and Patient C, on an unknown date. The NMC has not produced any other document that would provide greater details of what Patient C alleged. It is unclear why it was only raised with you several weeks after the event allegedly occurred.

Having considered all the contemporaneous evidence, the panel noted that there is nothing to suggest that you actively popped the blisters of Patient C. Therefore, the panel determined that, on the balance of probabilities, you did not unsafely break the skin of Patient C when popping blisters.

Charge 1)

'Between 12 December 2023 and 12 August 2024, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in the following areas:

- a) Medication administration,*
- b) Record keeping,*
- c) Patient safety*

As set out in, but not limited to, charges 2 to 10.'

This charge is found proved.

In relation to charge 1, the panel finds the facts alleged in relation to medication administration, record keeping and patient safety as set out in this decision. The panel would go onto determine whether they amount to lack of competence at the next stage.

Charge 11(a)

“Acted outside the scope of your competence, in that you:

On or around 11 April 2024, applied a compression bandage to Patient D when you had not been signed off as competent to do so;

This charge is found proved.

In reaching its decision, the panel took into account Patient D's patient notes, the file note made by Ms Grimshaw of the meeting between you and Ms Grimshaw dated 12 April 2024 and the oral and documentary evidence provided by Ms Grimshaw, Ms Golding and Ms Smith as well as your oral and documentary evidence.

The panel considered Patient D's notes, which confirmed that you had applied a compression bandage to Patient D. The panel then went onto consider if you had been signed off as competent to do so. The panel noted that, in your oral evidence, you said you had been verbally told you were competent to apply compression bandages to patients. However, Ms Grimshaw, Ms Golding and Ms Smith, during their oral evidence, stated clearly that sign offs always had to be in writing, rather than given verbally. Whilst you may have been told that you had performed supervised tasks well that was not sufficient, in the absence of written confirmation for you to be regarded as competent to perform these tasks without supervision. The panel also noted that, in your oral evidence, you said that you signed off students and health care support workers in their competencies so were aware of the Trust's expectations regarding written sign offs for competencies.

The panel then considered the file note between you and Ms Grimshaw, dated 12 April 2024, which states:

'I was aware Rachael had seen the clinic patients on her own and I wanted to confirm what she had done in terms of dressings. Rachael stated she felt it went really well, Rachael confirmed that she had applied KTWO and Actico [compression bandages] as per care plans to several patients in clinic. Rachael also confirmed that she saw a pop up message from DN SM to state to only apply double Klite [non-compression bandage] to all patients. Unfortunately SM went off line and Rachael unable to message back. Rachael was aware she hadn't been signed off as competent but she stated "I felt competent to undertake the compression bandaging"'

The panel noted that this file note indicates that, at the time of the incident, you were aware you had not been signed off as competent, rather you '*felt competent*'. In your oral evidence you said you had previously applied compression bandages to patients (including the week before to Patient D). You also said that Ms Golding had told you that you were competent to apply them. Nevertheless, the panel preferred the consistent evidence provided by Ms Golding, Ms Smith and Ms Grimshaw with the contemporaneous file note which stated clearly that you had not been signed off as competent to apply compression bandages and you were aware that this was the case. Further, the panel noted that you had been directed to use a non-compression bandage for Patient D but chose to disregard this.

Therefore, the panel determined that you had applied compression bandages to Patient D when you had not been signed off as competent to do so.

Charge 11(b)

"On 29 April 2024, undertook dopplers on Patient C when you had not been trained to do so and/or incorrectly calculated the results;"

This charge is found proved.

In reaching this decision, the panel took into account Patient C's notes, Ms Golding's file note of the meeting between you and Ms Golding, dated 7 June 2024, and the documentary and oral evidence of you, Ms Golding Ms Grimshaw and Ms Smith.

The panel accepted the evidence that you had received training in undertaking dopplers. It noted your statement, in which you say:

'I did training with other staff on dopplers and took it upon myself with authorisation from management to do a morning clinic at a different practice to gain competencies.'

This was confirmed by Ms Golding and Ms Grimshaw who stated that you had undertaken training in undertaking dopplers. Therefore, in relation to this aspect of the charge, the panel finds that you had received training and that part of the charge was not proved.

The panel noted that Patient C's notes record that you had visited the patient on 29 April 2024 for doppler assessment and lower limbs. The doppler measurements were recorded in Patient C's notes on 30 April 2024.

The panel then considered the file note, dated 7 June 2024, and Ms Grimshaw's witness statement, which makes reference to you incorrectly calculating the results of a doppler. In the file note, it states:

'Dopplers – explained she had undertaken dopplers without being supervised, and that unfortunately the calculations I had seen on patients... C were wrong.'

In her witness statement, Ms Grimshaw states:

"Ms Delaney had not been signed off as competent and therefore worked outside of her scope of practice. Due to Ms Delaney lack of competence, this resulted in incorrect results. They were incorrectly calculated, which could potentially then indicate a wrong treatment plan for the patient."

This was supported by Ms Grimshaw's oral evidence, in which she told the panel about this incident. During oral evidence, you also informed the panel that although you were confident to take the measurements, you were not confident to calculate the results of a doppler. You informed the panel that you usually sought Ms Goldings help in calculating dopplers but she was unavailable. You sought the help of another Band 5 but the calculation which was produced, as a result of that discussion, was wrong. The responsibility for seeing that the calculation was correct was yours.

The panel determined that, on the balance of probabilities, you had incorrectly calculated the results of Patient C's doppler.

Charge 11(c)(i)

"On 3 June 2024:

- i. Changed Patient E's catheter without clinical justification and/or when it was outside of your scope of competence;"*

This charge is found proved.

In reaching this decision, the panel took into account Patient E's patient record, Ms Grimshaw and Ms Goldings oral and documentary evidence, a file note made by Ms Golding following discussions with you on 7 June 2024 and your oral and documentary evidence. You admit that you changed the catheter. The panel noted that Ms Grimshaw and Ms Golding were not present at the time that the catheter was changed and their evidence was commentary of what they were told and what you had written.

The panel heard evidence from Ms Grimshaw, Ms Golding and Ms Smith that indicated that you were competent to carry out catheter changes on patients. The panel accepted this evidence and did not find that you had acted outside of your scope of competence when changing Patient E's catheter. The panel then considered whether it was clinically justified for you to have changed Patient E's catheter.

The panel noted Patient E's patient record, in which you stated:

'Yes patient requested catheter changing today instead of this Friday due to bypassing yesterday evening. Used clinical judgement and changed catheter to avoid any complications.'

The panel noted that this incident occurred on 3 June 2024, and this entry was amended by an entry submitted on 8 June 2024. You did not record that the catheter was bypassing at the time you changed it, rather you had been informed by Patient E's relative that the catheter was bypassing the night before. Nevertheless, you gave a detailed explanation of your rationale during oral evidence where you said it was bypassing at the time of the visit but this is not what you had recorded in the patient's amended notes. The panel also noted the oral evidence from Ms Grimshaw and Ms Golding, who told the panel that if the catheter was bypassing when you visited you would have had clinical justification to change it.

You told the panel that, having changed the catheter on 3 June 2024, you had checked Patient E's notes and seen the Trust's discharge summary, in which you said it was suggested that the catheter was a week overdue to be changed. The panel did not see this discharge note you referred to and therefore could not test this evidence. However, the panel did have sight of Patient E's patient record, in which you stated that the catheter was due to be changed "*this Friday*" (which would have been 7 June 2024).

Ms Grimshaw commented during her oral evidence that there was no written record that Patient E's catheter was bypassing at the time of your visit. In Ms Grimshaw's witness statement, she stated:

'Ms Delaney changed the catheter of a patient at risk of urinary sepsis on 3rd June 2024, despite it being unnecessary. It was unnecessary because there were no clinical indications that it needed changing. The catheter was bypassing the day before and the patient requested Ms Delaney to change the catheter even though at the time of the visit it was not necessary. Ms Delaney had not documented in System One that the catheter was bypassing the day before, and

confirmed in a discussion with Ms Golding that it was not bypassing and therefore there was no clinical reason to change the catheter.'

Ms Golding told the panel during oral evidence that changing the catheter of a very vulnerable patient, as discussed with the General Practitioner (GP) on 31 May 2024, would be a “*last resort*” and that other solutions would be tried first. She also told the panel that it was possible that a catheter would bypass intermittently. Ms Grimshaw told the panel during oral evidence that Patient E, at the time of the incident, was also constipated which can sometimes cause a supra-pubic catheter to intermittently bypass. She told the panel that the catheter change you carried out was not clinically justified in this instance due to Patient E’s high risk of sepsis and therefore changing the catheter presented a significant clinical risk to the patient.

In the contemporaneous file note taken by Ms Golding of a discussion between you and Ms Golding, dated 7 June 2024, it states:

‘Changing Patient E catheter - not due until Friday, and Rachael had documented this change was due to patient request. Discussed with Rachael whether she had a clinical rationale for this. She paused, and then stated Patient E husband had said it was bypassing on Monday. Then changed this to Sunday. At the point of changing it, it was not bypassing and there was no clinical justification. I also highlighted the documentation by myself and GP M Francis following both our reviews on Friday 31st May re Urinary Sepsis plan as patient is high risk of this... She stated that she had seen the patient before and changed it many times... I also stated that her skill in changing it was not in question, but the rationale and risk. She accepted that this was the wrong thing to do.’

The panel accepted the evidence from Ms Grimshaw and Ms Golding in relation to this charge. The panel was of the view that their assessment of events were consistent throughout their oral and documentary evidence, and with the file note, dated 7 June 2024, at the time of the incident.

You dispute the accuracy of the file note. It is accepted that Ms Golding did not send you a copy after it was prepared. The panel accepted that the file note was not a verbatim report of your entire meeting with Ms Golding. It was unable to determine the issue of whether or not it was a fully accurate version of the conversation between you and Ms Golding.

However, it found that it was highly likely that Ms Golding raised the issue of whether you had a clinical rationale for changing the catheter. She recorded that in dealing with this issue you informed her that the catheter was bypassing on Sunday but not at the time of your visit. You said nothing more to her in respect of a clinical rationale for changing the catheter.

The panel accepted the NMC evidence that, in the event of a catheter bypassing it would be necessary to carry out a clinical assessment to ascertain the cause of the bypass. This would include a nurse satisfying themselves that the only solution to the problem was to change the catheter. You provided no evidence, in the written records, that you carried out any assessment of the cause of the bypass. There is no contemporary record of you telling Ms Golding that you had carried out such an assessment.

In the absence of such an assessment being made the changing of the catheter was without clinical justification.

In summary the panel determined that this charge is proved, only in that you had changed Patient E's catheter without clinical justification.

Charge 12)

"On 8 June 2024, amended the patient notes at charge 11.cii. to indicate that Patient E's catheter was bypassing when it was not."

This charge is found not proved.

In reaching this decision, the panel took into account Patient E's patient notes and your oral evidence, as well as the oral and documentary evidence of Ms Golding and Ms Grimshaw.

You told the panel during oral evidence that you had amended the entry in Patient E's patient notes in order to accurately reflect the circumstances of the catheter change. The panel considered Patient E's patient notes and noted that you had amended the entry on 8 June 2024, five days after you had changed the catheter on 3 June 2024. You had amended the record following your discussion with Ms Golding on 7 June 2024 when she asked you about the clinical justification for the change.

The panel could not know what you had initially written in the patient record as it did not have access to the original entry from 3 June 2026. However, it can infer from the evidence that you updated the patient record to include a comment about the catheter bypassing the night before you changed it.

The panel accepted your evidence in relation to this charge. The panel noted you said you had amended the entry in Patient E's patient notes to more accurately reflect the discussion that had happened between you and Patient E's relative, in that they had told you the catheter had bypassed the day before. The panel was of the view that you had no reason to believe that the catheter had not bypassed the day prior to you changing it and there was no evidence before it that showed the panel definitively that it had or had not bypassed before you changed it.

The panel was of the view that, on the balance of probabilities, you had changed the entry in Patient E's notes to reflect the discussion with their relative rather than indicate the catheter was bypassing when it was not.

Therefore, the panel finds this charge not proved.

Having found charge 12 not proven, the panel allowed charge 13 to fall away.

Fitness to practise

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

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

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

Before hearing submissions on lack of competence and misconduct, the panel heard evidence from Miriam Garnett, a Clinical Lead Nurse and your line manager at Three Valleys Hospital (the Hospital), on your behalf.

Ms Garnett told the panel that the Hospital is a level two rehabilitation hospital for patients with severe and enduring mental health conditions. The Hospital does not accept acute admissions and is mainly responsible for supporting patients to develop essential life skills to move to a less secure setting. She told the panel that there are 35 beds, not all of which are currently occupied and you currently are the only substantive nurse in post responsible for the physical health of the patients. The other nurses are registered mental health nurses. It is these nurses who are responsible for the mental health aspect of patient care and the administration of medications. Ms Garnett also told

the panel that there is not a high turnover of patients in the Hospital and if any of the patients had any acute medical issues, 999 would be called.

Ms Garnett informed the panel that, in your current role, you are mainly responsible for managing the physical health of mental health patients, namely; assessments, care planning and talking about referrals with patients GPs. She also told the panel that you have assisted with ordering in medications, monitoring blood glucose, administering insulin and training members of staff in physical health needs.

Ms Garnett told the panel that, since you have been employed at the Hospital, there have been no concerns regarding your practice. You have adhered to the conditions imposed on your practice and all of the Hospital's policies and procedures. She told the panel that your clinical practice is to a high standard and you have brought expertise to the role and have helped improve patient care. You have worked collaboratively and accepted guidance when appropriate.

Ms Garnett told the panel that there have been no concerns regarding your record keeping or documentation which is at a high standard. She told the panel that, whilst you do not administer medication as part of your regular role, you have assisted in doing so. She told the panel that it is rare that patients at the Hospital require compression bandages or have catheters. However, she told the panel that on one occasion you were required to remove a patient's urethral catheter, which you did successfully. Further, she told the panel that you also applied a compression bandage to a patient and assisted in training other members of staff on how to apply compression bandages.

Submissions on lack of competence and misconduct

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

In coming to its decision, the panel also 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 Kabasinkas invited the panel to take the view that the facts found proved amount to lack of competence and/or 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. He referred the panel to the relevant documents and case law in relation to lack of competence and misconduct.

Mr Kabasinkas identified the specific, relevant standards where your actions amounted to lack of competence and/or misconduct. He submitted that your actions in charges 1 to 9 fell seriously short of the competence expected of a registered band 5 district nurse. He referred the panel to the notes of the meetings you had with Ms Golding and submitted that this is evidence that you were aware of your lack of competence in record keeping, medication administration and patient safety. He submitted that, as evidenced by your probationary period being extended and the probationary report, you were given multiple opportunities to improve your practice, and you were given additional support. He submitted that the contract termination letter you were sent by the Trust highlights the failings in your practice and shows that you had extra training to improve your practice. Therefore, he submitted that charges 1 to 9 amount to lack of competence.

Mr Kabasinkas submitted that your actions in charge 11(a), (b) and (c) amounted to serious misconduct. He submitted that your actions fell seriously short of the standards expected of a registered nurse and you placed patients at a real risk of harm. In relation to charge 11(a), he submitted that you were told not to apply pressure bandages to Patient D and you knew you were not competent to do so but did it anyway. Further, in relation to charge 11(b) he submitted that you knew you were not confident in calculating the results of a doppler but decided that you would do so regardless. In addition, in relation to charge 11(c) he submitted that Patient E was a vulnerable patient

who had a high risk of urinary sepsis. Despite this, you changed Patient E's catheter without clinical justification and placed Patient E at a real risk of harm. He submitted that your actions as set out in charge 11 amounted to serious misconduct.

Mr Wilkinson submitted that your actions at charge 11 in its entirety do not amount to misconduct. He submitted that, whilst he accepts that there was a risk of harm, no actual harm was caused to patients as a result of your actions. In relation to charge 11(a) he submitted that you applied compression bandages due to a lack of communication with the senior nurse. He submitted that communication issues do not amount to serious misconduct. In relation to charge 11(b), he submitted that you have been clear throughout the hearing that you were not confident in calculating dopplers and sought assistance from another registered nurse. He submitted that this does not amount to serious misconduct and no harm was caused to this patient as a result of your actions. In relation to charge 11(c)(i) he submitted that you accept that there was no clinical justification for changing the catheter and your actions amounted to misconduct. However, in relation to charge 11(c)(ii) your actions did not amount to misconduct, as given the lack of clinical justification in relation to charge 11(c)(i), it was technically correct not to record one.

In relation to charges 1 to 9, Mr Wilkinson submitted that your actions did not amount to a lack of competence. He submitted that, as you had recently passed your nursing degree in 2023 before joining the Trust, it would be extremely unlikely that you lacked competence in record keeping, medication administration and patient safety. He submitted that you accept that you made mistakes. He submitted that your actions in charges 1 to 9 could be largely explained by your lack of familiarity with the processes employed by the Trust, rather than a lack of competence in the areas identified. He accepted that charges 4, 7 and 9 were medication errors, but submitted that these took place when you were a new nurse and charge 9 in particular represented a learning opportunity. He further submitted that this is not a fair sample size of the work you did for the Trust, as it encompasses approximately 1% of the work you carried out between 12 December 2023 and 12 August 2024. He submitted that you were also responsible for assessing and signing off health care assistant's clinical skills. He submitted that a nurse lacking in competence would not be trusted with such a task. Therefore, he

submitted your actions as set out in charges 1 to 9 did not amount to lack of competence.

Submissions on impairment

Mr Kabasinskas 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kabasinskas submitted your misconduct and lack of competence, as listed in the charges found proved, put patients at a real risk of harm. He submitted that your actions in charge 8 caused emotional harm to a patient as they were in distress when they informed the Trust about your actions. He submitted that your actions brought the profession into disrepute and you did breach fundamental tenets of the profession, namely; failure to keep timely and accurate notes, patient safety and understanding your limitations.

Mr Kabasinskas submitted that your actions are remediable, as they relate to your clinical practice. He submitted that you have shown some developing insight into the allegations. However, he submitted that you have not accepted responsibility for some of your actions and you have not adequately addressed how your actions affected colleagues, patients, public confidence or the nursing profession. He submitted that you have undertaken relevant training in the areas of concern identified and you have had a sustained period of safe practice since these incidents occurred. However, he submitted that, in your current role, you are not required to administer medication nor are you often required to carry out doppler assessments, change catheters or apply compression bandages. Therefore, he submitted that, whilst you have taken good steps to strengthen your practice, you have not been able to demonstrate your competencies in your current role. Mr Kabasinskas submitted that there is a risk of repetition in this case.

Mr Kabasinkas submitted that, whilst this case is primarily related to protecting the public, there is an element of public interest in this case. He submitted that public confidence would be damaged if you are found not impaired.

Mr Wilkinson submitted that there have been no more concerns raised about your practice, therefore you do not currently put patients at a risk of harm. He submitted that you have shown full insight into the charges found proved and you have included examples of how you would do things differently if placed in a similar position today. He referred the panel to the numerous training certificates you have provided and submitted that you have undertaken extensive training in the areas of concern identified. In particular, he submitted that you have trained colleagues at the Hospital how to change catheters and apply compression bandages. Therefore, he submitted that a finding of impairment is not necessary to protect the public.

Mr Wilkinson submitted that a finding of impairment is not otherwise in the wider public interest. He submitted that a well-informed member of the public would not be concerned in this case, considering the significant insight you have and the relevant training certificates you have provided.

The panel accepted the advice of the legal assessor which included reference to the cases of *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Meadow v General Medical Council* [2006] EWCA Civ 1390, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Schodlok v General Medical Council* [2015] EWCA Civ 769, *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), *Vali v General Optical Council* [2011] EWHC 310 (Admin) and *Council for Healthcare 49 Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) (*Grant*) and *Holton v GMC* [2006] EWHC 2960 (Admin).

Decision and reasons on lack of competence and misconduct

When determining whether the facts found proved amount to misconduct and/or a lack of competence, the panel had regard to the terms of the Code. In particular, the panel found that the following standards were breached:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

6.1 make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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

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

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 complete the necessary training before carrying out a new role

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

20.1 keep to and uphold the standards and values set out in the Code

The panel bore in mind, when reaching its decision, that you should be assessed by the standards of an average registered nurse in your position carrying out the work you were performing, and not by any higher or more demanding standard. The panel accepts that lack of competence has to be demonstrated by reference to a fair sample of your work.

The panel was of the view that your actions, as set out in charges 1 to 9, highlight a clear lack of competence in relation to record keeping, medication administration and as a result patient safety. The panel noted the numerous file notes between you and Ms Golding and the file notes between you and Ms Grimshaw, and the incident reports. It also noted your competency booklet, in which you were not signed off as competent in several areas of your practice. The panel determined that this shows you were aware of the issues with your competence during your employment at the Trust.

The panel also noted the probationary review letter, dated 2 April 2024, which included a list of areas in which the Trust highlighted your lack of competence and provided an

action plan for you to improve your practice. Further, the panel noted that your probationary period had been extended for another three-month period to give you an opportunity to strengthen your practice in the areas identified. The panel therefore determined that you had been given a chance to improve your practice. The panel then noted the termination letter, dated 15 July 2024, which listed reasons for your termination and all the support you had received from the Trust, including 1:1s and the action plan. Therefore, the panel determined that you had been assessed further by the Trust and had failed to strengthen your practice adequately.

The panel considered Mr Wilkinson's submission regarding the sample size of the work you did for the Trust. The panel was of the view that you had limited opportunity to work independently without observations or supervision at the Trust. It noted that this was due to your several periods of absence and the Trust limiting your opportunity to practice independently due to your actions. Therefore, the panel determined that, although you had only practiced independently for a limited time period, the charges found proved represented an adequate sample size of your independent work at the Trust.

The panel has concluded that you demonstrated an unacceptably low standard of professional performance, based on these charges, which it judged to be a fair sample of your work and which could put patients at risk. It concluded your practice fell below the standard that one would expect of a registered nurse acting in the post to which you were appointed and performing the work you were carrying out.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then considered each of the charges separately and made the following misconduct findings:

Charge 11(a):

The panel considered the evidence relating to this charge, and noted that you were specifically told by another, more senior registered nurse not to apply compression bandages on Patient D, and to use an alternative bandage. Further, the panel noted

that you said yourself, in the file note of meeting between you and Ms Grimshaw, that you knew you were not signed off as competent to apply compression bandages to Patient D, but you did it anyway. The panel determined that, in applying compression bandages to Patient D despite knowing you were not signed off as competent to do so and against the advice of another registered nurse, your actions fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 11(b):

The panel accepted that you had received training in undertaking and calculating dopplers. It also accepted your evidence in relation to this charge, in that you were not confident in calculating dopplers and would usually seek assistance from other nurses in conducting this task. The panel was of the view that this was poor practice but was not serious enough to amount to misconduct.

Charge 11(c):

The panel noted that Patient E was a vulnerable patient with a supra-public catheter who was at high risk of urinary sepsis. The panel noted the context in which this incident occurred. Your probation had just been extended, and you would have been aware the situation you were in. Despite this, you did not escalate to a senior nurse on what to do in this specific situation. The panel was of the view that you acted without thought or care when you changed Patient E's catheter. It determined that your actions did fall seriously short of the standards expected by a registered nurse and did amount to misconduct.

The panel questioned why, despite your oral evidence, you had not included that the catheter was bypassing at the time of your visit to Patient E on 3 June 2024. You did not include this in the amended patient records as your clinical justification for changing it. The panel determined that, if you had seen the catheter bypassing at the time of your visit, you should have escalated this and recorded it in Patient E's patient notes as contemporaneously as possible. The panel also noted in the amended notes on 8 June 2024, you recorded that the catheter was due to be changed the following Friday, no

mention was made of the discharge summary and the need for an earlier change of catheter. Therefore, the panel determined that, in not recording your clinical justification for changing the catheter in Patient E's patient notes in a timely manner, your actions did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and 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. 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'*

The panel was of the view that limbs a, b and c of Grant were engaged in this case.

The panel finds that patients were put at risk of harm as a result of your lack of competence and misconduct. The panel determined that your misconduct and lack of competence had breached the fundamental tenets of the nursing profession, in particular; failure to keep accurate records, failing to ensure patient safety and failing to understand your limitations.

The panel next considered whether the concerns found proved can be improved by taking steps to strengthen practice, whether the concerns have been addressed and whether it is highly unlikely this lack of competence/misconduct would be repeated. The panel accepts the NMC submission that the lack of competence and misconduct in this case is capable of being remediated.

Regarding insight, the panel considered that you have provided developing insight into the allegations. Whilst you have accepted your actions factually, the panel was of the view that you have not adequately addressed how your actions may have impacted the trust patients and the wider public have in health care professionals, and also the impact of your actions on colleagues, the nursing profession and the NMC as a regulator.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account the numerous training certificates you have provided, including training in record keeping, medication administration, compression bandages and catheters. The panel was of the view that this training is relevant to the areas of concern identified and commended you on completing this training. The panel noted the evidence provided by Ms Garnett surrounding your record keeping and was satisfied that you have demonstrated good practice in your record keeping at the Hospital. The panel also accepted that you now have a better understand your limitations and the need to escalate appropriately.

In relation to ensuring patient safety, the panel was of the view that, in your current role, you have had limited opportunity to demonstrate your strengthened practice with regard to medication administration, changing catheters and applying compression bandages. Ms Garnett informed the panel that medication administration is not a regular aspect of your role. Therefore, the panel could not be satisfied that you have adequately demonstrated safe practice in relation to medication administration. Further, the panel noted that you are not regularly required to change patients' catheters or apply compression bandages. The panel was not assured that you have sufficiently embedded your clinical skills in a setting comparable to the Trust. Therefore, the panel determined that there is a risk of repetition in this case.

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

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 accepts the NMC submission that this case relates primarily to public protection. Nevertheless, it did go on to consider the wider public interest and determined that professional standards will be upheld and public confidence in the profession maintained by a finding of impairment of fitness to practise on ground of public protection with the option of a sanction.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had 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 Kabasinkas informed the panel that in the Notice of Hearing, dated 25 June 2026, the NMC had advised you that it would seek the imposition of a suspension order for a period of 6 to 12 month, with a review, if it found your fitness to practise currently

impaired. During the course of the hearing, the NMC revised its proposal and submits that a conditions of practice order for a period of 12 months is more appropriate in light of the panel's findings. He proposed several conditions for the panel to consider and invited it to impose a conditions of practice order for a period of 12 months.

The panel also bore in mind Mr Wilkinson's submissions. He submitted the panel could consider imposing a caution order. He submitted that you have completed several training courses relevant to the areas of concern identified and have practiced safely for a significant period of time. He submitted that a caution order would mark the seriousness of the charges and uphold the public interest. However, he submitted that if the panel were not minded to impose a caution order, it should consider imposing a conditions of practice order. He informed the panel that you have engaged with an interim conditions of practice order since September 2024, with various amendments. He proposed several conditions for the panel to consider, including allowing you to work for more than one substantive employer. He informed the panel about your personal circumstances and submitted that a suspension order or a striking off order would be wholly disproportionate.

The panel accepted the advice of the legal assessor.

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:

- Conduct which recklessly puts people receiving care at risk of suffering harm;
- A pattern of lack of competence over a period of time despite significant support;
- Vulnerability of the people receiving care;

- Failure to work collaboratively with colleagues.

The panel also took into account the following mitigating features:

- Early admissions to some of the facts;
- Relevant training courses;
- Evidence of developing insight.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that the public would not be protected nor would it be in the public interest to take no further action.

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

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

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practice would not protect the public. The panel also determined that it would not be in the public interest to impose a caution order.

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*
- *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 had regard to the fact that these incidents happened several years ago when you had just finished your training as a registered nurse. The panel was of the view that, whilst you were reckless in not escalating risks, in that you re-catheterised a vulnerable patient at high risk of sepsis without seeking advice and applied compression bandages when you were told not to. The panel also noted that there are concerns relating to your medication administration, however it was of the view that all these concerns can be mitigated by the imposition of a conditions of practice order and do not indicate a deep-seated attitudinal issue. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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 noted that you would be willing to comply with conditions of practice. The panel considered Mr Wilkinson's submission that you might want to work as a nurse at events to supplement your income. The panel was of the view that the supervision provided within this environment would be incompatible with the supervision you require to practice safely. The panel did note however that you are currently unable to demonstrate your skills in compression bandaging, catheter care and medication administration on a regular basis in a clinical setting. Therefore, the panel deemed it appropriate to allow you to seek work outside of your current employer for the purpose of embedding your clinical skills in a more high-pressured clinical environment.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case, considering your developing insight and the significant training you have undertaken.

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

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

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

1. You must limit your nursing practice to two substantive employers. Your secondary employer should be limited to the NHS, including bank work. This could allow you to embed your training and skills in:
 - Catheter care, including assessment, clinical judgement, intervention, evaluation and record keeping
 - Compression bandaging, including assessment, clinical judgement, intervention, evaluation and record keeping
 - Medication administration safety and record keeping into your clinical practice.
2. At any time you are undertaking clinical work, you must be indirectly supervised by a registered nurse of band 7 or above and/or a medical practitioner registered with the General Medical Council (GMC).

3. You must work with your line manager, mentor or supervisor to create a Personal Development Plan (PDP). Your PDP must address how to ensure your clinical practice in the areas identified below is competent and safe:
 - Catheter care
 - Medication administration safety
 - Compression bandaging
4. You must not undertake any catheter care, compression bandaging and medication administration on patients independently until you are assessed and deemed competent in delivering direct care by another registered nurse of band 7 or above in a clinical setting. You must send the NMC evidence of successful assessment within seven days of completion.
5. You must ensure that you have monthly meetings with your line managers, mentors, or supervisors to discuss and provide reflective accounts of:
 - Working within your scope of competence
 - Escalating matters outside of your scope of competence.
 - Safe clinical practice and record keeping
 - Effective team working
 - The wider impact of your actions on patients, colleagues and the wider nursing profession
6. You must provide to the NMC before any review hearing a report from your line managers, mentors or supervisors regarding your PDP, reflective learning and your compliance with these conditions.
7. You must keep the NMC informed about where 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.
8. You must immediately give a copy of these conditions to:
- a) Any organisation or person you work for.
 - b) Any employers you apply to for work (at the time of application).
9. You must tell your case officer, within seven days of your becoming aware of:
- a) Any clinical incident you are involved in.
 - b) Any investigation started against you.
 - c) Any disciplinary proceedings taken against you.
10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
- a) Any current or future employer.
 - b) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 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.

Any future panel reviewing this case would be assisted by:

- Evidence of further reflections which demonstrate your insight into how your actions have impacted patients, colleagues, the wider nursing profession and the NMC as regulator.
- Testimonials from your managers and colleagues regarding your current practice.
- Evidence of your compliance with these conditions.
- Your attendance at the next review of your hearing.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He submitted that an interim conditions of practice order, for a period of 18 months, is required in this case to ensure the public are protected and the public interest is upheld in case you are to appeal this decision. He invited the panel to impose an interim conditions of practice order with the same conditions as listed above.

Mr Wilkinson submitted that the interim conditions of practice order should mirror the conditions of practice order as set out above.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months. This would ensure the public are protected and the public interest is upheld during a potential appeal period.

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.