

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

Substantive Hearing

**Monday 3 – Tuesday 25 November 2025
Monday 23 March – Thursday 2 April 2026
Monday 27 July – Tuesday 28 July 2026 (in camera)
Tuesday 1 – Friday 4 September 2026
Wednesday 14 – Thursday 15 October 2026**

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ
and Virtual

Name of Registrant:	Moras Masih
NMC PIN:	02C19810
Part(s) of the register:	Nursing Sub part 1 RN1, Registered Nurse – 25 April 2002 RNMH, Registered Nurse - Mental Health (18 February 2005)
Relevant Location:	Bristol
Type of case:	Lack of Competence / Misconduct
Panel members:	Catherine Devonport (Chair Registrant member) Delecia Dixon (Lay member) Alison Smalley (Registrant member)
Legal Assessor:	Paul Housego Charlotte Mitchell-Dunn (27 - 28 July 2026) Attracta Wilson (1 - 4 September 2026) Caroline Hartley (14 - 15 October 2026)
Hearings Coordinator:	Rebecka Selva
Nursing and Midwifery Council:	Represented by Stephen Page, Case Presenter Vida Simpeh (23 March - 2 April 2026, 1 - 4 September 2026 and 14 - 15 October 2026)

Mr Masih:	Present and represented by Wafa Shah instructed by Royal College of Nursing (RCN)
No case to answer:	Rule 24(7) - charges 1.1.5, 1.1.6, 1.1.7, 1.5, 1.15, 1.18.2, 1.20, 2.1, 2.2, 2.4, 2.5, 2.7, 3.1, 3.2, 3.2, 3.3, 3.4, 4.1, 4.2 and 5 Rule 24(8) - charges 1.4 and 1.19
Facts proved:	Charges 1.1.3, 1.2.3, 1.2.5, 1.3, 1.7.3, 1.8, 1.9.1, 1.9.2, 1.9.4, 1.9.5, 1.10.1, 1.10.2, 1.10.3, 1.17.1, 1.17.2, 1.17.3, 1.18.1 and 2.8
Facts proved by way of admission:	Charges 1.13, 2.6 and 2.3
Facts not proved:	Charges 1.1.1, 1.1.2, 1.1.4, 1.2.1, 1.2.2, 1.2.4, 1.6.1, 1.6.2, 1.6.3, 1.6.4, 1.7.1, 1.7.2, 1.9.3, 1.11.1, 1.11.2, 1.12.1, 1.12.2, 1.14, 1.16, 3.5.1, 3.5.2 and 3.5.3
Fitness to practise:	Impaired
Sanction:	Suspension order with review (12 months)
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - suspension order

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Page, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 4a.

It was submitted by Mr Page that the proposed amendments would provide clarity and more accurately reflect the evidence.

4) On 12 July 2018:

a) ~~retrospectively amended a patient's medication card to remove a record of you having administered Apixaban 5mg.~~ having administered Apixaban 5mg you retrospectively amended a patient's medication card to remove a record of you having administered Apixaban 5mg.

5) Your actions at charge 4a and/or b were dishonest in that you knew you had administered Apixaban 5mg and you ~~where~~ **were** attempting to conceal this due to your understanding that this was a medication error.

The panel heard from submissions from Ms Shah on your behalf who supported the amendment.

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 interests 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.

Case Management Directions

The panel required precision as to charges 1-3. It suggested for charge 1, after the words “...following areas”, to include “*as identified in the formal capability process of Uphill Stroke Unit and...*” and identify where competence issues are to be found which predate 28 March 2022. If none were to be found, the stem of the charge must be amended to state from “28 March 2022 – August 2022”. The panel suggested for instance:

‘That you, a registered nurse, between July 2018 and August 2022:

1) Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas **as identified in the Formal Capability Process at Uphill Stroke Unit:**

- a) record keeping
- b) medication management
- c) medication administration
- d) wound management and pressure care
- e) patient observations
- f) prioritisation and escalation of care
- g) falls risk management
- h) manual handling

2) Failed to work cooperatively with colleagues **at Uphill Stroke Unit** in that you:

- a) did not engage constructively with colleagues.
- b) shouted at and/or were aggressive towards colleagues.
- c) refused to sign notes of meetings to confirm their accuracy when you knew the notes were accurate or, in the alternative, without suggesting amendments which you considered were needed to make the notes accurate.
- d) sent abusive and/or threatening emails to colleagues.
- e) failed to act in line with direct instructions from colleagues.

- f) completed an unsupervised medication round having been told you must be supervised due to concerns about your competence.
- g) refused to assist colleagues when asked to do so.
- h) inappropriately delegated tasks to colleagues.

3) At Uphill Stroke Unit Failed to treat patients with kindness, compassion or respect in that you:

- a) failed to respond timeously to patient requests for assistance.
- b) failed to take account of communication difficulties patients had when interacting with them.
- c) treated property belonging to patients with disrespect.
- d) failed to include patients in discussions about their treatment.
- e) administered care without:
 - i) introducing yourself.
 - ii) explaining the care you proposed to provide.
 - iii) obtaining consent.

4) Whilst working at The Copse Hospital on 12 July 2018:

- a) having administered Apixaban 5mg you retrospectively amended a patient's medication card to remove a record of you having administered Apixaban 5mg.
- b) failed to escalate that Apixaban 2.5mg was not available.'

The NMC was requested to provide a final evidence matrix by 14:30 on Wednesday 5 November 2025: only the documents referred to in that evidence matrix would be considered by the panel in relation to each charge. The evidence matrix should be precise and not generic.

The panel requested that Mr Page make an application to amend charges 1-3 at 14:30 on Wednesday 5 November 2025 so as to give precise allegations, either by suggesting amendment to the charges or by reference to specific documents in the bundle of

documents (for example 2d made an allegation about emails. The emails must be specified by document number or by date and addressee.)

The NMC provided a new bundle of documents with 21 additional pages. The panel agreed to use the new bundle of documents for these additional pages (262-281), but as all parties prepared using the 454 page bundle of documents, the panel directed that the 454 bundle would be used, referring only to the 475 page bundle as required.

Charges 2 and 3 required amendment to specify the place or places of work at which you are alleged not to have worked cooperatively with colleagues and failing to treat patients with kindness (etc). In particular, to state after “*colleagues*” and “*patients*” the words “*at Uphill Stroke Unit*” or as may be alleged.

Decision and reasons on application to further amend the charges

The NMC had served charges on you. At the commencement of the hearing, the panel considered that the charges served were generic, unparticularised and were unsupported by an evidence matrix. Further, the Exhibit bundle omitted many of the exhibits to witness statements. The panel considered that this meant it was difficult to deliver you a fair hearing, and difficult for the panel to give proper consideration to the competence and conduct issues raised.

The omissions in the documentation were addressed. Ultimately, by midday on Wednesday 5 November 2025, day 3 of the hearing, the panel required the NMC to draft properly particularised charges supported by an evidence matrix. This was not completed until Sunday night, 9 November 2025.

On Monday 10 November 2025 the panel reviewed the amended charges after correcting errors in them with the consent of Ms Shah (save as to one charge).

The panel heard and accepted the advice of the legal assessor.

The panel decided to amend the charges so that they read as below.

Details of charge

That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.1 On or around 31 March 2022;

- 1.1.1 Failed to count Patient 1's respiratory rate accurately.
- 1.1.2 Failed to prioritise Patient 1's transfer in order to commence nasal high flow oxygen.
- 1.1.3 Failed to complete Patient 2's dressings in order for them to be transferred.
- 1.1.4 Failed to follow the correct process for ordering medication, and/or consider other options to obtain medication including looking in the Clinical Room / other drug trolleys to obtain the required medication.
- 1.1.5 Failed to identify that a patient had developed a Grade 2 pressure injury, and
- 1.1.6 Failed to assess patient's pressure areas when repositioning them, and
- 1.1.7 Inaccurately documented that you had assessed the patient's pressure areas during the shift.

1.2 On or around 25 April 2022 whilst on a supervised drug round:

- 1.2.1 Lost the keys to the drugs trolley.
- 1.2.2 Failed to use the correct technique for giving an injection.
- 1.2.3 Failed to confirm a patient's identification prior to administering medication.

- 1.2.4 On one or more occasions re-sheathed needles despite being informed that this was not allowed.
 - 1.2.5 On one or more occasions left needles in trays unattended.
- 1.3 On or around 3 May 2022, during a supervised medication round, failed to recognise/understand that taking on extra tasks during a drugs round could delay medication doses to patients.
- 1.4 On or around 12 May 2022, failed to identify that the incorrect dose of Lansoprazole had been dispensed.
- 1.5 On or around 13 May 2022, left a patient who was a high risk of falls unattended.
- 1.6 On or around 19 May 2022, whilst on a supervised round:
 - 1.6.1 Hung fluid bottles that had the incorrect giving set.
 - 1.6.2 Having replaced the giving set, failed to identify that there was a large amount of air in the giving set.
 - 1.6.3 Failed to ensure that a patient had a safe blood glucose measurement prior to administering diabetic medication.
 - 1.6.4 Left bags of medication unattended on a chair.
- 1.7 On or around 20 May 2022:
 - 1.7.1 Attempted to use a Sera-Steady mobility aid on your own when you were aware that it requires two people to use it.
 - 1.7.2 Left the patient hanging over the bar of the Sera-Steady mobility aid.
 - 1.7.3 Attempted to remove a canvass sheet from underneath Patient 4 using an incorrect and/or dangerous technique.

1.8 On or around 25 May 2022, completed an unsupervised medication round having been informed at a midpoint management meeting that you were to be supervised until the end of the performance management.

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.1 Failed to provide water slowly to Patient A as required/requested.

1.9.2 On one or more occasions failed to identify/provide answers as to what the instructions in the drugs chart said.

1.9.3 Failed to identify that Patient C's Bisoprolol medication was incomplete.

1.9.4 In respect of Patient D, failed to recognise that the prescription for 'Prosource Plus Fluid' was not Phosphate Sandoz, and

1.9.5 Failed to recognise the implications of administering Phosphate Sandoz unnecessarily.

1.10 On or around 16 August 2022:

1.10.1 On one or more occasions left a patient at high risk of falls unattended despite being told to stay with the patient.

1.10.2 Left down the bed rails of a patient who was at high risk of falls.

1.10.3 Failed to complete a MUST in a timely manner.

1.11 On or around 22 August 2022:

1.11.1 On one or more occasions left the drug trolley unattended and/or unsupervised.

1.11.2 Left the bedside medications cabinet open with the keys in the lock unattended.

1.12 On or around 24 August 2022:

1.12.1 Left keys in the patients opened Pods.

1.12.2 Having been asked on one or more occasions failed to hand over a patient to the receiving Ward.

Whilst working on Draycott Ward:

1.13 On or around 19 December 2020:

1.13.1 Incorrectly categorised a patient's wound as a deep tissue wound.

1.13.2 Used incorrect type of bandage to bandage the wound.

1.13.3 Failed to bandage the wound from joint to joint.

1.13.4 Failed to follow the patient's care plan in respect of the wound.

Whilst working on Hutton Ward:

1.14 On or around 3 September 2020, incorrectly administered Novorapid to a patient whose blood sugar levels were above 12mmols.

1.15 On a date unknown incorrectly entered Code 1 on a patient's chart indicating that the patient had refused insulin when they had not.

1.16 On or around 19 February 2019 left a patient unattended who subsequently had a fall.

1.17 On or around 20 February 2019, having re-positioned a patient's nasal prongs:

1.17.1 Failed to assess / observe whether the patient was in respiratory distress before going on a break.

1.17.2 Failed to complete clinical observations before going on a break.

1.17.3 Failed to handover the patient to a doctor / nurse before going on a break.

1.18 On or around 20 February 2019:

1.18.1 Administered I/V medications having not been signed off as being competent.

1.18.2 Left a vulnerable patient:

1.18.1.1 Unattended with the bed rails down.

1.18.1.2 With a wet pad on.

1.19 On a date in January 2019, required assistance to set up an infusion pump.

Whilst working at Cefn Carnau Hosptial:

1.20 On or around 20 November 2019, incorrectly administered Novorapid to a patient instead of the prescribed Humalog 50.

2. On one or more dates set out in Schedule A, and on dates unknown, failed to work cooperatively with colleagues by:

2.1 Failing to engage constructively with colleagues.

2.2 Shouting and/or acted aggressively towards colleagues.

2.3 Refusing to sign notes of meetings to confirm their accuracy when you knew the notes were accurate or, in the alternative, without suggesting amendments which you considered were needed to make the notes accurate.

2.4 Sending abusive and/or threatening emails to colleagues.

2.5 Failing to act in line with direct instructions from colleagues.

2.6 Completing an unsupervised medication round having been told you must be supervised due to concerns about your competence.

2.7 Refusing to assist colleagues when asked to do so.

2.8 Inappropriately delegating tasks to junior colleagues / colleagues.

3. On one or more dates set out in Schedule B, and on dates unknown, failed to treat patients with kindness, compassion or respect by:

3.1 Failing to respond timeously to patient requests for assistance.

3.2 Failing to take account of communication difficulties patients had when interacting with them.

3.3 Treating property belonging to patients with disrespect.

3.4 Failing to include patients in discussions about their treatment.

3.5 Administering medication / care without:

3.5.1 Introducing yourself.

3.5.2 Explaining the care you proposed to provide.

3.5.3 Obtaining consent.

4. On 12 July 2018:

4.1 Having administered Apixaban 5mg you retrospectively amended a patient's medication card to remove a record of you having administered Apixaban 5mg.

4.2 Failed to escalate that Apixaban 2.5mg was not available.

5. Your actions at charge 4.1 and/or 4.2 were dishonest in that you knew you had administered Apixaban 5mg and you were attempting to conceal this due to your understanding that this was a medication error.

And in light of the above, your fitness to practise is impaired by reason of your lack of competence as set out in charge 1, and by your misconduct as set out in charges 2, 3, 4 and 5.

Schedule A:

‘On or around’:

- 31 March 2022
- 7 April 2022
- 8 April 2022
- 25 April 2022
- 29 April 2022
- 3 May 2022
- 13 May 2022
- 25 May 2022
- 26 May 2022
- 27 May 2022
- 28 June 2022
- 5 July 2022
- 19 July 2022
- 26 July 2022
- 4 August 2022
- 9 August 2022
- 15 August 2022
- 18 August 2022
- 17 December 2020
- 19 December 2020

- 25 December 2020
- 2 January 2021
- 3 September 2020
- 20 November 2019
- 20 February 2019

Schedule B:

'On or around'

- 18 May 2022
- 26 May 2022
- 28 June 2022
- 4 August 2022
- 15 August 2022
- 16 August 2022
- 22 August 2022
- 24 August 2022
- 31 August 2022
- 2 January 2021
- 20 February 2019

Agreement to the charges as amended

On your behalf Ms Shah accepted that these amended charges more clearly set out the matters of concern to the NMC, and that it was fair to you to amend the charges in this way as this gave clarity and so better enabled you to set out your defence to the charges.

Factual admission to charges

Ms Shah submitted that you denied all the charges.

You admitted the facts set out in charges 1.1.3, 1.3, 1.8, 2.3 and 2.6 but did not admit the charges as you denied the stem of charge 1.

Background

On 24 October 2018 the NMC received a referral from the Hospital Director of the Copse Hospital (Hospital 1) in respect of your fitness to practice involving an incident on 12 July 2018.

Further allegations were raised subsequently.

The further incidents are said to have taken place while you were working as a registered nurse across three settings, Hospital 1, Cefn Carnau Hospital (Hospital 2) and Weston General Hospital (Hospital 3), which included part time working at more than one hospital at the same time.

You worked at Hospital 1 from 24 October 2018 to 5 February 2021.

You worked at Hospital 2 from 4 July 2016 to 18 October 2018.

You worked at Hospital 3 from 2 September 2018 to 30 November 2022.

The allegations related to ongoing issues with your medication administration, record keeping, wound care management, prioritisation, escalation of care, falls and risk management, delegation of tasks, manual handling and your taking of observations. It is also alleged that you were unable to demonstrate consistently safe practice and had issues with your ongoing competence in a variety of areas of practice.

On 3 September 2020 you allegedly administered the wrong type of insulin to Witness 1 which resulted in them being admitted to an intensive care unit.

On a separate day it is alleged that you incorrectly classified a wound as a deep tissue wound where it should have been classified as a traumatic wound from a fall. In addition, you allegedly did not use the correct dressing or bandage.

Whilst working on the Hutton Ward in Hospital 3, you allegedly;

- incorrectly administered Novorapid to a patient whose blood sugar levels were above 12 mmol;
- incorrectly entered Code 1 on Medicines Administration Record (MAR) chart;
- left a patient unattended;
- repositioned a patient's nasal prongs, but failed to assess/observe whether the patient was in respiratory distress, and failed to complete clinical observations;
- left vulnerable patient unattended with the bedrails down and with wet pads on.

It is alleged that you failed to work cooperatively with colleagues at Hospital 2 and Hospital 3.

It is also alleged that you sent abusive and/or threatening emails to colleagues at Hospital 3.

It is alleged that on one occasion you pulled a patient's finger to take their blood sugar level, the patient was distressed and pulled their finger away. It is also alleged that you ignored a patient who had capacity while discussing their medication. It was alleged that this patient shared that this interaction made them feel they were a nuisance, and they lost confidence in their treatment as a result.

You were alleged to have failed to meet the required standard of a registered nurse as you did not successfully complete your competency workbook, set as part of a Performance Improvement Plan (PIP). Within this workbook you allegedly failed to achieve consistency in safe medication administration and communication or produce correct documentation to evidence this.

A service user was prescribed Apixaban 5mg which was reduced to 2.5mg on 12 July 2018. Soon thereafter the service user had to attend hospital (A & E) on 13 July 2018. It was alleged that you had administered 5mg of Apixaban, then realised that the dosage had been reduced to 2.5mg and you allegedly tried to cover up your mistake by scribbling over your signature on the MAR chart.

Further, you allegedly failed to document this as a medication administration error; either on Datix or via an incident report, nor did you escalate that Apixaban 2.5mg was unavailable. The NMC assert that there is evidence to suggest a mistake may have been made with the date entered on the MAR chart. It was alleged that these were dishonest actions.

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

During witness evidence, Mr Page made a request that this case be held partly in private on the basis that proper exploration of witness [PRIVATE]'s oral evidence involves references to her health. The application was made pursuant to Rule 19.

Ms Shah did not oppose the application.

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

The panel determined to go into private session in connection with [PRIVATE]'s health as and when such issues are raised in order to protect her right to privacy. This was extended to any mention of health in respect of yourself or of any other witnesses.

Evidence

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

- Aiesha Scannell: Student Nurse at Hospital 3 at the time of the incidents.
- Karen Low: Lead Acute Pain Nurse at Hospital 3.
- Sophie Phillips: Registered Nurse at Hospital 3 the time of the incidents.
- Andrea Milverton: Ward Sister at Hospital 3 at the time of the incidents.
- Tamsin Kay: Student Nurse at Hospital 3 at the time of the incidents.
- Kristina Keyte: Manager at Hospital 3.
- Charity Dube: Manager at Hospital 1 at the time of the incidents.
- Rahab Hashim: Diabetes Specialist Nurse at Hospital 3.
- Witness 1: Patient at Hospital 2 at the time of the incidents.
- Sarah Abdulgani: Your line manager at Hospital 3 at the time of the incidents.

- Ellen Parton: Ward Manager at Hospital 2.
- Drew Conners: Acting Ward Manager at Hospital 2.

Decision and reasons on application of no case to answer

Following the oral evidence of Drew Conners, the panel considered an application from Ms Shah that there is no case to answer in respect of charges: 1.1.5, 1.1.6, 1.1.7, 1.5, 1.8, 1.14, 1.15, 1.17, 1.18.2, 1.20, 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 2.8, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2 and 5. This application was made under Rule 24(7). Ms Shah provided written submissions, identified as Exhibit 15.

In relation to this application, Ms Shah submitted that the NMC had failed to provide evidence capable of proving these charges so that there is no case for you to answer in respect of these charges. In these circumstances, it was submitted that these charges should not be allowed to remain before the panel.

Ms Shah also made applications of no case to answer under Rule 24(8) in respect of the following charges: 1.4, 1.19 and 1.8. For charges 1.4 and 1.19, Ms Shah submitted that the evidence provided by the NMC was inadequate to establish that your fitness to practise was impaired and so there was no case to answer. In respect of charge 2.6 (which has the same factual basis as charge 1.8), Ms Shah submitted that this could not be serious enough to amount to misconduct and so there was no case to answer in respect of this charge also.

Mr Page, within his written submissions (Exhibit 16) opposed the application and identified the evidence which he submitted was specific to each charge before the panel and which he submitted amounted to a case to answer.

Ms Shah, in reference to Mr Page's written submissions concerning charges 1.1.5, 1.1.6, and 1.1.7, submitted that Mr Page referred to evidence that was not identified in the evidence matrix he had initially provided to the panel. Ms Shah highlighted that within Kristian Keyte's File note dated 31 March 2022, there is no reference to any concerns about pressure injuries, and this was also confirmed when Kristian Keyte was cross examined.

Ms Shah submitted that as a result of Mr Page referring to evidence other than what he stated in his evidence matrix, for this reason she did not cross examine Kristian Keyte on this topic. She further submitted that there is insufficient detail in respect of the patient who allegedly suffered from the pressure sores. Ms Shah orally revised her written submissions in regard to this charge from a submission that there was no evidence that could lead to the charge being proved to a submission that there is insufficient evidence to support the charge.

Ms Shah submitted that in reference to charge 1.1.5, the panel ought to consider the proper weight of this evidence.

The panel heard and accepted the advice of the legal assessor, who advised the panel about Rule 24(7), Rule 24(8) and the case of *R v Galbraith* [1973] Cr.App.R 12, CA.

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

Charge 1.1.5, 1.1.6 and 1.1.7 – **No case to answer**

The panel referred to the File note dated 31 March 2022 exhibited by Kristian Keyte in which there was no mention of any grade 2 pressure injuries. The witness stated in oral evidence that he had raised all the issues relating to 31 March 2022 in that File Note. For this reason, Ms Shah did not cross examine Kristian Keyte on this matter. The panel also

noted that there were no Datix or patient records exhibited in respect of any grade 2 pressure injuries, nor was this raised in your Mid-Point Review dated 20 May 2022. The panel noted that pressure injuries are a serious matter, but that the NMC had provided no evidence that there had there been a concern about a pressure injury on this day.

The panel determined that charges 1.1.6 and 1.1.7 could not be proved as charge 1.1.5 referred to a particular patient, who remained unidentified, and because there was no evidence provided of concern about a pressure injury or injuries for any patient on that day.

Charge 1.5 – No case to answer

In relation to this charge the panel had before it Nurse Nuttall's (a colleague) handwritten statements; both statements were half a page each, provided as separate documents and both undated. The panel noted that although this was hearsay, no hearsay application had been made to admit Nurse Nuttall's evidence. There was no other evidence in respect of this charge, and the hearsay evidence of Nurse Nuttall would therefore be both sole and decisive evidence. The panel determined that this evidence was vague or tenuous within limb b of *Galbraith*.

The panel was referred to Kristian Keyte's File note dated 13 May 2022 in which Nurse Quan (a colleague) referred to you having issues with a hoist – but this was unrelated to this, or any other, charge.

Charge 1.8 – Case to answer

In cross examination Kristian Keyte agreed that this incident could be due to confusion by Sister Milsom (a colleague) who was supervising you and was not aware of the restrictions imposed on your practice by the hospital. In a contemporaneous interview you stated that Sister Milsom said that you could go ahead with the medication round, saying it was her responsibility. Whether Sister Milsom knew of the restrictions on your practice, you do not deny that you were aware of them. The restrictions precluded you from conducting a medication round unsupervised. The panel decided that there is a case to answer in

respect of this charge, because whether or not your supervising nurse (through ignorance of the restriction or otherwise) approved the unsupervised drug round, there is an issue as to whether your undertaking this medication round in the light of the restriction on you demonstrated the knowledge, skill and, particularly, judgment required to practise without supervision as a Band 5 nurse.

Charge 1.14 – Case to answer

The panel noted that Rahab Hashim did not produce the drug chart and had no personal knowledge of whether Novorapid had been administered or not. Her evidence was that you had told her that you had administered Novorapid but later, that you had not. It is unfortunate that there is no documentary evidence in relation to this. The decision on this charge depends upon the panel's assessment of the evidence of Rahab Hashim and evidence from you, should you choose to give it, and therefore there is a case to answer.

Charge 1.15 – **No** case to answer

The panel determined that the evidence in relation to this charge is anonymous hearsay and Rahab Hashim in her evidence said that she only remembers the alleged incident '*vaguely*'.

Charge 1.17 – Case to answer

The panel noted that Karen Low gave evidence that;

- She was attending the patient in her capacity as a lead acute pain nurse, not to relieve you;
- You were leaving for a break as Karen Low arrived;
- Karen Low called you back and you readjusted the nasal prongs which were delivering oxygen to the patient and then left again, immediately and without any form of handover;
- That there was no other nurse in the vicinity;
- That Karen Low immediately conducted observations and as the patient's NEWS score was 8, they were moved to ICU forthwith.

Given this evidence there is a case for you to answer.

Charge 1.18.2 – **No** case to answer

The panel noted that in the evidence before it there is no reference to any patient as alleged in the charge. Within the Datix dated 20 February 2019 exhibited by Andrea Milverton, the evidence is essentially treble hearsay. As such the panel found that the hearsay evidence for this charge would be sole and decisive and following the guidance in *Thorneycroft v NMC* [2014] EWHC 1565 decided that this hearsay evidence was within limb b of the *Galbraith* test.

Charge 1.20 – **No** case to answer

The panel referred to Witness 1's oral evidence that you had injected him with Novorapid, however, the panel noted that Witness 1's witness statement and oral evidence contradicted each other. At times Witness 1 stated that he was allowed to inject himself and that this was '*normal*'. However, the witness also stated that due to self-harm risks this was not permitted in his case. The panel had no documentary evidence such as a MAR chart or Datix record to consider. The panel also did not have any evidence from Sarah Abdulgani, who investigated this matter. There was contradictory evidence about whether the patient (Witness 1) knew about the difference in the types of insulin pens. The panel noted that the report from the treating doctor, Dr Fischer, was hearsay. Further the report stated that Dr Fischer had treated the patient as if the drug administered was Novorapid (in case it had been) but also that she was a doctor specialising in diabetic medication, which was relevant to the weight to give to her evidence. Dr Fischer went on to say that she was uncertain whether the fast-acting component of Humalog could have been responsible for the deterioration in the patient's health and not Novorapid. The panel did not find your reported observation when asked about this that "*mistakes happen*" was sufficient reason to find that there was a case to answer because this was an immediate precursor to your denial that you had made that mistake. Therefore, the panel found that due to the inconsistent oral evidence, inconclusive documentary evidence and missing documentary evidence that there is no case to answer in respect of this charge.

Charge 2.1 – **No** case to answer

There were a few examples in the documentation, but without specifics. The panel determined that over a four-year span, on odd occasions not engaging constructively with colleagues may well be considered an employment matter but, on the evidence provided could not be serious enough to be considered misconduct, and therefore there is no case to answer.

Charge 2.2 – **No** case to answer

The panel referred to a letter addressed to you from your manager, Kristian Keyte, dated 20 April 2022. It considered that following this letter, there were no further reports of you being aggressive or threatening to colleagues. The panel also referred to Ellen Parton's evidence that you were '*persistently rude*', but she was unable to provide examples and did not allege that you shouted or acted aggressively. Kristian Keyte provided an example that in a meeting you were aggressive to the extent that your RCN representative at the time asked you to leave the meeting. However, the panel determined that this was an employment matter as outlined within NMC guidance FTP-2a and FTP-2b, and it was the only example of conduct which could be as described in the charge. The panel considered that the one incident and unparticularised assertions from a few colleagues, which were not repeated (or at least not actioned by your employer) subsequent to a warning letter would not be considered deplorable by fellow practitioners. Thus, it concluded that there was no case to answer in respect of this charge.

Charge 2.4 – **No** case to answer

The panel again referred to the letter addressed to you from Kristian Keyte dated 20 April 2022, within this letter, the email you allegedly sent was cited but the original email itself was not exhibited to the panel. The panel determined that this email may be considered prickly and unfortunately phrased, but the NMC has provided no email that was threatening or contained abusive language. The high-water mark was an email which stated that Kristian Keyte would have to explain his decision making to your union representative rather than to you. This may have been perceived by Kristian Keyte as challenging, but it is not threatening or abusive.

Charge 2.5 – **No** case to answer

Kristian Keyte referred to one incident of failing to listen to colleagues in the span of four years. The panel decided that one incident of failing to act in line with direct instructions from a colleague is not misconduct. Further, the charge is framed in the plural and so, as only one incident is referred to, is incapable of being proved.

Charge 2.6 – Case to answer

The panel noted that this charge is the same incident as charge 1.8 and as such there is a case to answer. Charge 1.8 alleges a competence issue, and charge 2.6 alleges the same factual matrix and therefore is also misconduct. There is a case to answer from both perspectives.

Charge 2.7– **No** case to answer

The panel referred to the contemporaneous statements exhibited by Tamsin Kay and Kristian Keyte. It determined that over a four-year span, there are suggestions of a lack of helpfulness but there is no evidence of you refusing outright to do tasks. No specific example was given, and a generalised allegation is not evidence. As there is no evidence capable of leading the panel to find the charge proved there is no case to answer.

Charge 2.8 – Case to answer

The panel referred to Tamsin Kay's evidence that you would continually delegate tasks to student nurses. The panel found this identified in Sophie Phillips and Kristian Keyte's evidence with sufficient specificity to conclude that there is a case to answer.

Charge 3.1 – **No** case to answer

The panel determined that the evidence in relation to this charge is entirely unparticularised hearsay, namely Nurse Nuttall reportedly saying that you would not answer call bells promptly, and therefore there is no case to answer.

Charge 3.2 – **No** case to answer

The panel had no information or evidence of patients who had any communication difficulties and therefore determined that there is no case to answer.

Charge 3.3 – **No case to answer**

The panel referred to a statement provided by Rachel Woodgate (a colleague) dated 27 May 2022. This was hearsay for which no hearsay application had been made. Had such an application been made the panel would have rejected it as this evidence was the sole and decisive evidence in respect of this charge. Accordingly, the panel could give it no weight, and thus there is no case to answer.

Charge 3.4 – **No case to answer**

The panel determined that there is no case to answer for this charge as the evidence of Kristian Keyte was that you did not treat the patient in question.

Charge 4.1 – **No case to answer**

This charge is predicated on you having administered a dose of 5mg of Apixaban to the patient. Your account to your employer was that you had made the note in advance but then scribbled out the note on the MAR chart of administering 5mg of Apixaban when you realised that the newly prescribed dose of 2.5mg was unavailable. The patient was transferred to A&E and the hospital's conclusion was that the patient had missed three doses of Apixaban. Charity Dube was clear that the patient needed to be transferred to A&E because they had *not* had Apixaban, not because they had. The basis of the charge cannot be established for this reason.

Further, it was accepted by the NMC's witnesses that the reverse of the MAR chart has space for explanation, but the reverse of the MAR chart was not produced by the NMC, and it would have been essential to review this to see whether it had any such entry and if so, what the entry was.

In addition, it was the evidence of the NMC's witnesses that if an entry requires correction the protocol is to strike it through and provide an explanation (on the reverse of the MAR

chart). You had scribbled out the entirety of your entry which was consistent with your stated position of not administering the drug.

Yet further, there was no evidence of a stock take to show the amount of Apixaban in stock, which would have shown whether a dose had been administered to the patient.

Charge 4.2 – **No** case to answer

The panel considered that the Apixaban 2.5 mg arrived on 14 July 2018. The panel was not given the handover note for 12 July 2018. The handover note produced did not assist and did not identify the patient in question. The panel noted your explanation given in a disciplinary hearing on the 13 September 2018 when you stated that you informed the ward manager of this medication being out of stock, but that they had not ordered it before 3pm. This would have been appropriate escalation, together with documentary evidence. There was no evidence heard from the ward manager. The NMC's witnesses conceded that the drug may have been ordered on 12 July 2018 after 3pm, that it had to be ordered by a nurse and that it was unknown whether any other nurse was on duty on the relevant date. This is all consistent with the account you gave in your disciplinary hearing: that you ordered it after 3pm on the day so that it arrived 2 days later.

A handover sheet in the documentation had the wrong date. There was no other documentation relating to the patient and so there was no evidence that you failed to escalate the absence of Apixaban 2.5mg.

Consequently, the NMC cannot discharge the burden of proof in respect of this charge by reason of the paucity of the evidence provided.

Charge 5 – **No** case to answer

As there is no case to answer for charges 4.1 and 4.2, this charge falls away.

The panel then considered the applications under Rule 24(8).

Charge 1.4 – **No** case to answer

The panel referred to *R v Calhaem* [1985] QB 808 and determined that this was an isolated incident, not particularly grave, and so not a fair sample of your work and therefore would not amount to misconduct.

Charge 1.19 – **No** case to answer

The panel noted that you were new on the ward and had not used an infusion pump for some time. The panel determined that there was no harm in requiring assistance to set up an infusion pump, and it noted that numerous witnesses in their oral evidence stated there is nothing wrong with asking for assistance with an unfamiliar task, to the extent that it is best practice to do so. Accordingly, there is no case to answer.

Further admission to charges

Ms Shah submitted that you admitted charges 1.13, 2.3 and 2.6.

Decision and reasons on facts

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 Page on behalf of the NMC and by Ms Shah 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 also heard evidence from you under oath.

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

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

Charge 1.1.1

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.1 On or around 31 March 2022;

1.1.1 Failed to count Patient 1’s respiratory rate accurately.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the File Note dated 31 March 2022 exhibited by Kristian Keyte:

‘During the morning, MM informed KK that the respiratory rate of the acutely unwell patient that needed to go to Cheddar ward was 30 respirations per minute. The patient had had no treatment or intervention to reduce this and previously had respirations of 57 per minute. KK immediately went to the patient and could see that the patient’s respirations remained between 55 and 60. KK instructed MM to

count the respirations again. When raised with MM, he informed KK and SP that he had not falsified this and he had measured the respirations with the Nursing Assistant (NA). MM was aware that the NA was not qualified to measure observations as he had previously discussed this with SP. MM reminded of ensuring he is taking responsibility for his actions and is not asking non-registered nursing staff to carry out tasks that they are not qualified to do.'

The panel also referred to Kristian Keyte's statement:

'There was an incident that happened on 31 March 2022 which was a few days into Moras starting on the unit. I think it was his first or second shift. Moras didn't recognise that a patient was acutely unwell. I was observing Moras during a drug round in the morning and I noticed that a patient didn't look well and Moras hadn't notice. I understand that to look at someone and know they are unwell is not a tangible measure but what followed concerned me. I did observations on the patient and respiratory rate was 57. The normal rate should be between 10-20. 57 is very concerning and a trigger for escalation, which I did. Moras then repeated observations which is a basic task and said the respiratory rate was 30. The only way the respiratory rate could go from 57 to 30 is with intervention/treatment. Within a minute or so between him saying that I went to check the patient's respiratory rate and it was still 57.'

The panel considered that there is no record of documentary observations taken at the time before the panel such as NEWS scores, nor is there any evidence from the Nursing Assistant (NA) referred to by Kristian Keyte. In oral evidence, Kristian Keyte was not able to provide specific details regarding this incident: *'From three years down the line I can't give specifics I think the HCA [NA] did complete a set of observations'*.

The panel noted that it is your case that the NA was only helping to prop the patient up into sitting position – not that they had completed the observations on your behalf.

The panel noted that by the time Kristian Keyte took his observation of Patient 1 there is no record of when you took your observations and as such there is a paucity of evidence to link the times you took your observation of Patient 1's respiratory rate of 30 and Kristian Keyte's observation recorded a respiratory rate of 57. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was a lack of clarity as to whether you failed to count Patient 1's respiratory rate accurately.

As such, it concluded that this charge is not found proved on balance of probabilities.

Charge 1.1.2

That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.1 On or around 31 March 2022;

"1.1.2 Failed to prioritise Patient 1's transfer in order to commence nasal high flow oxygen."

This charge is found NOT proved.

In reaching this decision, the panel took particular account of both Kristian Keyte's and your documentary and oral evidence.

The panel referred to Kristian Keyte's statement:

'Also on that day a patient had to be moved to the respiratory unit. This patient needed to go onto nasal high flow on the respiratory unit which is an upgrade in care that couldn't be provided on Uphill Stroke Unit. Moras was asked a number of times by me and a junior sister to move the patient as the porter was on their way to take the patient to the respiratory unit. This didn't initiate any action from Moras and he stood at the end of the patient's bed flicking through the patient's notes. Eventually the porter was at the end of the bed for a number of minutes whilst I was taking the paperwork off Moras. Moras was flicking backwards and forwards through a folder containing documents that weren't relevant to moving the patient from the unit. There was nothing within the folders that Moras needed to know more so than the patient moving to the respiratory unit. Once the patient went, I discussed what had happened with Moras with the junior sister present. I discussed with Moras accountability and ladder of priorities. I wanted Moras to understand that when the junior sister called the porter action needed to happen there and then. I wanted to use the experience for him to learn but I don't think that message was ever really absorbed by Moras.'

The panel referred to your witness statement:

'I do not agree I was asked several times to move the patient. While waiting for the porter to arrive, I was reading the patient's notes, including the DNAR form, so that I could properly hand over. As soon as the porter arrived, I was fully engaged in the transfer and did not continue to read or complete any notes.'

The panel considered that there was a discrepancy about whether the porter was present or on their way. The panel noted that in respect of failing to prioritise Patient 1's transfer in order to commence nasal high flow oxygen the only evidence produced by the NMC is that of Kristian Keyte, which at its height alleges that the porter was at the end of Patient 1's bed *'for a couple of minutes'* awaiting transfer and there was no need for you to be looking at patient notes. The panel noted that it was your evidence that you were waiting for the

porter and engaged in other aspects of Patient 1's transfer, such as reading the patient's notes.

The panel noted that there were a number of other potential witnesses to the transfer of Patient 1 who could have been called by the NMC on this issue but were not. The panel therefore had to assess the two conflicting accounts without any further corroborating evidence.

The panel noted the evidence of Kristian Keyte, namely, '*There was nothing within the folders that Moras needed to know more so than the patient moving to the respiratory unit*'. However, the panel considered that there may be valid reasons for checking a patients notes prior to their transfer.

The panel considered that even if according to Kristian Keyte's case that the porter had arrived - a delay of a 'couple of minutes' to check a patients notes was not sufficient to amount to a failure to prioritise Patient 1's transfer in order to commence nasal high flow oxygen. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was a lack of clarity as to whether or not the porter was delayed and the panel considered the evidence of Kristian Keyte at its height did not amount to a failure to prioritise the patient's transfer. Therefore, on the balance of probabilities, this charge is not found proved.

Charge 1.1.3

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.1 On or around 31 March 2022;

1.1.3 Failed to complete Patient 2's dressings in order for them to be transferred."

This charge is found proved.

The panel noted that you had admitted the facts of this charge but not the stem.

In reaching this decision, the panel took into account of your oral and documentary evidence.

The panel referred to your witness statement:

'I admit charge 1.1.3. Patient 2 was due to be transferred, and the Tissue Viability Nurse had prepared fresh dressings. I accept it was my job to complete them and that I did not do so between 11:30 and 14:30. I did attempt to change the dressing, but Patient 2 refused. I recorded this in the patient notes. I agree that in the three hours that followed I should have gone back to try again or should have handed this over to someone else and that I failed to do so. The student nurse eventually changed the dressing.'

The panel considered your oral evidence in which you stated that the ward was 'very busy' and was often short staffed. However, the panel concluded that even if the patient had refused to get their dressing changed, with all the dressing equipment laid out ready, you delayed this process by up to three hours. You also did not hand over this duty to another colleague who could have changed the dressing faster, nor hand over the task at the end of your shift. The panel considered that in failing to complete Patient 2's dressing you failed to demonstrate standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse.

Therefore, on the balance of probabilities the panel found this charge proved.

Charge 1.1.4

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.1 On or around 31 March 2022;

1.1.4 Failed to follow the correct process for ordering medication, and/or consider other options to obtain medication including looking in the Clinical Room / other drug trolleys to obtain the required medication.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the File Note dated 31 March 2022 exhibited by Kristian Keyte:

‘During 08.00 drug round, a patient was due Doxazosin, however this was not with their medications or in the drug trolley. I informed MM that he would need to check the stock cupboards in the Clinical Room and the other drug trolleys and if it was not on the ward, to order it from Pharmacy. MM did not check the drug trolleys or the Clinical Room. During the 12.00 drug round, SP supervised MM with his drug round and identified that MM had documented that he had ordered the medication. SP found the medication in the Clinical Room and it was administered. When raised with MM to remind him to check the stock cupboards, MM took no responsibility for

not checking the stock cupboard and insisted that he was told the medication is not stock. MM was unable to tell KK or SP who informed him of this.'

The panel noted that this evidence is hearsay evidence which amounts to a recollection by Kristian Keyte of his discussion with Sophie Phillips. The panel heard evidence from Sophie Phillips however she did not give evidence of this conversation. Sophie Phillips in her evidence did not raise any concerns about a failure to follow the correct processes for ordering medications by you and did not produce a Direct Observation of Practice Record as would be expected. As such, the panel attached limited weight to the hearsay evidence of Kristian Keyte as it was not supported by Sophie Phillips who could have given direct evidence as to this allegation.

The panel referred to your witness statement:

'I deny charge 1.1.4. I did check the clinical room and the other trolley, and I did follow the correct process for ordering new medication by completing the checks required. I was new on the ward, and it is possible others were able to find what I had missed due to them being more familiar'

The panel considered that in your oral evidence you stated that on this day it was only your first or second shift at this ward. It noted that Kristian Keyte also agreed this in his oral evidence. The panel noted that you would have been unfamiliar with the layout of the stock cupboard and the ward in general. The panel considered it was possible that you looked but failed to find the medication in the clinical room or on the other drug trollies. The panel however did not have any evidence of you failing to follow the correct process for ordering medication and considered that as you were new to the ward it was entirely possible that you checked for the medications in these areas but did not find them.

The panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was a lack of evidence from Sophie Phillips, a direct witness of this allegation and

an alternative explanation for you not obtaining the medication in the clinical room or from the drug trolleys. Therefore, on the balance of probabilities, this charge is not found proved.

Charge 1.2.1

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.2 On or around 25 April 2022 whilst on a supervised drug round:

1.2.1 Lost the keys to the drugs trolley.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 25 April 2022 exhibited by Kristian Keyte:

‘Lost the keys – found in open bedside locker in bay without staff member in...Discussed with MM after drug round. MM asked how he thought the drug round went; MM could not identify any errors.’

The panel noted that it was Kristian Keyte’s evidence that the keys were found by a member of staff in a room where there were no staff members present.

The panel were not provided any evidence of how it was the case that the keys could have been found in a room where no staff members were present and Kristian Keyte did not describe within his evidence finding the keys himself.

The panel also referred to Kristian Keyte's oral evidence:

[Ms Shah]: in fact, Mr Masih knew exactly where the keys were and he said, 'I put them in the patient locker only while I am here dispensing medication.' But you assumed that he'd lost them and you didn't put what he said in response in the chart, the observation chart. Do you agree?

[Kristian Keyte]: No'

Although Kristian Keyte denied making an assumption that the keys were lost and not recording your response in this regard, Kristian Keyte did not offer any further explanation as to how he had come to the conclusion that the keys were lost, nor how they came to be found. The panel were not provided with a clear explanation as to how Kristian Keyte came to record the Direct Observation of Practice Record and how he knew that the keys were lost.

The panel then referred to your witness statement:

'I deny charge 1.2. Kristian Keyte's file note about this incident is false and part of an attempt on his part to get rid of me. The keys were in the patient locker while I was in the room doing the drug round and I was aware of where they were at all times.'

The panel considered that this was consistent with your oral evidence that you were standing close to the patient locker. The panel considered that you were consistent in your account of where the keys were and that they were not lost at any time.

It further considered that in the Direct Observation of Practice Record your alleged loss of the keys was not named as a learning point. The panel considered that had Kristian Keyte observed you losing the keys directly, which would have been a serious error, Kristian Keyte would have recorded this as a learning point on the Direct Observation of Practice Record.

Overall, the panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was a lack of clear evidence from Kristian Keyte as to the alleged loss of the keys.

Charge 1.2.2)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.2 On or around 25 April 2022 whilst on a supervised drug round:

1.2.2 Failed to use the correct technique for giving an injection.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 25 April 2022 exhibited by Kristian Keyte:

‘Injection technique not correct for subcutaneous injections – injected into pinched thigh at 90° – informed after drug round that technique was incorrect.’

The panel considered within the same record Kristian Keyte stated as a learning objective:

‘Needs to remember injection techniques e.g. 45° for subcutaneous and 90° for intramuscular’

The panel noted your account that you have practiced for many years and used both 45° and 90° angles for subcutaneous injections without ever having been questioned on it. The panel considered there was an absence of information before it, given the contrary accounts, as to which technique was appropriate for the patient in the particular circumstances. The panel did not have before it any hospital policies or clinical guidance regarding injection technique at Hospital 3. In Kristian Keyte’s evidence the panel considered that there was a lack of clarity in respect of the details of the patient, type of drug being administered, the size of the needle used. Kristian Keyte also failed to provide evidence of why injecting this particular patient at a 90° angle into a pinched thigh was wrong and what, if any, harm it could have caused.

Overall, the panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was limited information provided by Kristian Keyte as to the correct injection techniques employed within Hospital 3.

Charge 1.2.3)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.2 On or around 25 April 2022 whilst on a supervised drug round:

1.2.3 Failed to confirm a patient's identification prior to administering medication."

This charge is found proved.

In reaching this decision, the panel took particular account of Kristian Keyte's and your documentary and oral evidence.

The panel referred to your Medicines Competency Assessment exhibited by Kristian Keyte in which it outlines:

'Check patient's identity by asking the patient to state their full name and date of birth. Check patient wrist band against the prescription chart making sure all details match including hospital number. Check the patient's allergy status by asking them or checking their wrist band.'

The panel referred to the Direct Observation of Practice Record dated 25 April 2022 exhibited by Kristian Keyte:

'Patient in Side Room 2 had no wrist band, MM gave Thiamine without confirming patient's ID and prior to placement of wristband – pulled up on it, MM said he did check ID but I did not hear this happen...'

Further learning objectives identified following discussion

◆ ID checking:

o should check wristband AND verbal ID against drug chart when patient able to communicate

o Should ensure patients without ability to verbally confirm ID have a wrist band before administering any medication'

The panel referred to your witness statement:

'I confirmed the patient's identity by asking verbally and checking their wristband.'

The panel found this to be inconsistent with your oral evidence on the basis that during your oral evidence you accepted that the patient did not have a wristband and stated that you identified the patient by confirming verbally their name and date of birth.

The panel considered that the Medicines Competency Assessment requires you not only to check verbally the patients name and date of birth but also to check the patient's wristband against the prescription chart making sure all details matches including the hospital number and any known allergies. The panel considered in the absence of the patient wristband you would not have been able to correctly confirm the patient's identity prior to administering the medication in line with clinical guidance.

On the basis of your admission that the patient did not have a wrist band the panel found on the balance of probabilities that you failed to confirm the patient's identification prior to administering medication.

Charge 1.2.4)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.2 On or around 25 April 2022 whilst on a supervised drug round:

1.2.4 On one or more occasions re-sheathed needles despite being informed that this was not allowed."

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Kristian Keyte's and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 25 April 2022 exhibited by Kristian Keyte:

'IV prepared with good technique and instructions checked on Medusa properly, although had to be told not to re-sheath needles 3 times...Needs to stop re-sheathing needles, even when the needle has not been used on a patient'

The panel noted that it was your position in your written evidence that you did not re-sheath any needles which was consistent with your oral evidence. In oral evidence you confirmed that you were not allowed to re-sheath any needles, this was not the correct process and to do so would pose a risk of injury. You said that you would have the sharps bin under the drug trolley which you would use.

The panel considered the oral evidence of Kristian Keyte in which questions were raised in respect of the needles being re-sheathed:

[Ms Shah]: And you repeatedly raised that he wasn't re-sheathing needles, but you were doing that before he'd had an opportunity to re-sheath them.

[Kristian Keyte]: To stop it from happening. So it would be attempt to begin to re-sheath needles, 'Please don't do that,' as he is about to put the cap back on the needle so as to avoid Mr Masih incurring a sharps injury.'

The panel noted that during Kristian Keyte's oral evidence it became apparent that you had not actually re-sheathed needles, as suggested in the Direct Observation of Practice Record, and Kristian Keyte's position changed in that he stated that this was something you allegedly attempted to do.

The panel considered in the light of the evidence of Kristian Keyte whether or not it would be fair to amend the charge to state that you attempted to re-sheath needles. The panel noted that this was not an application advanced by the NMC. Further it considered that amending the charge at this late stage in proceedings would be unfair on the basis that Kristian Keyte's written and oral evidence was inconsistent such that Kristian Keyte had initially raised concerns about needles actually being re-sheathed. The panel noted that you had prepared your case in this regard and considered that amending the charge would be attempting to fit the charge to the inconsistent oral evidence.

Overall, the panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was inconsistent evidence provided by Kristian Keyte to suggest that any needles were actually re-sheathed. Therefore, the panel did not find this charge proved.

Charge 1.2.5)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.2 On or around 25 April 2022 whilst on a supervised drug round:

1.2.5 On one or more occasions left needles in trays unattended."

This charge is found proved.

In reaching this decision, the panel took particular account of Kristian Keyte's and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 25 April 2022 exhibited by Kristian Keyte:

'Left tray with used needle on notes trolley and walked away to get something. Left tray with used needle on counter in clinical room, went to walk away and I asked him to dispose of his sharps before moving forward.'

The panel referred to your witness statement:

'I did not leave needles in trays unattended'

The panel also referred to Kristian Keyte's oral evidence:

'[Ms Shah]: And the same process followed where before he'd even done something or started doing something you would say, 'Don't do that. You're doing that wrong.'

[Kristian Keyte]: That is not the way in which those conversations or interactions happened. But essentially, before a patient came to harm the incident was stopped.'

The panel concluded that on the balance of probabilities, this charge is found proved as the panel accepted that Kristian Keyte was intervening before something happened to prevent any harm. The panel noted that Kristian Keyte had kept a contemporaneous record through the Direct Observation of Practice Record which was supported by his written and oral evidence. The panel gave weight to the fact that Kristian Keyte reported that this concern arose on a number of occasions and within the record it states that you were called back after leaving needles on a counter in a clinical room.

Overall, the panel concluded that this charge is found proved on the balance of probabilities. In the circumstances the panel found Kristian Keyte's evidence on this issue to be clear and consistent. Therefore, the panel found this charge proved.

Charge 1.3)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.3 On or around 3 May 2022, during a supervised medication round, failed to recognise/understand that taking on extra tasks during a drugs round could delay medication doses to patients.”

This charge is found proved.

The panel noted that you had admitted the facts of this charge but not the stem.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to your witness statement:

‘I admit charge 1.3. The patient asked for bloods to be taken. The nurse who was supervising me left me alone, and so I was unable to dispense medication because I was not supervised. I therefore used the time to do the bloods. This was discussed during the meeting on 3 May 2022, when I said “patient choice comes first”. I regret becoming defensive when I was offered the opportunity to improve my practice. I felt attacked and did not respond appropriately’

The panel referred to the File Note dated 13 May 2022 exhibited by Kristian Keyte:

'Practice Observation from Medication round 03/05/2022 with Sister Milsom. MM stopped halfway through his drug round to take a patient's blood. MM took 1 hour and 45 minutes to do breakfast medication round for 6 patients. MM informed that this is not good practice as it will distract him from his medication round and could lead to medication errors. MM reminded that his concentration during medication rounds must be on his medication round and if other tasks are asked of him, unless it is an emergency, they should wait. MM argued that the patient chose to have his bloods taken at that time so patient choice should come first in this situation. MM unable to understand that taking on extra tasks during medication rounds can lead to medication errors and will delay future medication rounds unnecessarily. MM encouraged to work faster, but still maintain safety during medication rounds as the length of time he is taking to administer medications is beginning to impact on future doses of medication and delaying care for patients. MM reminded that medications management is part of his informal performance management plan and this must be completed by 20/05/2022. MM continued to discuss the patient in Bay 1 Bed 1.'

The panel considered that there were inconsistencies in your oral and documentary evidence about whether a doctor asked you to take this patient's bloods. However, it concluded that whether a doctor asked you to take bloods or not during this drugs round you should not have agreed to the task.

The panel considered that you admitted the facts of the charge but not the stem, namely, that your actions amounted to a failure to demonstrate the standards of knowledge, skill and judgement required of you. The panel noted your explanation as to why you took on the extra task, however, it considered in doing so you were at risk of making errors and further delaying medication administration to other patients on the ward. The panel noted the evidence of Kristian Keyte that this was poor practice, and it considered that it amounted to a failure to demonstrate the knowledge, skills and judgement required of you in the circumstances.

Therefore, the panel found this charge proved.

Charge 1.6.1)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.6 On or around 19 May 2022, whilst on a supervised round:

1.6.1 Hung fluid bottles that had the incorrect giving set.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 18 May 2022 exhibited by Kristian Keyte. The panel noted that this Direct Observation of Practice Record was completed by Joanne Hartmann (a colleague):

‘Prior starting the drug round Moras was hanging a bottle of fluids for a patient, he had the incorrect giving set, which he did not realise until he had opened it and punctured the bottle’

The panel referred to your witness statement:

‘I did not hang the incorrect set of fluid bottles, I was only checking them.’

The panel noted that this was consistent with your oral evidence that you did not hang the bottle but only checked them.

The panel considered that the evidence for the charge is from Joanne Hartmann, a witness not called by the NMC, and is therefore hearsay evidence. The panel noted that although this was hearsay evidence, no application to adduce such evidence was made. There was however no application to exclude this evidence by Ms Shah. The panel noted the advice provided in respect of hearsay evidence namely reference to the case of *Thorneycroft*. The panel considered the *Thorneycroft* principles; it noted that the evidence of Joanne Hartmann is sole and decisive evidence for this charge. The evidence is challenged by you, and the panel were not provided with any reasons for the non-attendance of Joanne Hartmann. The panel were not given any indication as to whether the NMC took any steps to secure her attendance. In the absence of any information about Joanne Hartmann, the panel were not able to determine whether or not she had any reason to fabricate her evidence. The panel considered that this is a serious charge which would have an impact on you if an adverse finding was made. In all the circumstances and having considered the *Thorneycroft* criteria the panel found that the hearsay evidence should not be admitted under Rule 31 on the basis that to do so would be unfair.

Therefore, the panel found this charge not proved on the balance of probabilities.

Charge 1.6.2)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.6 On or around 19 May 2022, whilst on a supervised round:

1.6.2 Having replaced the giving set, failed to identify that there was a large amount of air in the giving set.”

This charge is found NOT proved.

The panel found that this charge is based on the Direct Observation of Practice Record dated 18 May 2022 exhibited by Kristian Keyte. The panel noted that this Direct Observation of Practice Record was completed by Joanne Hartmann, who the NMC did not call as a witness. The panel noted that there was no other evidence advanced by the NMC to support this charge. The panel considered its findings for charge 1.6.1 as to the admissibility of the hearsay evidence of Joanne Hartmann. Having found that it would be unfair to admit this evidence under Rule 31, the panel found this charge not proved.

Charge 1.6.3)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.6 On or around 19 May 2022, whilst on a supervised round:

1.6.3 Failed to ensure that a patient had a safe blood glucose measurement prior to administering diabetic medication.”

This charge is found NOT proved.

The panel found that this charge is based on the Direct Observation of Practice Record dated 18 May 2022 exhibited by Kristian Keyte. The panel noted that this Direct

Observation of Practice Record was completed by Joanne Hartmann, who the NMC did not call as a witness. The panel noted that there was no other evidence advanced by the NMC to support this charge. The panel considered its findings for charge 1.6.1 as to the admissibility of the hearsay evidence of Joanne Hartmann. Having found that it would be unfair to admit this evidence under Rule 31, the panel found this charge not proved.

Charge 1.6.4)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.6 On or around 19 May 2022, whilst on a supervised round:

1.6.4 Left bags of medication unattended on a chair.”

This charge is found NOT proved.

The panel found that this charge is based on the Direct Observation of Practice Record dated 18 May 2022 exhibited by Kristian Keyte. The panel noted that this Direct Observation of Practice Record was completed by Joanne Hartmann, who the NMC did not call as a witness. The panel noted that there was no other evidence advanced by the NMC to support this charge. The panel considered its findings for charge 1.6.1 as to the admissibility of the hearsay evidence of Joanne Hartmann. Having found that it would be unfair to admit this evidence under Rule 31, the panel found this charge not proved.

Charge 1.7.1)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.7 On or around 20 May 2022:

1.7.1 Attempted to use a Sera-Steady mobility aid on your own when you were aware that it requires two people to use it.”

This charge is found NOT proved.

The panel noted that the NMC relied upon the witness statement of Tamsin Kay at paragraphs three and four, which referred to her local statement dated 20 May 2022:

‘As I was leaving, I noticed that [a patient] started to slump over the Sera Steady, which Moras said he would rectify. While I was briefly gone, Moras left the bay and, in doing so, left [the patient] hanging further over the bar of a Sera-Steady behind curtains.’

The panel noted that within this statement there is no reference to you attempting to use the Sera-Steady mobility aid on your own. The panel further noted that the NMC referred the panel to the Supporting Performance Report exhibited by Kristian Keyte dated 28 September 2022 for this charge, however, it considered that this was a timeline of events but not evidence itself with no additional information or reference to you using the Sera-Steady on your own.

The panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found there was no evidence before it in relation to this charge.

Charge 1.7.2)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.7 On or around 20 May 2022:

1.7.2 Left the patient hanging over the bar of the Sera-Steady mobility aid.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Tamsin Kay’s and your documentary and oral evidence.

The panel referred to a statement exhibited by Tamsin Kay dated 20 May 2022:

‘As I was leaving, I noticed that [a patient] started to slump over the Sera Steady, which Moras said he would rectify. While I was briefly gone, Moras left the bay and, in doing so, left [the patient] hanging further over the bar of a Sera-Steady behind curtains... but luckily one of the band six nurses who came by noticed this assisted with getting him stood back up.’

The panel also referred to Tamsin Kay’s oral evidence:

[Panel question]: In particular – sorry... I might not have been as clear as I could have been – it was the bit about when you returned to the bay. Could you just talk us through what happened when you returned?

[Tamsin Kay]: So I went out, I got the iPad, I spoke to the nurse in charge to see if there was anything else that needed to be done and then I mentioned that the patient was starting to flop over the Sera Steady. And she said, sort of educated

me, obviously two people should say, 'You should have got someone else'. I apologised. I didn't realise, I thought it was just when you actually physically mobilising them that you had to have to people. I thought one person could have stayed. So the sister came back with me, we entered in – like behind the curtains – she entered in first, I came in after her, and the patient was just flopped over the bar of the Sera Steady. So it was just me and her behind the curtain and the patient.'

The panel considered that Tamsin Kay's recollection of the involvement of the Band 6 nurse was inconsistent on the basis that it was unclear whether the band 6 nurse had found the patient and was already assisting the patient or whether, Tamsin Kay had left to get the help of the Band 6 nurse to assist her with the patient. The panel noted that it is alleged that there were other witnesses to this incident who have not been called by the NMC to give evidence, including, the Band 6 nurse, who would have been senior to both you and Tamsin Kay and would have been able to assist the panel.

It also considered that there was no Datix evidenced before it identifying who the patient was and no evidence of a safeguarding referral. The panel noted the evidence of Tamsin Kay that she was too junior to have completed the Datix for this incident, but she would have expected one to be completed. The panel noted that given the severity of the allegation, that a Datix or safeguarding referral would have been relied upon by the NMC to support the allegation.

Overall, the panel concluded that this charge is not found proved on the balance of probabilities. In the circumstances the panel found that the NMC failed to discharge its burden of proof as there was limited evidence before it. Therefore, the panel did not find this charge proved.

Charge 1.7.3)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.7 On or around 20 May 2022:

1.7.3 Attempted to remove a canvass sheet from underneath Patient 4 using an incorrect and/or dangerous technique.”

This charge is found proved.

In reaching this decision, the panel took particular account of Tamsin Kay’s and your documentary and oral evidence.

The panel referred to a statement exhibited by Tamsin Kay dated 20 May 2022:

‘Following this incident, Moras left one of his patients...on a canvas sheet for a lengthy time. Before I headed back into my bay, I offered to assist in removing the canvas sheet from under...to prevent pressure sores from developing and allow him to be a bit more comfortable. Moras agreed, so we went to sort this and pulled the curtains around [the patient]. Before I had a chance to say or do anything, Moras started trying to pull the canvas sheet which... was on over him. I informed Moras to stop as this may hurt’.

The panel also referred to Tamsin Kay’s witness statement to the NMC dated 15 June 2023:

‘On 20 and 26 May 2022 I worked alongside Mr Masih and had concerns regarding poor practice in relation to manual handling procedures and lack of knowledge regarding pressure care.’

In oral evidence, Tamsin Kay said that the canvas sheets are rough and if pulled it could lead to skin damage, she said that you were trying to pull the canvas sheet over the patient as opposed to rolling them, which she was concerned could lead to skin tear and break down. Tamsin Kay was asked about these matters in cross-examination and confirmed that she helped to remove the canvas sheet to assist you.

The panel noted that you denied this charge in your written evidence. It was put to Tamsin Kay on your behalf that she did not help you. However, in oral evidence, you stated that you could not recall whether Tamsin Kay was there or not, but you did recall the incident. You were challenged in respect of this in cross-examination and when asked whether this was your patient you stated that you could not remember but the staff helped each other in different bays. During your oral evidence you stated that people did not help you and that you had to wait a long time but stated that eventually someone did come and help you. The panel considered this to be inconsistent with the position put on your behalf that Tamsin Kay did not assist you at all.

The panel concluded that on the balance of probabilities, this charge is found proved as the panel accepted Tamsin Kay's evidence that she intervened whilst you attempted to remove a canvass sheet from underneath Patient 4 using an incorrect and/or dangerous technique. The panel noted that Tamsin Kay provided a contemporaneous record through her local statement which was supported by her written and oral evidence. The panel gave weight to the fact that Tamsin Kay was consistent in her evidence that she was present when the incident occurred.

Overall, the panel concluded that this charge is found proved on the balance of probabilities. In the circumstances the panel found Tamsin Kay's evidence on this issue to be clear and consistent. Therefore, the panel found this charge proved.

Charge 1.8)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.8 On or around 25 May 2022, completed an unsupervised medication round having been informed at a midpoint management meeting that you were to be supervised until the end of the performance management.”

This charge is found proved.

The panel noted that you had admitted the facts of this charge but not the stem.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to your witness statement:

‘I admit charge 1.8. There was some confusion around this, with different supervisors interpreting the requirements differently, but I accept it was my responsibility to act according to my own understanding, which was that I should be directly supervised at all times when completing a medication round.’

The panel noted in oral evidence you stated that you refused initially and then became ‘scared’ after Sister Milsom allegedly told you that you were competent and ‘forced’ you.

You said that you accepted your mistake in carrying out the medication round.

The panel noted that in Kristian Keyte's oral evidence he accepted that Sister Milsom told you to do the drugs round when you were not meant to. However, the panel concluded that you were aware that you were not to complete any unsupervised medications rounds at this time.

The panel considered that you admitted the facts of the charge but not the stem, namely, that your actions amounted to a failure to demonstrate the standards of knowledge, skill and judgement required of you. The panel noted your explanation as to why you took on the unsupervised medication round, however, it considered in doing so you were knowingly acting outside of your competencies. The panel considered that this amounted to a failure to demonstrate the knowledge, skills and judgement required of you in the circumstances.

Therefore, the panel found this charge proved.

Charge 1.9.1)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.1 Failed to provide water slowly to Patient A as required/requested."

This charge is found proved.

In reaching this decision, the panel took particular account of both Kristian Keyte's and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 4 August 2022 exhibited by Kristian Keyte:

‘Patient [A]: Sign on wall behind patient’s bed saying water and food at slow pace. MM rushed the patient when giving him water, causing him to start coughing. Was forceful with the water and had to be told twice to slow down.’

The panel considered that in both your witness statement and oral evidence you denied this allegation.

The panel concluded that on the balance of probabilities, this charge is found proved as the panel accepted that Kristian Keyte observed that you failed to provide water slowly to Patient A as required/requested. The panel noted that Kristian Keyte had kept a contemporaneous record through the Direct Observation of Practice Record which was supported by his written and oral evidence. The panel gave weight to the fact that Kristian Keyte was consistent in his account that he directly observed your failure and this failure was documented in contemporaneous records.

Overall, the panel concluded that this charge is found proved on the balance of probabilities. In the circumstances the panel found Kristian Keyte’s evidence on this issue to be clear and consistent. Therefore, the panel found this charge proved.

Charge 1.9.2)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.2 On one or more occasions failed to identify/provide answers as to what the instructions in the drugs chart said.”

This charge is found proved.

In reaching this decision, the panel took particular account of both Kristian Keyte’s and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 4 August 2022 exhibited by Kristian Keyte:

‘IV antibiotics had finished on previous day. MM argued that they needed to continue onto the next page despite lack of prescription. MM asked multiple times what the instructions in the drug chart said and he was unable to answer.’

When asked about this in oral evidence you told the panel that the aforementioned record is not accurate, you said that many of the allegations against you have resulted in a no case to answer and you said that Kristian Keyte has made up several of these allegations to ‘get [you] out’. However, it also considered that on this Practice Record, many times ‘No issues’ was stated and as such this record appears to be balanced, and therefore the panel did not accept your contention that Kristian Keyte fabricated allegations.

The panel concluded that on the balance of probabilities, this charge is found proved as it accepted that Kristian Keyte observed you on one or more occasions where you failed to identify/provide answers as to what the instructions in the drugs chart said. The panel noted that Kristian Keyte had kept a contemporaneous record through the Direct Observation of Practice Record which was supported by his written and oral evidence. The panel gave weight to the fact that Kristian Keyte was consistent in his account that he directly observed your failure and this failure was documented in contemporaneous records.

Overall, the panel concluded that this charge is found proved on the balance of probabilities. In the circumstances the panel found Kristian Keyte's evidence on this issue to be clear and consistent. Therefore, the panel found this charge proved.

Charge 1.9.3)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.3 Failed to identify that Patient C's Bisoprolol medication was incomplete."

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Kristian Keyte's documentary evidence.

The panel referred to the Direct Observation of Practice Record dated 4 August 2022 exhibited by Kristian Keyte:

'Patient was self-medicating. Identified that Bisoprolol prescription was incomplete so omitted and noted to inform doctor.'

In oral evidence you stated you denied this charge; it is your case that you followed standard procedure and correctly noted that the prescription was incomplete. For that reason, you omitted to administer Patient C the Bisoprolol and informed the doctor.

The panel considered all the evidence before it relative to this charge. It noted that the NMC did not provide the Bisoprolol prescription, the subject of the charge. The panel would have expected this document to be produced to support the NMC case. The panel also noted Kristian Keyte's evidence that you acted appropriately in the circumstances charged, supports your evidence.

For these reasons, the panel accepted the evidence and therefore found this charge not proved.

Charge 1.9.4)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.4 In respect of Patient D, failed to recognise that the prescription for 'Prosource Plus Fluid' was not Phosphate Sandoz, and."

This charge is found proved.

In reaching this decision, the panel took particular account of both Kristian Keyte's and your documentary and oral evidence.

The panel referred to the Direct Observation of Practice Record dated 4 August 2022 exhibited by Kristian Keyte. It noted that this is a contemporaneous record:

‘Insisted that prescription for ‘Prosource Plus Fluid’ was Phosphate Sandoz despite being told otherwise. Was preparing to give Phosphate Sandoz until I stopped him and told him what should be being given. Did not seem to understand implications of giving Phosphate Sandoz unnecessarily’

The panel noted that in oral evidence you explained to the panel the difference between the two medications, namely that one is a sachet and the other is not.

The panel noted that at the relevant time Kristian Keyte was checking your work. The panel acknowledged the difficulties between yourself and Kristian Keyte at this time, however, it considered that Kristian Keyte’s evidence that despite being told of the issue, you *‘insisted’* you were correct was important. This is a strong word in this context and significantly Kristian Keyte’s evidence is the Direct Observation of Practice Record, a contemporaneous account. For these reasons the panel found this charge proven on the balance of probabilities.

Charge 1.9.5)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.9 On or around 4 August 2022, during a supervised drug round:

1.9.5 Failed to recognise the implications of administering Phosphate Sandoz unnecessarily.”

This charge is found proved.

In reaching this decision, the panel took particular account of both Kristian Keyte's and your documentary and oral evidence. It took into account that Kristian Keyte's evidence was supported by the Direct Observation of Practice Record dated 4 August 2022:

'...Was preparing to give Phosphate Sandoz until I stopped him and told him what should be being given. Did not seem to understand implications of giving Phosphate Sandoz unnecessarily'

The panel noted that at the relevant time Kristian Keyte was checking your work. The panel also acknowledged the difficulties between yourself and Kristian Keyte at this time and noted your evidence that you did not agree that the Direct Observation of Practice Record was accurate. It also noted that the Direct Observation of Practice Record has not been signed by you.

The panel considered the evidence in its totality and noted that the Direct Observation of Practice Record is a contemporaneous record. It took into account your evidence that it was not an accurate record. However, it is a contemporaneous record and is consistent with Kristian Keyte's oral evidence. Further on the balance of probabilities, the panel is satisfied that Kristian Keyte as a registered nurse would have been unlikely to fabricate the Direct Observation of Practice record.

For these reasons the panel preferred Kristian Keyte's evidence and find this charge proved.

Charge 1.10.1)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.10 On or around 16 August 2022:

1.10.1 On one or more occasions left a patient at high risk of falls unattended despite being told to stay with the patient.”

This charge is found proved.

In reaching this decision, the panel took particular account of Kristian Keyte’s, Sophie Phillips’ and your documentary and oral evidence.

The panel had sight of a Direct Observation of Practice Record dated 16 August 2022 exhibited by Kristian Keyte but was completed by Sophie Phillips:

‘My second concern throughout the day was MM did not notice he was leaving high falls patients at risk of falling on numerous occasions, MM would leave the bay in which a high falls risk patient was in after being asked to stay in the bay until someone else could cover.’

The panel referred also to Sophie Phillips’ witness statement:

‘My concerns were about time management; leaving falls risk patients at risk of falling/leaving patients unattended’

The panel also referred to Sophie Phillips’ oral evidence in chief:

‘there was multiple times where I would ask, ‘Please stay in the bay, there’s high falls risk patients. Or if you’re going to leave the bay for whatever reason, just ask someone to go into the bay’ and I would get up and there would be no one in there. I don’t know where he would be. Occasions, there was times where he wasn’t around on the ward and I didn’t know where he was.’

The panel noted that you did not sign the Direct Observation of Practice Record, that you denied this charge and that you referred to Sophie Phillips as part of the staff who were '*ganging up*' on you. However, it also considered that in Sophie Phillips' oral evidence she stated that she '*did [her] utmost best to support [you]*' and that she '*would have heard [your] side out*'.

The panel considered Sophie Phillips to be consistent in her evidence overall. Her evidence is supported by a contemporaneous record and the panel found it unlikely that she, as a registered nurse would have fabricated her evidence. Sophie Phillips' contemporaneous evidence, oral evidence and witness statement were consistent and coherent, and therefore on the balance of probabilities the panel found this charge proved.

Charge 1.10.2)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.10 On or around 16 August 2022:

1.10.2 Left down the bed rails of a patient who was at high risk of falls."

This charge is found proved.

In reaching this decision, the panel took particular account of Sophie Phillips' and your documentary and oral evidence.

The panel had sight of a Direct Observation of Practice Record dated 16 August 2022 exhibited by Kristian Keyte but completed by Sophie Phillips:

'I also noticed him leave bed rails down with a patient after seeing them, who was at risk of falling from the bed. When challenged on these concerns MM was unable to give me a logical reason for them, I explained how the patient was at high risk of falling and to be aware for future it as could lead to a serious incident, however again I noticed multiple times throughout the day he was leaving patients unattended and had no logical reason into this.'

The panel considered Sophie Phillips to be consistent in her evidence overall. Her evidence is supported by a contemporaneous record and the panel found it unlikely that she would have fabricated her evidence. Sophie Phillips' contemporaneous evidence, oral evidence and witness statement were consistent and coherent, and therefore on the balance of probabilities the panel found this charge proved.

For reasons given in relation to its findings in charge 1.10.1 the panel find this charge proved on balance of probabilities.

Charge 1.10.3)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.10 On or around 16 August 2022:

1.10.3 Failed to complete a MUST in a timely manner."

This charge is found proved.

In reaching this decision, the panel took particular account of Sophie Phillips' and your documentary and oral evidence.

The panel had sight of a Direct Observation of Practice Record dated 16 August 2022 exhibited by Kristian Keyte but completed by Sophie Phillips:

'A final concern with MMs performance on this day would be when observing him from the morning I asked him to make sure patients MUSTs were completed by the end of the day as it two hadn't been done since admission and this was vital for the patients rehab and nutritional needs. At the end of the shift the MUSTs had still not been completed and when challenged on this MM said the weighing scales had broken, I checked the scales and they were working fine so this is concerning as MM either was not telling the truth or didn't know how to use the machine, however when I showed MM the machine and how to turn it on with one button he again could not give a valid reason for not doing as asked.'

The panel referred to Sophie Phillips' oral evidence:

'I specifically, on many occasions, would ask for him to make sure MUST were completed and up to date and by the end of the day, they still weren't done... It should be completed within a reasonable period. I mean, when a patient is admitted, ideally within six hours of admission. So if it's a new patient that comes to our ward, we would want to get that done within six hours. Understandably, it's a busy ward and I get that things can't always be done. But at the time when I was observing him and he only had four or five patients, I felt he definitely had the time in his day to make sure that these things were done and they just weren't being done. And it was multiple things like that.'

The panel noted your witness statement that:

'I deny charge 1.10. While I agree the MUST was not completed in a timely manner, this is because working scales were not available to me.'

The panel also referred to your oral evidence where you could not remember if on 16 August 2022 you managed to retrieve a working scale machine.

The panel balanced Sophie Phillips' evidence against your evidence. It noted that Sophie Phillips' oral evidence was supported by a contemporaneous record. It noted that your recollection is unclear as to whether you managed to retrieve a working scale machine on 16 August 2022 to enable you to complete a MUST.

For these reasons the panel preferred Sophie Phillips' evidence and found this charge proven on the balance of probabilities.

Charge 1.11)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.11 On or around 22 August 2022:

1.11.1 On one or more occasions left the drug trolley unattended and/or unsupervised.

1.11.2 Left the bedside medications cabinet open with the keys in the lock unattended."

These charges are found NOT proved.

The panel considered both charges 1.11.1 and 1.11.2 together due to the nature of the evidence.

In reaching this decision, the panel took particular account of Kristian Keyte's evidence. The panel noted that the subject matter of these charges is not mentioned by Kristian Keyte in his NMC witness statement but is exhibited under KK/1 as Appendix 62 in the supporting performance report.

The panel noted that Appendix 62 is unsigned and does not identify the author and, in any event, is hearsay evidence.

The panel considered that Appendix 62 is the only evidence supporting charge 1.11. Appendix 62 records the following:

'Moras left the drug trolley many times for a variation of things.

-Getting meds from the clinical room not on the trolley

-Finding drug charts

-Fetch pharmacy medication prescription sheet

-Left his pen in the clinical room

This made the drug round longer than it should have been.

During this time he assumed I would be staying with the drug trolley. He often left the patients pod door open with the keys in whilst he walked off and the drug trolley open. He never asked me to look after the open trolley or attempt to close either the pod or the drug trolley.

I had to tell Moras at one stage, if he kept wandering off, he would never finish the drug round. Even one of the patients got frustrated with Moras and his attitude.'

The panel noted that Appendix 62 was not signed, nor in the Trusts' official document lay out (such as the File Note or Direct Observation of Practice Record template), and although Kristian Keyte exhibited it, it is hearsay evidence. The panel considered Rule 24(7) of the Rules and the guidance in *Thorneycroft*. It noted that hearsay evidence can be admitted into evidence subject to the requirements of relevance and fairness.

The panel took into account that Appendix 62 is unsigned and comes from an unidentified source. Although it is referred to in Kristian Keyte's index within his Supporting Performance Management report, it is not otherwise referred to in evidence. Further and significantly, it also is the sole evidence supporting charge 1.11.1 and 1.11.2. The panel therefore decided that no weight should be placed on this document.

In the absence of any other evidence to support charges 1.11.1 and 1.11.2 the panel found these charges not proved on the balance of probabilities.

Charge 1.12)

"That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working at the Uphill Stroke Unit:

1.12 On or around 24 August 2022:

1.12.1 Left keys in the patients opened Pods.

1.12.2 Having been asked on one or more occasions failed to hand over a patient to the receiving Ward."

These charges are found NOT proved.

In reaching this decision, the panel took particular account of Kristian Keyte's documentary evidence.

The panel had sight of a Direct Observation of Practice Record dated 24 August 2022 exhibited by Kristian Keyte but was completed by Maridel Arcabal (a colleague). The panel noted that this record provides no clear evidence related to the matters as charged.

The panel also considered Appendix 62 as in charge 1.11, which provided hearsay evidence relative to the charges on or around that date. The panel noted the same considerations in relation to hearsay evidence outlined at charge 1.11, applied to this charge.

Therefore, on the balance of probabilities the panel found these charges not proved.

Charge 1.14)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working on Hutton Ward:

1.14 On or around 3 September 2020, incorrectly administered Novorapid to a patient whose blood sugar levels were above 12mmols.

This charge is found NOT proved.

In reaching this decision, the panel took particular account of all the evidence in this case it was not provided with any clinical records to indicate the precise dosage of Novorapid which was prescribed for the patient and gave no indication as to whether the medication was administered incorrectly as charged.

The panel had sight of a contemporaneous records completed by Rahab Hashim in which she stated that you had initially told her you had given the dose of Novorapid and later informed her that you had not. These records were not signed or dated.

In circumstances where the panel were not provided with clinical records and there were differing accounts between Rahab Hashim and yourself, the panel could not be satisfied on the balance of probabilities that you on or around 3 September 2020, incorrectly administered Novorapid to a patient whose blood sugar levels were above 12mmols.

Charge 1.16)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working on Hutton Ward:

1.16 On or around 19 February 2019 left a patient unattended who subsequently had a fall.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Andrea Milverton’s documentary and oral evidence.

The panel referred to a Datix dated 21 February 2019 exhibited by Andrea Milverton referring to the alleged incident, however, the panel noted that the Datix did not identify any link to you. The panel also considered that there was no documentary evidence before it as to whether you were allocated to the bay. It further noted that Andrea Milverton could not recall, in oral evidence, whether there was any rota available to assist the panel. As such, due to the lack of evidence, the panel could not be satisfied on the balance of probabilities that on or around 19 February 2019 you left a patient unattended who subsequently had a fall. Consequently, the panel found this charge not proved.

Charge 1.17.1)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working on Hutton Ward:

1.17 On or around 20 February 2019, having re-positioned a patient’s nasal prongs:

1.17.1 Failed to assess / observe whether the patient was in respiratory distress before going on a break.

1.17.2 Failed to complete clinical observations before going on a break.

1.17.3 Failed to handover the patient to a doctor / nurse before going on a break.”

These charge are found proved.

The panel considered charges 1.17.1, 1.17.2 and 1.17.3 together due to the nature of the charges and the commonality of the evidence.

In reaching this decision, the panel took particular account of Karen Low’s, Andrea Milverton’s, and your documentary and oral evidence.

The panel considered a Datix dated 26 February 2019 completed by Karen Low:

‘The patient was sat out in a chair with her call bell on the floor. She had oxygen via nasal prongs insitu and looked very scared -eyes wide and unable to clearly speak to me. I called the trained Nurse first name Marus over and he correctly repositioned her nasal prongs as I kneeled down to reassure her she was going get help as I could see she was scared and finding it difficult to breath. Marus trained nurse left when I was talking to her.’

The panel had sight of Andrea Milverton's undated NMC written statement:

'Datix 46159 was completed by pain specialist nurse Karen Low. I vaguely remember Karen coming to me and raising the concerns as I was quite shocked about the incident. I would have spoken with Moras the same day. The initial and final risk has not been assessed which I am surprised about as it went through without grading. The Datix doesn't allow you to complete until the severity and consequence are completed. The incident occurred in February 2019 when Moras left a patient in a bay who had oxygen via nasal prongs finding it difficult to breath.'

The panel referred to Karen Low's NMC written statement signed and dated 10 May 2023:

'As I arrived on the ward; Moras was just leaving bay 3. He was pulling the curtain back of the patient I needed to see; and I told him I was attending in the pain role to see the patient. I went into the bed space and pulled the curtain around for privacy. Moras had just left this bed space of this patient on the bay. Before I picked up the patient's notes from the bed end, I could see the patient was in obvious distress. I escalated this observation as an emergency. The patient was in the chair but sliding down it. She had oxygen on, but the prongs weren't positioned well; they were falling down from her nose not insitu. Her eyes were wide open, and she couldn't even talk. I called nurse Moras back; he returned to the bed space; repositioned the nasal prongs and walked away. I further checked and positioned the nasal prongs and turned the oxygen up to 4L/min from 2L/min I had knelt down to reassure the patient I would help her'

The panel also had sight of your written statement:

'I agree I repositioned a patient's nasal prongs shortly before I left bay 3 to go on my break. There was no emergency at that point, the patient was stable and comfortable. I had previously been encouraged by Andrea Milverton not to miss my break unless there was an emergency because break times are allocated to ensure

staffing levels. [PRIVATE]. I nevertheless offered to stay but Karen Low told me she did not need me and that I should go on my break. I told the senior sister and ward manager that the pain control specialist nurse was there to see the patient and asked them to look after the bay while I was on my break. I took observations frequently and escalated the NEWS score to the on-duty doctor and on call medics'

In oral evidence you stated that when Karen Low found the patient, it was around the time when you would have most likely left on your break, and you acknowledged that you were called back. You also accepted that Karen Low, as a registered nurse would have no reason to fabricate her evidence. The panel took particular note that the Datix was detailed and contemporaneous and it considered that this supported Karen Low's evidence. Further the panel heard evidence from Karen Low that this had been a distressing event for her and in oral evidence she explained that for this reason she had a clear recollection of what had occurred. The panel had sight of Andrea Milverton's written statement. Andrea Milverton was not a direct witness to events as charged. Her account is a recollection of information provided to her by Karen Low.

The panel had written and oral evidence from Karen Low. She completed the Datix. The panel noted consistency between Karen Low's Datix, her NMC statement and her oral evidence and considered that her evidence is supported by the hearsay evidence of Andrea Milverton.

It is clear from the evidence of these witnesses that having repositioned the nasal prongs you left the patient to go on your break. The panel considered whether the patient was in such distress when you left to go on your break that observations and handover were required as a matter of priority.

The panel considered your evidence that the patient was not in distress when you left. However, given the overall consistency of Karen Low's evidence, the fact that it is supported by the Datix and the hearsay evidence of Andrea Milverton the panel preferred their evidence.

The panel is therefore satisfied that on the balance of probabilities; On or around 20 February 2019, having re-positioned a patient's nasal prongs: you failed to assess / observe whether the patient was in respiratory distress before going on a break, you failed to complete clinical observations before going on a break and you failed to handover the patient to a doctor / nurse before going on a break.

Accordingly, the panel found these charges proved on the balance of probabilities.

Charge 1.18.1)

“That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse in respect of the following areas in that:

Whilst working on Hutton Ward:

1.18 On or around 20 February 2019:

1.18.1 Administered I/V medications having not been signed off as being competent.”

This charge is found proved.

In reaching this decision, the panel took particular account of Andrea Milverton's and your documentary and oral evidence.

The panel considered a Datix dated 27 February 2019 exhibited by Andrea Milverton which stated:

‘registered nurse administering IV medication, not having competencies completed...nurse attended IV training but did not understand the competencies had to be signed off before practicing skills.’

The panel gave weight to the Datix because it is a formal record completed in or around the relevant time.

The panel also referred to your written statement:

'I deny charge 1.18. I have only administered the medication whether intravenous, intramuscular or any other way when I was had been assessed as competent by others'

The panel considered your oral evidence and your explanation that you believed yourself to be signed off as competent because it was not explained to you that you needed sign off by the training department. Further the panel noted that the Datix record identifies your lack of understanding of the sign off process, which supports your account. Nevertheless, the panel is satisfied that on 20 February 2019 you administered I/V medications having not been signed off as being competent.

Having considered the totality of the evidence the panel is satisfied that this charge is found proved.

Charge 2.8)

"That you, a registered nurse:

2. On one or more dates set out in Schedule A, and on dates unknown, failed to work cooperatively with colleagues by:

2.8 Inappropriately delegating tasks to junior colleagues / colleagues."

This charge is found proved.

In reaching this decision, the panel took particular account of Kristian Keyte's, Tamsin Kay's, Sophie Phillips' and your documentary and oral evidence.

The panel first considered the definition of 'delegation' according to the NMC:

'Delegation is defined as the transfer to a competent individual, of the authority to perform a specific task in a specified situation...

Delegation of an activity may be from:

- one registered professional to another.*
- a registered professional to an unregulated member of staff.*
- a registered or unregistered person to a carer or family member.'*

The panel referred to your written statement:

'I deny charge 2.8. I don't believe I have ever asked a care assistant or student nurse to do something that was my job.'

The panel referred to a File Note dated 27 May 2022 created and exhibited by Kristian Keyte:

"MM reported to have been delegating tasks to [Tamsin Kay] throughout the shift on 26/05/2022, including admitting and discharging patients. TK reports MM was delegating tasks to her and other staff, then just standing around the bays and doing nothing. TK reports MM 'totally overwhelmed' her and did not support TK with anything.'

The panel then referred to a local statement written by Tamsin Kay, who was a student nurse at the time of the incidents, referring to 20 May 2022:

'Furthermore, throughout the day, Moras had been delegating tasks for people to complete on his behalf inappropriately, as Moras had sufficient time within his shift to complete these tasks. These tasks included connecting patients up to cardiac monitors, collecting urine samples, and filling out his paperwork.'

The panel also had sight of a Direct Observation of Practice Record dated 16 August 2022 created by Sophie Phillips:

‘ At many times I find MM sat at a computer recording emails or filling in a datix and asking staff members to complete his work, this is inappropriate as shouldn’t be done in work time especially when other responsibilities are required. When MM is challenged with such behaviour he again does not give a valid reason for doing so.’

The panel noted that Kristian Keyte, Tamsin Kay and Sophie Phillips’ accounts provided from various dates, provided consistent evidence that you were frequently and consistently delegating tasks to colleagues when you should not have done so. Accordingly, the panel found this charge proved on balance of probabilities.

Charge 3.5.1)

“That you, a registered nurse:

3. On one or more dates set out in Schedule B, and on dates unknown, failed to treat patients with kindness, compassion or respect by:

3.5 Administering medication / care without:

3.5.1 Introducing yourself.”

This charge is found NOT proved.

In reaching this decision, the panel took particular account of Kristian Keyte’s and your documentary and oral evidence.

In oral evidence you denied this charge stating that you introduced yourself as per Trust policy.

The panel referred to specific dates:

18 May 2022

For this date the panel referred to the File Note dated 18 May 2022 signed by Joanne Hartmann. The panel considered this document to be of limited weight as it was untested - as neither Joanne Hartmann was called to give oral evidence for this hearing nor the patient in the document identifiable, so it was unparticularised hearsay.

24 August 2022

For this date the panel referred to a document provided by Kristian Keyte within the Supporting Performance Report dated 28 September 2022, subsection titled 'Timeline of Events'. The panel considered that other than an allegation in this document, there was no evidence to support the charge.

31 August 2022

For this date the panel referred to Aiesha Scannell's oral evidence who stated that though she was at a considerable distance from you (*'approximately 10 metres away on a quiet ward'*), she would have heard if you had introduced yourself. However, in cross examination, Aiesha Scannell stated that she was at a considerable distance from the patient.

The panel noted that you denied this charge.

The panel considered that it could not be satisfied on the balance of probabilities that Aiesha Scannell would be close enough to hear whether you introduced yourself or not.

In considering each of these dates, on the balance of probabilities, the panel found this charge not proved.

Charge 3.5.2 & 3.5.3)

"That you, a registered nurse:

3. On one or more dates set out in Schedule B, and on dates unknown, failed to treat patients with kindness, compassion or respect by:

3.5 Administering medication / care without:

3.5.2 Explaining the care you proposed to provide.

3.5.3 Obtaining consent.”

These charges are found NOT proved.

In reaching this decision, the panel referred to its findings for charge 3.5.1.

Fitness to practise

Having reached its findings of fact, the panel next considered whether those findings amounted to a lack of competence or misconduct as alleged by the NMC. It noted that charge 1 alleged a lack of competence and charge 2 alleged misconduct.

The panel accepted the advice of the legal assessor. It reminded itself that findings of fact, statutory grounds and current impairment are separate stages of the investigatory process. The fact that an allegation has been found proved does not, of itself, establish the statutory grounds of lack of competence or misconduct relied upon. The panel was therefore required to determine whether the facts found proved established the statutory grounds alleged before going on to consider whether your fitness to practise is currently impaired.

The panel considered each statutory ground in turn.

Your Evidence on Impairment

You gave evidence on oath.

You said that you have been registered as a general nurse and a mental health nurse since 2002.

You said that your first role in the UK was in 2002 at Hartcliffe Nursing Home in Bristol.

You told the panel that you are currently looking for work and have been offered a job role with a commencing date of 8 September 2026 in South Wales as a registered nurse. You said that you have also been offered a full-time role in Devon as a registered nurse however you are awaiting the outcome of this hearing.

You said that you are not particularly seeking out work in a nursing home, it is more that they are the roles being offered to you. You said that you would prefer an NHS role, however, the previously imposed interim conditions of practice order was limiting the work offered to you.

You stated in evidence that other than this hearing, you have never had a finding of misconduct or lack of competence before the NMC.

[PRIVATE].

You told the panel that you were working on Hutton ward for around 6 months prior to being moved to Uphill stroke unit as management did not want you working amongst COVID patients.

[PRIVATE]

[PRIVATE]

[PRIVATE] you have started partaking in numerous sporting activities.

You said that even though you are currently out of work, you wanted to complete your revalidation portfolio.

You said that through the training you have undertaken you have found it important to remain humble and be patient with other people.

You said that in the future if you were on a medication round and the medication trolley was untidy, you would organise it prior to starting the round. You said that you have also learnt that patients should have more of a say in their medications and you have also learnt when to say no to doctors or colleagues when you feel overworked. You said that in the future, if someone asked you to help with a task when you did not have the capacity to do so, you would ask for help or appropriately hand over to a colleague. You said that in the future you would place utmost importance on documenting all of your actions.

You told the panel that in the future, you would ensure that all of the patients under your care were stable prior to going on a break, stating you said that you would do this by carrying out full observations and you would check if the person you were handing over to were competent as teamwork is important. You clarified that if they were a junior colleague and they were not comfortable, you would not handover to them.

Ms Simpeh, on behalf of the NMC provided the panel with Exhibit 30, a previous NMC Conduct and Competence decision following a hearing in 2014 which resulted in you being suspended for 6 months. The charges found proved were:

'That you, a registered nurse

1. *Whilst working on a bank shift on Lime Unit on 18 February 2010, administered medication inappropriately to Patient A in that you:*

(a) ...

(b) *Held Patient A's head back and forcibly administered medication;*

(c) *Did not obtain consent from Patient A before administering medication.*

2. *Whilst working on Hazel Unit on 27/28 February 2010:*

(a) *Poured water on Patient B's head to wake him up.*

(b) *Told Healthcare Assistant Ms 1 to leave Patient B when he had been incontinent using words to the effect of "leave him, he always does this".*

(c) *Bent Patient B's forefinger back when staff nurse Ms 2 was trying to take a BM reading;*

(d) *Spoke inappropriately about Patient B to staff including Ms 2 and Mr 3 by saying words to the effect of "I can't help him, I'll smack him".*

And in light of the above, your fitness to practise is impaired by reason of your misconduct'

Ms Simpeh suggested to you under cross examination that you were incorrect when you said there was no previous regulatory finding of misconduct against you. You responded that you did not remember this until Ms Simpeh had brought it up. You said that you did not deliberately try to hide this, but you were focusing on the matter before the panel today. You clarified that though these charges were found proved, there were lengthy contextual matters. You initially stated in evidence that you had returned to work '*after a couple months*' and following further questioning you stated that you returned to work after a '*month*'. It was unclear to the panel how much time elapsed prior to returning to work after the 2014 suspension order.

You confirmed that you have not worked as a registered nurse since 2024.

You accepted your mistake of leaving needles unsheathed and you apologised for that. You stated you know the importance of this as you have suffered from needle stick injury multiple times.

You said that if you did not feel 100 per cent well, you would not continue to work.

In response to panel questions, you said that if Phosphate Sandoz was administered unnecessarily, it would lower the patient's blood pressure.

Lack of competence (Charge 1)

Submissions on lack of competence

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.'

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

Ms Simpeh provided the panel with written submissions, Exhibit 31:

- 1. It is submitted that having found the charges which you found proved under Allegation 1, it demonstrates that Mr Masih lacks competence.*
- 2. It is submitted that it is a fair sample of his work – the charges proved demonstrate a continuous lack of competence in relation to the administration of*

medication and delivery of patient care. There were concerns relating to his administration of medication between

3. *It is submitted that the charges proved fall within 4 areas of the standards of proficiency for registered nurses, which specifies the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings.*
 - a. *Being an accountable professional - which requires registered nurses to act in the best interests of people*
 - b. *Assessing needs and planning care*
 - c. *Providing and evaluating care*
 - d. *Improving safety and quality of care*
4. *Mr Masih is an experienced Band 5 nurse, who had worked for approximately 40 years in nursing. It is submitted that he is expected to demonstrate his knowledge and skills meet the standards of proficiency required of all nurses.*
5. *However, there were two areas of significant concern, namely medication and patient care.*
6. *As determined by the Panel, Mr Masih failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse as:*
 - e. *He Failed to complete Patient 2's dressings in order for them to be transferred – Mr Masih had on his own account left Patient 2 for an extended period of time, 3 hours, without taking proactive steps to change the dressing or to hand over to a colleague to enable this to be done.*

- f. Also failed to use the correct technique for giving an injection and on or more occasions re-sheathed needles despite being informed that this was not allowed. It is submitted that his conduct was contrary to the need for nurses to improve safety and quality of care as required. It is submitted that his conduct placed patient safety and his own safety at risk.*
- g. He failed to recognise/understanding that taking on extra tasks during a drugs round could delay medication doses to patients. It is submitted that nurses must demonstrate knowledge and skills and judgment in assessing needs and planning care and evaluating care, for example by demonstrating demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs.*
- h. He also on or around 4 August 2022, during a supervised drug round:*
 - i. Failed to provide water slowly to Patient A as required/requested.*
 - ii. On one or more occasions failed to identify/provide answers as to what the instructions in the drugs chart said.*
 - iii. Failed to identify that Patient C's Bisoprolol medication was incomplete.*
 - iv. In respect of Patient D, failed to recognise that the prescription for 'Prosource Plus Fluid' was not Phosphate Sandoz, and*
 - v. Failed to recognise the implications of administering Phosphate Sandoz unnecessarily.*
- i. On or around 20 February 2019:*
 - i. Administered I/V medications having not been signed off as being competent.*

The standards of proficiency require nurses [4.14] to understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines [4.15] to demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage.

It is submitted that Mr Masih failed to meet the standards of proficiency required of him.

- j. Mr Masih also on or around 16 August 2022
 - i. on one or more occasions left a patient at high risk of falls unattended despite being told to stay with the patient*
 - ii. Left the bed rails of a patient that was a high risk of falls.*
 - iii. Failed to complete a MUST in a timely manner.**
- k. On or around 20 February 2019, having re-positioned a patient's nasal prongs:
 - i. Failed to assess / observe whether the patient was in respiratory distress before going on a break.*
 - ii. Failed to complete clinical observations before going on a break.*
 - iii. Failed to handover the patient to a doctor / nurse before going on a break.**

It is submitted that Mr Masih failed to demonstrate the skills and knowledge and judgment required to ensuring safety and quality of care.'

Ms Shah orally submitted that the charges before the panel span a short number of years around the time of COVID. [PRIVATE].

Ms Shah reminded the panel that a number of charges have fallen away due to lack of evidence.

Ms Shah invited the panel to not look at the history of the errors but view them as a progression of someone who felt aggrieved and that they could do no right.

Ms Shah requested the panel to consider the impact this would have had [PRIVATE].

Ms Shah submitted that albeit the clinical errors demonstrate that you were performing at a standard below that expected of a registered nurse, this is not a fair sample of your work.

Ms Shah submitted that you recognise that you were making errors, and you accept that you were not working to the standard you normally would, as such, she submitted that the facts found proved do not amount to a lack of competence.

Decision and reasons on lack of competence (Charge 1)

The panel carefully considered the facts found proved in relation to charge 1, the submissions made by Ms Simpeh and Ms Shah, your oral evidence, your documentary evidence, the relevant provisions of the Standards of Proficiency for Registered Nurses, NMC guidance and the advice of the legal assessor.

In determining whether the statutory ground of lack of competence was established, the panel considered your practice as a whole rather than viewing each failing in isolation. It was satisfied that the concerns found proved under charge 1 demonstrated repeated deficiencies across a broad range of fundamental nursing competencies. Those deficiencies extended to patient observation and assessment, clinical judgement, medication management, inappropriate delegation of tasks, prioritisation, workload management, recognition of deteriorating patients and the delivery of safe and effective care. Taken cumulatively, they demonstrated significant shortcomings in your knowledge, skills and professional judgement.

The panel had particular regard to the provisions of the Standards of Proficiency for registered nurses. Whilst recognising that a breach of the Standards of Proficiency does not, of itself, establish a lack of competence, the panel considered that the breadth of your deficiencies engaged numerous fundamental professional standards including:

‘Platform 1

...

- 1.5 *understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health.*

Platform 3

...

- 3.9 *recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable*

Platform 4

Registered nurses take the lead in providing evidence-based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard.

...

- 4.5 *demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people’s needs*
- 4.7 *demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based, person-centred nursing care to meet people’s needs related to mobility, hygiene, oral care, wound care and skin integrity*

- 4.8 *demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain*
- 4.10 *demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions*
- 4.12 *demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence-based, person-centred care*
- 4.14 *understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines*
- 4.17 *apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration*

Platform 6

...

- 6.1 *understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments*

The panel had regard to NMC Guidance that lack of competence involves an unacceptably low standard of professional performance, judged on a fair sample of a professional's work, which could put people receiving care at risk. This includes when a professional on the register demonstrates a lack of knowledge, skill or judgement which shows that they are incapable of safe and effective practice.

The panel further reminded itself that it was necessary to consider whether the findings represented a fair sample of your work during the relevant period. In doing so, it was required to evaluate both the breadth and nature of the concerns found proved, together with the context in which they arose, before determining whether the statutory ground was established. The panel considered that the concerns took place over a three-year period

which is a significant period of time, in three separate clinical ward areas with different teams supporting you with your practice and performance. As such, it determined this to be a fair sample of your work.

The panel considered your role as a registered band 5 nurse at the relevant time and in considering lack of competence applied the standards expected of a competent nurse at that band and in your role with reference to the Standards of Proficiencies for registered nurses. The panel considered that your failings demonstrated repeated deficiencies across a broad range of fundamental nursing competencies as described above when measured against what would be expected of a competent nurse in your role.

The panel noted that although there is no evidence of patients being harmed, the potential for serious harm was high.

The panel concluded that your failings under charge 1 demonstrated severe shortcomings in your knowledge, skills and judgement of such a nature and extent that they amounted to a lack of competence.

Submissions on misconduct (Charge 2)

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.*'

Ms Simpeh 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.

Ms Simpeh, within her written submissions in Exhibit 31, identified the specific, relevant standards where your actions amounted to misconduct. She referred the panel to Codes 8.2, 8.4, 8.5, 11.1, 11.2, 11.3, 20.1 and 20.8.

Ms Simpeh submitted that having found charges 2.3, 2.6, 2.8 proved, your conduct amounts to misconduct.

Ms Shah submitted that you were under a great amount of stress and the matters before the panel may come down to a lack of judgement as opposed to misconduct.

Ms Shah submitted that asking a colleague to do something does not place onus on the colleague to do it and therefore there is limited harm.

Ms Shah submitted that charge 2 is an example of someone who was overwhelmed, rather than someone who has fallen short and deemed to amount to misconduct.

Ms Shah invited the panel to take the view that the facts found proved do not amount to misconduct.

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. Specifically:

‘8 *Work co-operatively*

To achieve this, you must:

8.2 maintain effective communication with colleagues

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.

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

To achieve this, you must:

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

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.5 complete the necessary training before carrying out a new role

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered each of the sub charges under charge 2 individually before making a finding. The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code.

Charge 2.3

As a registrant you have a duty to engage openly and honestly with investigations or meetings with your employer. The panel noted that you engaged with the local

performance related meetings but refused to sign those meetings because you did not agree that they were accurate. The panel further noted you did not suggest any amendments to the records of the meetings to correct what you considered to be inaccuracies.

By refusing to sign meetings without suggesting amendments which you considered were needed to make the notes accurate, you demonstrated a failure to work cooperatively.

The panel considered therefore that you failed to meet professional obligations and fell seriously below the standards of professionalism and accountability expected of a registered nurse.

The panel was satisfied that your conduct represented a serious departure from the standards properly expected of a registered nurse so as to amount to misconduct.

Charge 2.6

The panel considered that as an experienced registered nurse, it is incumbent on you to be aware of professional standards and requirements expected of you. You had previously attended numerous meetings with senior colleagues regarding concerns about your medicines management skills. These had resulted in Performance Support Plans which required you to be supervised at all times when undertaking medicines administration activities.

The panel noted your explanation for acting outside of your competence by completing a medication round without supervision. However, it considered that patient safety should have been your primary concern. You would have been aware of the risk of harm to patients from your actions. The panel considered that as a registered nurse of some considerable experience you should have refused to carry out any instruction requiring you to act outside of your competence.

In respect of charge 2.6 the panel was satisfied that your conduct represented a serious departure from the standards properly expected of a registered nurse, so as to amount to misconduct.

Charge 2.8

The panel considered that on the occasions you delegated tasks inappropriately you had no evidence of any reasonable explanation for doing so. It considered that you were the more experienced member of staff on the ward at the relevant time and the tasks you delegated included discharging patients, connecting patients up to cardiac monitors, collecting urine samples, and filling out your paperwork. The panel considered that all of those tasks fell properly within your own role.

The panel noted evidence from student nurse Tamsin Kay describing how you caused her to be overwhelmed by your actions and your failure to supervise and support her in carrying out the delegated tasks. The panel noted that this was not only isolated to Tamsin Kay as other senior colleagues observed you on numerous occasions delegating to other colleagues inappropriately.

Taking all of these factors into account the panel considered that your conduct at Charge 2.8 represented a serious departure from the standards properly expected of a registered nurse so as to amount to misconduct.

Accordingly, having considered the matter in the round, the panel concluded that the conduct under charge 2 found proved was sufficiently serious to amount to misconduct.

Current impairment

The panel considered whether your fitness to practise is currently impaired by reason of your lack of competence and/or misconduct.

The panel accepted the advice of the legal assessor and reminded itself that a finding that one or more statutory grounds has been established does not automatically result in a finding that a registrant's fitness to practise is currently impaired. The question of current impairment is a separate statutory exercise requiring the panel to make an evaluative judgment based upon the evidence as a whole and the circumstances existing at the date of the hearing.

In undertaking that assessment, the panel considered both the public protection and the wider public interest component of impairment. In considering the protection of the public, the panel had regard to the nature and seriousness of the concerns identified, your level of insight, the extent to which the concerns were capable of remediation, whether they had been remedied and the likelihood of repetition.

In considering the wider public interest component, the panel had regard to the need to maintain public confidence in the nursing profession and the regulatory process and declare and uphold proper professional standards.

The panel considered the components separately before reaching its overall conclusion on current impairment.

Submissions

Ms Simpeh in her written submissions in Exhibit 31 submitted:

Public Protection Ground

...

Question a

18. *It is submitted that Mr Masih in the past placed patients at unwarranted risk of harm.*

19. Further, Mr Masih's conduct in relation to patient care, including failing to complete the Patient's dressing, failing to use the correct technique for giving an injection, re-sheathing needles despite being informed that this was not allowed, attempting to remove a canvas sheet, completing unsupervised medication rounds, failing to provide water slowly to a patient, failing to recognise the Patient C's prescription and the implications of administering Phosphate Sandoz, leaving a patient at high risk of falls unattended, not completing MUST in a timely manner, incorrectly categorising patients wound, using the incorrect bandage, failing to bandage and follow the patient's care plan, failing to assess and observe whether a patient was in respiratory distress before going on a break, failing to complete clinical observations before going on a break, not handing over the patient before going on a break, administering IV medications when he had not been signed off as competent and inappropriately delegating tasks to junior colleagues, placed patients at unwarranted risk of harm.

20. It is submitted that nurses are required to be competent in administering of medication due to the effects and risk of harm should the wrong medication be administered. Mr Masih was aware that he was not to complete medication rounds and yet proceeded to complete an unsupervised medication round.

21. It is submitted that having regard to the issues concerning his competence it was imperative that Mr Masih ensured that he was being supervised and his failure to do so, placed patients at unwarranted risk of harm.

22. Further, as a nurse with 40 years of experience, it is submitted that Mr Masih was aware of what was required of him of the code and the impact on patient care of his conduct. As noted by him in his evidence concerning the re-sheathing of needles, he was aware of the dangers and had himself experience at least a couple of times needle stick injury. Consequently, it is expected that having experienced himself the dangers of his conduct, he would ensure that he was acting properly.

Question b: has the professional in the past brought and/or is liable in the future to bring the profession into disrepute; and/or

23. It is submitted that Mr Masih has brought the profession into disrepute. Registered nurses are expected to ensure that they do not act in a way which would place patients at unwarranted risk of harm. Further, registered nurses occupy a position of privilege and trust in society and are always expected to be professional and to maintain a high standard of care. It is submitted that Mr Masih's conduct placed patients at unwarranted risk of harm. In addition, there was a failure to work cooperatively with colleagues to ensure that concerns were addressed and he repeatedly failed to adhere to what was required of him as a Band 5 nurse.

Question c: Whether the professional has in the past breached and/or is liable in the future to breach a fundamental tenet of the profession

24. It is submitted that Mr Masih has in the past breached fundamental tenets of the profession.

25. As I have outlined above, Mr Masih's conduct was in breach of Codes 1, 8, 11, 13, 18 and 20.

26. It is submitted that Mr Masih failed to deliver the fundamentals of care effectively and to make sure that any treatment for which he was responsible was delivered without undue delay. He had delayed the transfer of a patient but failing to complete the Patient's dressings and had failed to deliver care effectively repeatedly, for example, attempting to remove a canvass sheet from underneath Patient 4, which could have caused significant harm to the patient.

27. Mr Masih failed to share information to identify and reduce risks to patients as he did not handover the care of patients when he should and failed to recognise and work within his limits of competence by completing unsupervised medication rounds.

28. *Mr Masih also attempted to provide medicines, such as Phosphate Sandoz, when he did not have enough knowledge and could not be satisfied that the medicines served the patient's health needs.*

29. *Moreover, it is submitted that Mr Masih failed to maintain effective communication with colleagues by not signing the notes and did not work with colleagues to evaluate the quality of his work with colleagues to preserve the safety of those receiving care. Mr Masih failure to sign the notes and completing an unsupervised medication round when told not to were indicative of these failures.*

30. *Further, Mr Masih in delegating tasks to junior colleagues did not consider the competence of his colleagues, failed to ensure that those he would be delegating to would be adequately supervised and supported and did not confirm the outcome of any task he had delegated. It is submitted that as an experienced nurse, his conduct fell far short of what was required and breached the fundamental tenets. Mr Masih was expected to act as a role model and failed to act as a role model to junior colleagues and to support his junior colleagues. In addition, the purpose of ensuring that tasks were delegated appropriately was to ensure the safety of patients.*

31. *It is submitted that although not every breach of the code would lead to a finding of impairment, in Mr Masih's case the breaches were significant and placed patients at risk of harm.*

Liable in the future to put patients at risk of harm, bring the profession into disrepute and breach fundamental tenet

32. *It is submitted that Mr Masih is liable in the future to place patients at unwarranted risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession.*

33. *Firstly, although it is accepted that his previous finding of misconduct was some years ago, it is submitted that it demonstrates a history of previous placing*

patients at unwarranted risk of harm, bringing the profession into disrepute and breaching fundamental tenets of the profession.

34. Further, his previous allegations 1b and 1c related to his administration of medication to patients. It is submitted that his administration of medication was an issue which these current allegations related to and therefore demonstrates a failure to understand what is required of him in the administration of medication to patients.

35. Moreover, Mr Masih was not forthcoming and honest. He asserted in his evidence to you that he did not have any previous findings of misconduct against him. When his previous fitness to practice matters were put to him, he noted that he did not remember these but only remembers being suspended for a short period of time.

36. Mr Masih had indicated to the Panel on that occasion that he would be mindful of his duty to provide a high standard of care. It is submitted that having regard to the allegations proved against him, Mr Masih was not mindful of his duty to provide a high standard of care.

37. Having regard to his failure to disclose to the Panel that he had a previous finding of misconduct and his failure to be mindful of his duty to provide a high standard of care, this panel cannot be satisfied that Mr Masih's assertions about not repeating conduct are true.

38. Mr Masih's conduct was also repeated and there were several concerns relating to his administration of medication and his delivery of patient care.

39. Further, Mr Masih has not worked for 2 years and there is no evidence before this Panel to demonstrate that there has been any practical strengthening of his practice. At present, Mr Masih's assertions of lessons learnt are all theoretical and having regard to his previous history, it is my submission that the panel cannot be satisfied that in the absence of practical clinical evidence demonstrating that he would not repeat such conduct matters his conduct would not be repeated.

Context

...

41. *It is submitted that although a nurse's health can impact on their ability to provide adequate care, it must be noted that Mr Masih was aware that he is under a duty to ensure maintain the level of health needed to carry out his professional role. It is noted that the errors were over a significant period of time across three separate wards. It is submitted that he would have been aware of the impact of his health and his personal circumstances and it was incumbent on him to take relevant steps, [PRIVATE] to prevent his professional role being compromised. Further, we heard evidence from Mr Keyte's that a capability plan was put in place to support Mr Masih and he still failed to meet the requirements of that plan.*

42. *In those circumstances, although it is recognised that Mr Masih's personal circumstances and health could have an impact on his practice, it is submitted that having regard to the support he received and that his conduct was over a significant period of time with no evidence of steps taken by him to address those issues adequately, very little weight if any should be given to this.*

Insight

...

45. *The panel heard evidence from Mr Masih and has also been provided with various character references and training undertaken by Mr Masih.*

...

47. *It is submitted that although Mr Masih has shown some insight, there remains further work to be done. Mr Masih within his reflections continues to blame others and suggests excuses for his conduct. For example, he raises that some incidents occurred either because of a lack of staffing or emergencies, however*

accepted that this was usual state of affairs within healthcare. Mr Masih was unable to provide concrete steps of how he would navigate those circumstances should it arise. He was also unable to provide adequate steps to demonstrate that should he experience high levels of stress what will be done to prevent these concerns relating to his practice arising again.

48. Further, there is no evidence of practical steps to strengthen his practice. Mr Masih has been not worked for 2 years and is therefore not able to demonstrate that his theoretical learning could be applied sufficiently in practice. It is submitted that this is imperative having regard to the fact that Mr Masih is an experienced nurse who was aware of what was required of him and yet still failed to adhere to the code of conduct and meet the standards of proficiency. It is submitted that the Panel can therefore not satisfy itself that Mr Masih would not repeat the conduct.

49. It is submitted that for the reasons above, Mr Masih is impaired on public protection grounds.

Public Interest Ground

...

53. It is submitted that this is a case where a finding of impairment is necessary to uphold proper professional standards and to maintain public confidence in the profession. It is submitted that in this case, Mr Masih's conduct placed various patients at unwarranted risk of harm. His conduct was repeated and despite capability process being in place to support him, he did not meet the capability requirements and also acted outside his competence by completing medication rounds unsupervised. He also has a history of misconduct which he was not forthcoming about and having regard to all the circumstances there remains a risk of repetition.

54. It is submitted that if the panel do not find that Mr Masih is impaired, it would be tantamount to an indication on behalf of the profession that conduct of the kind

need not have regulatory consequences, this would be an unacceptable conclusion.

55. *It is submitted that the Panel should therefore find that Mr Masih is currently impaired on public interest ground also.'*

Ms Shah submitted that it has been four years since the last set of incidents and during this time you have invested time in upskilling yourself. She referred the panel to your training certificates which address the charges.

Ms Shah submitted that you want to start performing at the required standard which shows insight as your actions show that you are committed to improving your practice.

Ms Shah submitted that you have engaged through a very lengthy process with the NMC despite it being disheartening which demonstrates the salutary effect on you and in turn, a reduced risk of repetition.

Ms Shah submitted that there are no wider public interest concerns in this case.

Ms Shah invited the panel to conclude that your fitness to practise is currently not impaired.

Decision and reasons on impairment

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 28 January 2026, which states:

'We do this by assessing whether the professional would pose a risk to public safety, the public's confidence in their profession or professional standards if they were permitted to practise without restrictions. 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. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) 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)'

The panel first considered the ground of public protection. In doing so, it considered the seriousness of the concerns found proved. It noted that the question is whether you are currently impaired. It considered the extent to which your failings were capable of remediation, whether they had in fact been remediated and the likelihood of repetition.

The panel considered your reflections and your current level of insight.

The panel recognised that the concerns arose whilst you were working within a busy acute hospital environment and considered your evidence that you were [PRIVATE] and working at a reduced pace at the relevant times due to [PRIVATE]. However, the panel was satisfied that the deficiencies were numerous, wide ranging, occurred over an extended period of time across multiple clinical settings and could not be justified by your personal circumstances.

Your actions breached fundamental aspects of nursing practice, including patient assessment, clinical decision-making, medication management, and demonstrated shortcomings which had the potential to place patients at an unwarranted risk of harm.

The panel also considered that your misconduct and lack of competence put patients at unwarranted risk of harm, breached fundamental tenets of the nursing profession and brought its reputation into disrepute in the past.

The panel directed its mind to the risk of repetition taking into account that limbs a, b and c of the *Grant* test were engaged.

In assessing whether you are liable in the future to cause unwarranted risk of harm, bring the profession into disrepute and/or breach one of the fundamental tenets of the medical profession the panel applied the test as set out in *R(on the application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) with regard to impairment:

- a. is the misconduct easily remediable?*
- b. has the misconduct already been remediated?*
- c. is the misconduct highly unlikely to be repeated?*

The panel considered both your lack of competence and misconduct on the whole. In doing so, it considered the seriousness of the concerns found proved, your level of insight, the extent to which those concerns were capable of remediation, whether they had in fact been remediated and the likelihood of repetition. The panel carried out that assessment in light of all the evidence before it and having regard to the findings it had already made in relation to lack of competence and misconduct.

The panel carefully considered your oral evidence and all of the material provided by you. This included four character references from members of your church, 85 training certificates spanning from 28 June 2024 to 20 August 2026, timesheets dated 14 June 2023, 29 June 2024 and 21 February 2025, end of placement assessment forms dated 21 February 2023, 21 February 2025, 26 June 2024, two on 29 June 2024 and your written insight into the proved allegations. However, the panel considered that whilst the references before it were positive, your referees were not from a clinical setting and were therefore unable to comment on your clinical practice. It also considered that your written insight before the panel was limited in addressing the facts found proved and the impacts on patients and colleagues. Furthermore, it considered that there was no evidence of demonstration of strengthening of practice in applying your training in any clinical setting. The panel referred to your oral evidence at the impairment stage. It considered that it was lacking in detail and did not demonstrate any strengthening in your nursing knowledge, skills and judgement since the incidents. The panel determined that you still could not

correctly explain the effects of unnecessarily administering Phosphate Sandoz despite it being a fact found proved against you.

The panel, having considered both your written and oral evidence at this stage, concluded that you had provided limited evidence of insight into the concerns found proved. In particular, the panel was not satisfied that you had demonstrated a full appreciation of either the breadth or the seriousness of the deficiencies identified, or the potential impact of those deficiencies upon patient safety, colleagues, public confidence or the reputation of the profession. In the panel's judgment, your written insight material did not demonstrate full acceptance of responsibility for the failings found proved.

The panel next considered whether the concerns were capable of remediation and, if so, whether they had been remediated. The panel accepted that the deficiencies identified were, in principle, capable of remediation. It also accepted that you had undertaken some training during the relevant period and had produced documentary evidence in support of that. However, you offered no reflection on this training to evidence any learning, nor did they demonstrate that the extensive deficiencies identified by the panel had been addressed in clinical practice.

The panel also considered your written 'insight' document carefully but concluded that, for the reasons already identified, it did not demonstrate insight or meaningful remediation of the concerns found proved. The panel further noted that there was no more recent evidence before it of any further supervised practice, continuing professional development or other material demonstrating that the deficiencies identified had since been addressed.

Finally, the panel considered the risk of repetition. In light of your limited insight, the absence of evidence that the deficiencies had been remediated in clinical practice, the NMC Competence and Conduct findings against you in 2014 and the imposition of a 6-month suspension order. The panel did not accept, as plausible, your evidence that you had no recollection of the findings against you in 2014. It noted that the findings followed a physical hearing and resulted in a period of suspension from practice. The panel

considered it highly unlikely that you could not recall an event of such significance in your nursing career.

The panel determined that in expressing your remorse you do so in general terms but considered that you fail to appreciate the seriousness of your failings, the potential for harm to patients and the negative impact of your conduct on others. The panel was not satisfied that the risk of repetition had been adequately addressed.

The panel considered your practice between the end of the suspension period in 2014 and further concerns being raised in 2019. From your CV it is unclear where you have been working in those interim years and what role (if any) you undertook and for how long. The panel had sight of the feedback forms from some shifts in your role as a Healthcare assistant from 2023 onwards but considered that they were brief and unparticularised.

In further considering the risk of repetition, the panel determined that the concerns found proved today were of a similar nature to some of those found proved in 2014. The panel therefore considered the similarity of some of these failings were indicative of attitudinal issues on your part and concluded that this heightened the risk of repetition.

Drawing these matters together, the panel concluded that you have not yet demonstrated any meaningful insight into your lack of competence and misconduct. It also concluded that you have not demonstrated that those concerns have been adequately remediated and the panel determined that the risk of repetition is high. Accordingly, the panel concluded that your fitness to practise is currently impaired on the ground of public protection.

The panel next considered the wider public interest. In doing so, it reminded itself of the need to maintain public confidence in the nursing profession and the regulatory process, and declare and uphold the proper standards of conduct, competence and behaviour expected of registered nurses.

The panel recognised that the ground of public interest requires a broader assessment than the ground of public protection. Accordingly, the panel was required to consider whether the nature and seriousness of the concerns found proved required a finding of current impairment in order to maintain public confidence in the profession and uphold proper professional standards.

The panel had found that your lack of competence was extensive, persistent and concerned fundamental aspects of nursing practice. The deficiencies identified by the panel included but were not limited to patient observations and assessment, medication management, clinical decision-making, inappropriate delegation of tasks and the recognition and escalation of clinical concerns.

The panel considered that a reasonable member of the public who was aware of these factors and all the circumstances of this case would expect a finding of current impairment. The panel therefore concluded that public confidence in both the nursing profession and the NMC as its regulator would be seriously undermined if a finding of current impairment were not made.

The panel was equally satisfied that a finding of current impairment was necessary to declare and uphold the proper professional standards expected of registered nurses. To conclude that your fitness to practise was not currently impaired in the circumstances of this case would fail to mark the seriousness of the concerns found proved and would risk undermining confidence in the standards expected of members of the profession.

Accordingly, and wholly independently of its conclusions on the ground of public protection, the panel concluded that your fitness to practise is currently also impaired on the ground of public interest.

Interim order

On the last day of sitting on 4 September 2026, following the hand down of the panel's decision on lack of competence, misconduct and current impairment at around 15:00, it was decided that there was not enough time to proceed to hear submissions from parties and for the panel to make a decision on sanctions. Ms Simpeh clarified that her instructing lawyers were not available for the rest of the day. The panel 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.

Submissions on interim order

Ms Simpeh submitted that an interim conditions of practice order would be proportionate to impose, based on the panel's findings at the impairment stage. She submitted that this interim order would address public protection and the wider public interests.

Ms Simpeh submitted that this is important as you have informed the panel that you are set to undertake nursing week from as soon as next week, starting 8 September 2026 onwards.

Ms Simpeh recommended interim conditions such as supervision, not to be the nurse in charge, to work with a single employer and for a supervisor or manager to provide a report.

Ms Shah referred the panel to a previous High Court decision, *NMC v Masih* [2026] EWHC 2094 (Admin); she invited the panel to consider this. She submitted that it is disproportionate to restrict yourself at this time with an interim order.

Ms Shah submitted that you have only just been allowed for unrestricted practice from a former interim conditions of practice order and obtained offers of nursing work. She submitted that the impact of an interim order would be grave on yourself and in public

interest. She added that if you were able to practice as a registered nurse you could demonstrate a strengthening of clinical practice before returning in October 2026.

Ms Simpeh submitted that the High Court decision had been made at a time when there were no facts found proved nor was there any finding of impairment and as such there is a material change before the panel today.

The panel heard and accepted the advice of the legal assessor.

In response to panel questions, Ms Simpeh clarified that any duration of an interim order would need to cover the time period until the hearing resumes in October 2026. She suggested a period of 6 months but clarified that she did not receive instruction on this matter specifically.

Decision and reasons on interim order

The panel was of the view that based on its findings at the impairment stage, there is a real risk of repetition and consequent risk of serious harm to the public. In finding this to be the case, the panel considered its findings on lack of competence, misconduct and the risks it identified in its decision on impairment.

The panel concluded that the risk of harm flows from the wide-ranging deficiencies in your clinical practice which have not been remedied and in respect of which the panel have already identified a real risk of repetition.

The panel therefore concluded that some form of interim order is necessary on the grounds of public protection and is also otherwise in the public interest.

The panel first considered whether an interim conditions of practice order could be devised to protect the public and the wider public interest.

The panel considered its findings to date, the submissions of both representatives, the NMC guidance on interim orders and the case of *NMC v Masih*.

The panel considered that the guidance in the above case must be considered in the context that your fitness to practice has now been found to be impaired on both public protection and public interest grounds. This is a material change in your circumstances although the panel noted that no decision had been made regarding sanction.

The panel took into account the wide-ranging nature of the deficiencies in your clinical practice amounting to both misconduct and lack of competence. It took into account its findings regarding your attitude. The panel noted in particular that at a time when you required supervision to administer medication, you knowingly acted outside of the scope of your competence and proceeded to carry out a medication round unsupervised.

The panel was satisfied that any interim conditions of practice order would require a supervisory element to ensure patient safety. However, because of the circumstances described above the panel could not be satisfied that any interim condition requiring supervision would be workable or adhered to by you.

The panel therefore could not be satisfied that an interim conditions of practice order could be devised which would be workable, measurable or sufficient to protect the public and meet the wider public interest given its findings at the impairment stage.

The panel is satisfied therefore that, in the particular circumstances of this case, an interim suspension order, whilst the most restrictive is the only appropriate and proportionate interim order to adequately protect the public.

The panel decided to make this interim suspension order for a period of 6 months to cover the period until the hearing resumes in October 2026 and in the event that the October sitting is delayed for any reason.

The panel has noted that this interim order will prevent you from working as a registered nurse and, as a consequence, may cause you [PRIVATE] hardship given the oral evidence you provided the panel with. However, in applying the principle of proportionality and fairness, the panel determined that, in any event, the need to protect the public and the wider public interest outweighed your interest in this regard.

Unless your case has already been concluded or there has been a material change of circumstances, a panel will review the interim suspension order at a review meeting within the next six months and every six months thereafter. The reviewing panel will be invited by the NMC to confirm the interim suspension order at this meeting, and you will be notified of the panel's decision in writing following that meeting.

You or the NMC may ask for the interim order to be reviewed if any new evidence becomes available that may be relevant to the interim order. A panel will review the interim order at a hearing which you will be invited to attend in person, send a representative on your behalf or submit written representations for the panel to consider. At any such review hearing the reviewing panel may revoke the interim order, it may confirm the interim suspension order, or it may replace it with an interim conditions of practice order.

The hearing went part heard on 4 September 2026.

Sanction

The hearing resumed on 14 October 2026.

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

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

Submissions on sanction

The panel noted that in the Notice of Hearing, dated 3 October 2025, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and Ms Simpeh submitted that a suspension order with review for a period of 12 months is more appropriate in light of the panel's findings.

Ms Simpeh submitted that the aggravating factors in this case are that: you inappropriately delegated tasks repeatedly to more than one colleague; the deficiencies in your practice were numerous, wide ranging, occurred over an extended period of time, across multiple clinical settings and could not be justified by your personal mitigating factors; you have provided limited insight into your conduct; you have provided limited insight into the impact of your conduct on your colleagues and patient safety.

Ms Simpeh submitted that your conduct now found proved placed patients at unwarranted risk of harm and had a detrimental impact on a junior colleague.

Furthermore, Ms Simpeh outlined you have previous proven allegations of misconduct, which are both similar in nature to the ones found in this hearing and serious; you were not open and honest about having a previous finding of misconduct against you and asserted that you had '*forgotten*', which, the panel had found was not plausible.

Ms Simpeh submitted that to take no further action or impose a caution order would not be appropriate given the panel's finding of impairment.

Ms Simpeh submitted that a conditions of practice order would also not be appropriate given that your lack of candour regarding your previous finding of misconduct may be indicative of attitudinal issues. She submitted that conditions are not workable for behavioural concerns.

Ms Simpeh submitted that a suspension order would be appropriate. She submitted that the charges found proved are serious, wide ranging, repeated and occurred across various clinical settings. She submitted that you are an experienced nurse with almost 40 years in the nursing profession and thus there is an expectation that you would be held to a higher standard of knowledge, skills, and experience than a recently qualified nurse.

Ms Simpeh submitted that though it is accepted that your conduct is remediable, allowing you to return to practice, even with conditions, would not be sufficient to address the identified risks.

Ms Simpeh submitted that a period of suspension would enable you to fully reflect, strengthen your practice and develop your insight and remediation.

Ms Simpeh noted that although you have undertaken a significant number of courses, you have not yet demonstrated that you fully understand how your training applies in practice.

Ms Simpeh submitted that you have been out of nursing practice for some years now, and together with your limited insight, if you were to return to practice it would place patients at significant risk.

Ms Simpeh submitted that the concerns are so serious that public confidence in the profession and professional standards could not be maintained if you were able to continue practising without stopping for a period of time.

Ms Simpeh submitted that despite the seriousness of what happened, you have engaged in the proceedings and shown at least some meaningful insight which evidences a realistic

possibility that you could continue to develop your insight, address the concerns and return to practice.

In response to panel questions concerning the usefulness of a further period of suspension when the 6 month suspension in 2014 still resulted in another referral and repetition of the concerns, Ms Simpeh submitted that the NMC did appreciate the previous finding in 2014 but you practised safely for 10 years prior to the concerns before the panel today.

Ms Shah on your behalf, invited the panel to first consider whether a conditions of practice order would address the concerns, and only if that would not be sufficient or satisfy the public interest should the panel consider a suspension order.

Ms Shah submitted that you have had a finding of misconduct in the past. She reminded the panel that those matters occurred a very long time ago, an approximate period of 10 years has lapsed since you were suspended prior to being referred again which resulted in this hearing.

Ms Shah outlined that the suspension was lifted, and although there are concerns that have been repeated, this is isolated to medications management and administration errors. She submitted that these types of errors are capable of being addressed by conditions, rather than an outright suspension.

Ms Shah submitted that although the panel have found limited insight, you have engaged with this process throughout, despite it being spread out over a lengthy period of time and has been particularly stressful for you and thus harder to engage with. She submitted that you have fully participated in the proceedings, and you wish to cooperate with the NMC.

Ms Shah submitted that there is a public interest in nurses returning to the profession in a safe manner, and in particular a nurse who has demonstrated a desire to cooperate with the NMC.

Ms Shah proposed that the panel could consider conditions which included: to be directly supervised whilst administering medication; periodic meetings; imposing a Personal Development Plan (PDP) which would address clinical failings and provide reflections on relevant areas of practice.

Ms Shah noted the question to Ms Simpeh by the panel and submitted that it would serve the public by getting a good nurse back into practice either via stringent conditions or a further period of suspension.

Ms Shah outlined that you have provided the panel with an updated reflection, multiple training certificates, numerous references and testimonials.

Ms Shah informed the panel that you have secured work as a healthcare assistant, and as of today have completed a short number of shifts, but should the panel impose a conditions of practice order there is a nursing role available to you should you pursue it.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Repeatedly delegated tasks inappropriately to more than one colleague
- Deficiencies in clinical competence and conduct were numerous, across multiple setting and took place over a lengthy period of time

- Lack of meaningful insight into failings and the impact of them on colleagues and patients
- Previous regulatory finding of misconduct suggesting attitudinal issues
- Lack of candour in not disclosing previous finding of misconduct when questioned on this under oath
- Placed patients at an unwarranted risk of harm
- Patients affected by your conduct were subject to additional vulnerability factors
- Failure to work collaboratively

The panel also took into account the following mitigating features:

- A reflective statement which has been subsequently revised throughout the progression of this hearing
- Some evidence of training albeit limited

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions

imposed must be proportionate, measurable and workable. The panel considered its findings in its previous sitting as to why it imposed an interim suspension order as opposed to an interim conditions of practice order.

It also considered the multiple training certificates before it but noted that there was no connection made by you in your reflective statement, between the training and your past failings. Further, the panel noted that of your training certificates, seven were completed on one day: the panel could not determine that this training was meaningfully undertaken. The panel considered that relevant learning focussed on areas of your practice where deficiencies have been identified, is still required.

Whilst the panel acknowledged there is an amended reflective statement from you, the panel noted that there was limited additional substance to your original statement, and there is still a limited acceptance of your role in and responsibility for the concerns found proved.

The panel bore in mind the findings from the regulatory proceedings which arose out of allegations that occurred in 2010. As a result, there was a finding of misconduct against you, and you were subject to a 6-month suspension order in 2014. The panel noted that the facts found proved in this hearing relate to concerns that arose in 2018, 2021 and 2022. The panel considered the short time frame between the suspension order in 2014 and the first referral within this hearing that arose in 2018, which the panel considered was indicative of deep-seated attitudinal issues.

The panel considered that contrary to Ms Shah's suggestions, the concerns were not isolated to medications management and administration errors. The panel considered that there are in fact multiple concerns which are similar in nature to the ones found proved in this hearing.

The panel also considered that your failure to disclose, under oath, the previous finding of misconduct was another example of deep-seated attitudinal issues which would be difficult to address via conditions.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel considered that your willingness to adhere to any conditions imposed could not be assured in light of facts found proved, namely charge 1.8.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public nor satisfy the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective*

The panel also had regard to the key considerations as set out in the NMC Guidance. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their*

practice through reflection, the development of their professional skills and / or development of insight and remediation

- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel was satisfied in this case that your professional conduct was not fundamentally incompatible with remaining on the register.

The panel considered that the majority of the more serious concerns relate to a wide-ranging lack of competence across numerous clinical settings over a substantial period of time. In addition, the panel found misconduct for three other charges of a less serious nature. The panel considered whether a striking-off order would be appropriate but, taking account of all the information before it, the sanctions guidance and in light of the above, the panel concluded that it would not. The panel's consideration of the most appropriate sanction was informed by its finding of impairment on lack of competence as opposed to its finding of misconduct.

The panel acknowledged that a suspension order may have a punitive effect and noted the hardship a suspension order may cause you. However, this is outweighed by the need to protect the public and satisfy the public interest in this case.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel considered that this order is necessary for the protection of the public, to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the panel's findings.

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

Any future panel reviewing this case would be assisted by:

- Continued engagement with the NMC.
- Attendance at a future review.
- A further developed reflective statement using a recognised model (e.g. Gibbs model) showing insight into the impact of your clinical and behavioural failings on patients, colleagues and the nursing profession as a whole.
- Evidence of relevant learning focussed on your identified clinical failings and supported by reflective statements which include how you have brought this into your practice.
- Recent testimonials from your current or recent employer/voluntary work/colleagues.

Interim order

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

suspension order 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 Ms Simpeh. She submitted that an interim suspension order for a period of 18 months is required on both public protection and public interest grounds. She invited the panel to impose the interim suspension order on the same factual and regulatory basis as the substantive suspension order.

Ms Simpeh submitted that the interim suspension order should be imposed for 18 months to cover any potential appeal period.

Ms Shah submitted that an interim suspension order should not automatically follow a substantive suspension order.

Ms Shah submitted that an interim suspension order is not necessary in this case given your full engagement with the proceedings, you have provided reflections, insight and testimonials.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential appeal period.

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

This will be confirmed to you in writing.

That concludes this determination.