Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 18 July-Wednesday 19 July 2023

Virtual Hearing

Name of Registrant:	Sandreen Prescot
NMC PIN	16D0338E
Part(s) of the register:	RNA, Registered Nurse-Adult (September 2016)
Relevant Location:	Hertfordshire
Type of case:	Misconduct
Panel members:	Anthony Kanutin (Chair, lay member) Jim Blair (Registrant member) Scott Handley (Lay member)
Legal Assessor:	Gelaga King
Hearings Coordinator:	Yewande Oluwalana
Nursing and Midwifery Council:	Represented by Samantha Forsyth, Case Presenter
Miss Prescot:	Present and unrepresented
Facts proved:	All charges proved by way of admission
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (9 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charges

That you, a registered nurse, whilst employed at Lister Hospital;

1) On or around 14/15 October 2017; **[PROVED BY ADMISSION]**

a) Did not administer Patient A's insulin as prescribed.

b) Did not check whether Patient A had the capacity to self-administer insulin.

c) Did not accurately record the administration time/dose of insulin to Patient A.

d) On one or more occasion used the incorrect code in the blood glucose monitoring meter.

e) On one or more occasion did not use the correct NHS number for patients in the blood glucose monitoring meter.

f) Did not comply with the staff nurse competency book.

2) On 18 October 2017 when Patient B was in a collapsed state; **[PROVED BY ADMISSION]**

a) Did not provide adequate support to Colleague A in that you;

i) Did not enquire/communicate with Colleague A about Patient B's deteriorating condition.

ii) After bringing the arrest/resuscitation trolley to Patient B's bedside, left the bay/Colleague A alone.

iii) Did not provide Colleague A with advice.

iv) Did not provide Colleague A with any clinical support/assistance.

3) On 1 November 2017; **[PROVED BY ADMISSION]**

a) Did not ensure that Patient C was administered intravenous antibiotics/Tazocin as prescribed.

b) Did not ensure that Patient D was administered IV fluids/Dexamethasone as prescribed.

c) Did not alert Colleague B to administer the medication prescribed for;

i) Patient C.

ii) Patient D.

4) On 10 November 2017; **[PROVED BY ADMISSION]**

a) Did not ensure that Patient C was administered evening insulin.

b) Did not notify Colleague C that Patient C was to be administered evening insulin.

5) On 28 November 2017 after being placed on restricted clinical duties; **[PROVED BY ADMISSION]**

a) Carried a needle/syringe driver through a public area/lifts.

b) Removed a cannula/pain medication from a patient, without questioning the instruction.

c) Left a syringe driver containing a controlled drug in an unsecure area.

d) Left a syringe driver by Patient D's bedside with;

i) An exposed needle.

ii) A used needle.

iii) A needle wrapped in Tegaderm.

6) As a result of your actions in charges 5 a), 5 b), 5 c), & 5 d) above, Colleague D suffered a needle stick injury. **[PROVED BY ADMISSION]**

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

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

At the outset of the hearing, Ms Forsyth on behalf of the Nursing and Midwifery Council (NMC) made an application that parts of this case be held in private on the basis that proper exploration of this case involves reference to your personal matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application to the extent that any reference to your personal matters should be heard in private.

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

The panel determined to go into private session when reference to your personal matters is raised in order to protect your privacy.

Background

You were referred to the NMC on 17 April 2018 from East and North Hertfordshire NHS Trust ('the Trust'). You were employed as a Band 5 staff nurse at Lister Hospital working on Ward 10B at the time of the allegations which related to clinical concerns between October 2017 and November 2017.

It is alleged that on 14/15 October 2017, you used a blood glucose monitoring meter incorrectly and failed to comply with a staff nurse competency book. A further concern was raised in relation to your inappropriate communication.

On 18 October 2017 it is alleged that you left the ward during a shift without authorisation and did not inform the nurse in charge; and It is further alleged that you did not report to your manager your failure to attend planned Trust preceptorship training program as rostered and recommended as part of your development and support on 10 May 2017 and 19 October 2017.

Further incidents are alleged to have occurred and were investigated by the Trust.
On 1 November 2017 it is alleged two patients within your care did not receive medication as prescribed, which were intravenous antibiotics ('IV') and IV fluids and you did not alert

another nurse to advise that the medication had not been administered. On 10 November 2017 it is alleged that you failed to ensure that a patient in your care received insulin as prescribed. It is further alleged that you did not advise your colleague about this patient's insulin requirements despite telling the colleague about other patients who required medication.

On 15 November 2017 a concerns and capability review meeting was held by the Trust following the alleged drug errors on 1 and 10 November 2017. Your shifts were changed, and you were working supernumerary and placed under supervision.

On 18 November 2017 it is alleged that you failed to provide an acceptable standard of support to a Clinical Support Worker who was dealing with a patient in a collapsed state. It is alleged that you brought the Arrest Trolley to the patient's bedside and then left the bay. It is further alleged that following a conversation of concern, you left the ward during a shift without authorisation and did not inform the nurse in charge.

On 28 November 2017, you were advised not to undertake medication duties alone; it is alleged that you failed to maintain the health and safety of yourself and others in that you failed to follow the correct procedures for the prevention of sharp injuries. It is alleged that your failure to follow the Trust's sharps policy, on one occasion which resulted in a needle stick injury to a colleague.

On around 22 March 2021 you left your employment at the Trust.

On the 2 March 2021 you agreed to undertakings with the NMC to complete the competencies that were outstanding and this was due to be completed by 2 November 2021. On 11 September 2020 you emailed the NMC with drafted copies of the work that you had undertaken while you were working at Luton and Dunstable Hospital and before the COVID pandemic happened. The deadline for the undertakings was extended until 4 December 2021. The NMC subsequently received an email from your manager at the time who provided a report. This stated that they felt you were unsafe on medication rounds

and had not completed the relevant competencies. Following this report, the NMC case examiners referred your case to the fitness to practise committee for review.

Decision and reasons on facts

At the outset of the hearing, you made full admissions to charges 1,2,3,4,5 and 6.

The panel therefore finds charges 1,2,3,4,5 and 6 proved in their entirety, by way of your admissions. It noted your completed case management form dated 16 August 2022 and your email to the NMC dated 3 July 2023 where you admitted to all the charges.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

Miss Forsyth 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 Forsyth identified the specific paragraphs of the Code, 1.2, 2.1, 6.2, 8.1, 8.2, 8.3, 8.5., 8.6, 10.3, 11.1, 11.3, 13.1, 13.2, 13.3, 13.4, 15.2, 19.1, 19.3, 19.4, 20.1. She referred the panel to the Trust's own policies relating to their Medication Policy and Safe Disposal of Sharps Policy and also your job description at the time. Ms Forsyth submitted that your actions relating to the charges, individually and collectively amounted to misconduct, as your actions fell short of the standards expected of a registered nurse and relate to the basic fundamentals of nursing.

You gave evidence under affirmation. You submitted that you accept your failures and that you wanted to be held accountable for your actions. You said that you take full responsibility for your actions and the allegations against you and that this amounted to misconduct. You said that your actions were not those expected of a registered nurse.

Submissions on impairment

Ms Forsyth moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Cohen v GMC* [2007] EWHC 581 (Admin) and invited the panel to consider *Dame Janet Smith's Fifth Shipman Report endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Forsyth referred the panel to paragraph 76 of Mrs Justice Cox in the case of *CHRE v NMC and Grant,* where she 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Forsyth submitted that limbs a), b) and c) are engaged in your case but not limb d). She submitted in relation to limb a) that patients were put at risk of harm by your actions, they did not receive their medications, the withdrawal of strong pain killing medication without question, not assisting when a patient had collapsed and also leaving a syringe driver by a patient's bedside.

In relation to bringing the reputation of the profession into disrepute, Ms Forsyth submitted that despite you being given a lot of support you still have not met the level required to be able to practise as a nurse safely. She submitted that you have breached one of the

fundamental tenets of the nursing profession by not practising effectively or preserving safety, as you caused a colleague to sustain a needle stick injury.

Ms Forsyth highlighted to the panel that there were contextual factors at the time of the incidents to be considered. She said that you had personal matters occurring at the time of the incident, and also referred to the working environment and culture at Lister Hospital. Ms Forsyth referred the panel to the investigatory report dated 12 January 2018 of the Matron of Ward 10B at Lister Hospital, who identified challenges that the ward was facing at the time.

Ms Forsyth further submitted that you have demonstrated learning and insight in the steps you have taken to strengthen your practise. Ms Forsyth referred the panel to your reflective pieces dated 26 June 2018 and 25 January 2019. She indicated that you accepted the charges at the earliest opportunity at the case examiner's stage when undertakings were given and then again within the case management form and via email on 3 July 2023.

Ms Forsyth informed the panel that you had undertaken training in Medicines Management and Management of deteriorating patients, certificates were provided within your bundle at the time you were working at Luton and Dunstable Hospital. She also mentioned that you have undertaken online training in the following: Introduction to Insulin Safety: An introduction for Everyone, Statutory & Mandatory Training: Medication Awareness & Management, Statutory & Mandatory Training: Basic Life Support (Clinical), Safe Use of Insulin: Administration. However, Ms Forsyth submitted that you have not been able to work as a nurse and are therefore unable to demonstrate what you have learned, or put your knowledge into practice.

Ms Forsyth submitted that although clinical failings are generally remediable, in these particular circumstances she stated they were not remediable. She invited the panel to consider the case of *Cohen v GMC* when looking at remediation. She submitted that concerns have been raised about a number of areas of your practise and despite the level

of support you received following the charges and the undertakings. Ms Forsyth submitted that you have still not been signed off yet as being able to work safely as a registered nurse. She further submitted that some of the concerns could be said to have an attitudinal factor to them.

Ms Forsyth, therefore submitted that in order to protect the public, satisfy the collective need to maintain confidence in the profession, as well as declaring and upholding proper standards of conduct and behaviour. A finding of current impairment of both public protection and public interest grounds as necessary.

You said you take full responsibility for your actions and that it was never your intention to cause harm to patients or your colleagues. You said that you had been qualified as a registered nurse for just over a year and thought that you were *"doing good"* in relation to patient care at the time when working, however in hindsight you were struggling and should have spoken up at the time.

You provided the panel with some context regarding the incident with the patient that had collapsed. You said you felt "*overwhelmed and just froze"* as you were not sure what to do. Following a panel member's question, you were able to say what you would now do and should have done differently and provided the steps you would have taken if a similar situation was to arise.

You said that you have accepted the feedback and the concerns that have been provided by managers. You said that you want to work, even if it is at a lower band in order to build your confidence as a nurse, know the routine and ask for support when working on shift. You emphasised that you want to practise and make a difference to patients' lives and also help your colleagues.

You expressed remorse for the harm caused to your colleague who was injured due to the needled stick injury. You said that you have read up on policies and are now confident about what you would do differently.

You provided the panel with some context around the working environment in Lister Hospital. You said the working environment was not great, there were staffing issues and that you should have asked for support.

You said you have learned your lesson and understand where you went wrong. You informed the panel when you were working at Luton and Dunstable Hospital and carrying out the undertakings, that it was during the COVID pandemic, and you were just returning from maternity leave. You felt that you had lost your confidence and were not able to cope with the stresses of the ward. You discussed your personal matters and indicated that this may have affected you when working.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, and *Cohen v GMC.*

Decision and reasons on misconduct

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

The panel 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 a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

***8.2** maintain effective communication with colleagues*

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

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

***8.6** share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

To achieve this, you must:

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

…

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

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

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

13.4 *take account of your own personal safety as well as the safety of people in your care*

…

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

…

15.2 *arrange, wherever possible, for emergency care to be accessed and provided promptly*

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

To achieve this, you must:

…

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

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions at the time fell well below the standard expected of a registered nurse. It noted that at the time of these incidents there were identified staff issues at Lister Hospital and there was no identifiable person on staff who was designated to support you at the time of certain incidents. It considered that you appeared to be overwhelmed when working and were put into positions that you may have avoided had there been better support, monitoring and supervision.

Taking everything into consideration, the panel noted that the charges relate to serious breaches of medication errors, after protocols had been put in place for you to practise safely and also specific breaches of the hospitals policies. Harm was caused to a colleague following a needle stick injury, patients were placed at genuine risk of harm. Patients did not receive their insulin and when a patient collapsed you were unable to provide the appropriate support for a colleague which should have been provided by a registered nurse and froze.

The panel, therefore determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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 finds that a colleague was harmed and patients were put at risk and may have been caused physical and emotional harm as a result of your misconduct. You were unable to assist with a patient who had a cardiac arrest and left your colleague alone during this incident. The panel was of the view that you should have been able to respond to the situation and not have frozen. It considered your misconduct in not administering insulin to patients when they were required to or notifying a colleague of the patients needing to receive the medication had the potential for serious harm. An incident of a medication error where a potential wrong dose of medication was nearly given to a patient, this was only prevented by your supervisor. This occurred when you were working at Luton and Dunstable Hospital whilst you were subject to undertakings, and were aware of the need to check medications thoroughly. The panel found that your misconduct for charges 1 to 6 had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was of the view that a member of the public would find your conduct concerning and confidence in the nursing profession and the NMC as a regulator would be undermined if a finding of current impairment was not made.

The panel considered that you made admissions to the charges at the earliest opportunity of the investigation and have admitted the charges in the Case Management Form and the email to the NMC dated 3 July 2023. It was of the view that you are still developing your insight and have shown some understanding that your actions were wrong as demonstrated in your reflective accounts and your oral evidence today. You demonstrated, during questions from the panel, sincere remorse and were able to describe what you would have done differently in certain situations if faced with similar scenarios. You have demonstrated that you have undertaken training in the areas of concern that were identified, however you have not been able to work as a nurse and cannot evidence this in a clinical setting.

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether your misconduct was remediable and whether it had been remediated. The panel then considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin).

The panel was satisfied that the misconduct in this case is potentially capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you have undertaken training while working at Luton and Dunstable Hospital in Medicines Management and Management of deteriorating patients. You also completed online training in July 2023 in the following areas: Introduction to Insulin Safety: An introduction for Everyone, Statutory & Mandatory Training: Medication Awareness & Management, Statutory & Mandatory Training: Basic Life Support (Clinical), Safe Use of Insulin: Administration. From your submissions today, you told the panel you were reading policies around medication management and administration and reading articles relating to the nursing profession.

The panel considered Ms Forsyth's submission that they could be attitudinal issues. The panel was not persuaded that given the circumstances it was attitudinally based misconduct.

The panel considered your submissions that you want to return to your nursing and demonstrated your passion and determination to even initially return at a lower band in order to build your confidence and understand working on a ward. The panel noted the many personal challenges you have faced and were impressed by your resilience, determination and commitment to nursing.

However, the panel is of the view that there is a risk of repetition based on the facts of the case, as these were not isolated incidents. Concerns were raised at two different hospitals, the latter hospital being Luton and Dunstable, you were subject to undertakings, and it was reported to the NMC, on your last supervision of a medication round that you

had to be stopped from administering the wrong dose of medication to a patient. The manager indicated in an email to the NMC dated 8 December 2021 stating:

> '*She has not met the requirements stated in the restrictions to practice which were imposed.*
>
> *The deadline to be able to complete her objectives in order to practice safely have not been met (after an extension following her maternity leave and COVID etc the timescale had been extended to the 4th December 2021)*
>
> *She is unsafe with her medication rounds…'*

The panel was of the view that you are currently not in employment and have therefore been unable to demonstrate your ability to practise safely and effectively and address the concerns raised. There is no evidence before the panel today which shows you have put your training regarding medication management and administration into practice in the health or social care sector. Therefore, the panel cannot be satisfied that you have remediated and strengthened your practice. The panel determined that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of nine 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

Ms Forsyth informed the panel that in the Notice of Hearing, dated 19 June 2023, the NMC had advised you that it would seek the imposition of a 6-12 month suspension order with a review if it found your fitness to practise currently impaired.

Ms Forsyth submitted that the following aggravated features applied to this case:

- Failure to provide adequate care relating to fundamental nursing practices.
- A pattern of misconduct.
- A failure to demonstrate through completion of the undertakings that your practise is now safe.
- Harm caused to a colleague.
- Conduct which put patients at risk of suffering physical and emotional harm.

Ms Forsyth further submitted the following mitigating features:

- Your remorse and insight that you have shown regarding your understanding that your actions were wrong.

- You have attempted to remedy the concerns through undertaking further training.
- Your difficult personal circumstances at the time of the incident.
- The difficult and challenging working environment at Lister Hospital.

Ms Forsyth referred the panel to the SG and explained what the appropriate sanction for this case should be. She submitted that no order or a caution order would be appropriate in this case as the misconduct is serious and it would not protect the public. She said it is clear at this stage that you are not safe to practice unrestricted.

Ms Forsyth further considered a conditions of practice order. She submitted that this would be insufficient to protect the public and satisfy the public interest of this case. This was due to the fact that whilst you were subject to undertakings and working at Luton and Dunstable Hospital, evidence provided by your manager at the time was that despite the support given, they could no longer support you. You were described as being unsafe on medication rounds as well as having other developmental needs. She submitted that during your oral evidence you stated a desire to return to a lower level that would allow you to get to know the team, become familiar with the ward and get your confidence back. Ms Forsyth referred the panel to an email from a matron at Luton and Dunstable Hospital offering you a healthcare assistant role.

Ms Forsyth went on to consider a suspension order and submitted that this would be the appropriate order for this case. She further submitted that this is a serious case in relation to the initial concerns and also that you were unable to fulfil the undertakings when supported and that a temporary removal from the register is required.

Ms Forsyth informed the panel that you have been subject to an interim suspension order since February 2022 and therefore have not been able to practise as a nurse and therefore have had limited chance to demonstrate having addressed the risks in your practice.

Following Ms Forsyth's submission regarding suspension order, she submitted that a striking-off order in your case would be wholly disproportionate. Given your insight and commitment that you gave during your oral evidence that you wanted to prove you are safe to practise.

In response to the panel questions, Ms Forsyth submitted that if a suspension order is imposed that only your registration as a registered nurse would be suspended, but you would still be able to work in a healthcare assistant role that does not require your PIN. She also submitted that a conditions of practise order would not be appropriate, taking into consideration that you were unable to complete the undertakings and your conduct could have led to harm to a patient whilst being supervised. Ms Forsyth submitted that the NMC felt that you are currently unsafe to practise as a nurse.

The panel also bore in mind your submissions that a conditions of practice order would be best for your case. You submitted that a suspension order would be restrictive as it would not allow you to work independently.

You further submitted that a conditions of practice order would allow you to return to a clinical environment. It would allow you the opportunity to discuss with your employer the implementation of an action plan outlining your learning needs. You said it would be you taking responsibility and being accountable for your actions. It would also allow you to demonstrate your maintenance of the standards and safe practice.

You submitted that a suspension order would not allow you to demonstrate this.

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:

- Failure to provide adequate care relating to fundamental nursing practices.
- A pattern of misconduct over a period of time.
- Non-compliance with undertakings which were in place for a considerable amount of time and where you were supported.
- Harm caused to a colleague .
- Conduct that put patients at risk of suffering physical and emotional harm.

The panel also took into account the following mitigating features:

- Admissions of the charges.
- Your remorse and insight that you have shown regarding your understanding that your actions were wrong.
- Your attempts to remedy the concerns through undertaking further training.
- Your difficult personal circumstances at the time of the incident.
- The difficult and challenging working environment at Lister Hospital.
- Working during the COVID pandemic which may have been difficult in you receiving adequate support and supervision.

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 took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…*

The panel is of the view that there are currently no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case is capable of being remedied, but despite the level of insight demonstrated, you are not yet at a point where you are clinically able to integrate your learning and knowledge into independent safe practise within a clinical setting. The panel noted that there were no allegations of general incompetence put before it. The panel considered that there was no evidence before it today, that you have strengthened your practice clinically since you stopped working. The panel have had sight of online training certificates, but it was of the view that you have not been able to demonstrate how you would function safely in a pressurised clinical environment e.g. on a ward.

The panel noted that Luton and Dunstable Hospital have indicated that you are able to return to work as a Healthcare Assistant as that option is available to you. It considered

your own oral submissions that you wish to return at a lower band, to build your confidence and familiarise yourself with the ward.

Furthermore, the panel concluded that a conditions of practice order would restrict your ability to practice unrestricted and protect the public. However, the panel found that there were no workable conditions that could be imposed as any condition implemented would be so restrictive that it would be tantamount to suspension.

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:

- *…*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *…*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It found that the circumstances of this case were incompatible with the implementation of a conditions of practice. The panel determined that a suspension order would restrict you from working as a nurse, this would protect the public and satisfy the public interest. It also considered that you would be able to work as a Healthcare Assistant, which you indicated during oral evidence that you would like to initially start off to build your confidence and also allow you to reintegrate into a clinical setting.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public protection issues and the public interest in this case.

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

The panel determined that a suspension order for a period of nine months was appropriate in this case to mark the seriousness of the misconduct.

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:

- Evidence of professional development by way of your progress and performance in a clinical setting e.g. as a Healthcare Assistant.
- Testimonials from your employer in a clinical role about your progress and performance as a Healthcare Assistant.
- Any training you have undertaken by providing certificates and how you have kept up to date with the nursing profession.

- A reflective piece addressing the charges found proved, this should include how you have learnt and how you will deal with clinical situations differently to demonstrate safe practise.

This will be confirmed to you in writing.

Application for an Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, Ms Forsyth made an application on behalf of the NMC for the imposition of an interim order.

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 sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Forsyth. She submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

Ms Forsyth submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the risk of repetition of the misconduct.

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 in order to protect the public and the wider public interest to cover the 28-day appeal period and the duration of any appeal should you decide to appeal against the panel's decision.

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.

That concludes this determination.