Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 12 August – Friday, 23 August 2024
Tuesday, 27 August 2024

Virtual Hearing

Name of Registrant:	**Nimmy George**
NMC PIN	22G0727O
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (14 July 2022)
Relevant Location:	Cumbria
Type of case:	Misconduct and Lack of competence
Panel members:	Rachel Childs (Chair, Lay member) Vivienne Stimpson (Registrant member) Joanna Bower (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Tyrena Agyemang (12 August 2024) Nicola Nicolaou (13 – 27 August 2024)
Nursing and Midwifery Council:	Represented by Aliyah Hussain, Case Presenter
Ms George:	Not present and not represented at the hearing
Facts proved:	Lack of competence charges 1b, 2, 3a, 3b, 3c, 3d, 3e, 3f, 4, 5a, 5b, 5c, 5d, 5e, 5f, 5g, 5h, 5i(i), 5i(ii), 5i(iii), 5i(iv), 6a(i), 6a(ii), 6b(i), 6b(ii), 6b(iii), 6c, 6d, 6e(i), 6e(ii), 6f(i), 6f(ii), 6g(i), 6g(ii), 7a, 7b(i), 7b(ii), 7b(iii), 7c, 8a, 8b, 8c, 8d, 8e, 8f, 9a, 9b, 9c, 9d, 9e, 10a, 10b, 10c, 10d, 10e, 10f, 10g, 10h, 10i, 11a, 11b, 11c, 11d, 12a, 12b, 13a, 13b, 13c, 13d, 13e, 13f, 14a, 14b, 15, 16, 17a, 17b, 17d, 17e(i), 17e(ii), 17f, 17g(i), 17g(ii), 18, 19a,

	19b, 19c, 19d and Misconduct charges 1a, 1b, 2 and 3
Facts not proved:	Lack of competence charges 1a, 1c, and 17c
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms George was not in attendance and that the Notice of Hearing letter had been sent to Ms George's registered email address by secure email on 26 June 2024.

Ms Hussain, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms George's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms George has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms George

The panel next considered whether it should proceed in the absence of Ms George. It had regard to Rule 21 and heard the submissions of Ms Hussain who invited the panel to continue in the absence of Ms George. She submitted that Ms George had voluntarily absented herself.

Ms Hussain submitted that there had been no engagement by Ms George with the NMC in relation to these proceedings, since her email dated 26 September 2022 and, as a consequence, there was no reason to believe that an adjournment would secure her

attendance on some future occasion. She reminded the panel that there are a number of witnesses scheduled to attend the hearing and not proceeding may inconvenience the witnesses and their employers, particularly those involved in clinical practice.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Ms George. In reaching this decision, the panel has considered the submissions of Ms Hussain, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms George;
- Ms George has not engaged with the NMC since September 2022 and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Nine witnesses are due to give evidence throughout this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms George in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made only a very limited response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms George's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms George. The panel will draw no adverse inference from Ms George's absence in its findings of fact.

Details of charges (as amended)

That you, between 20 December 2021 and 12 September 2022, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that;

1. On one or more occasions demonstrated poor moving and handling practice by attempting to hoist a patient on your own on or around;

    a. 2 May 2022.
    b. 7 May 2022.
    c. 8 May 2022.

2. On 8 May 2022 did not record a patient's oral intake in their food diary and/or recognise the importance of completing the patient's food diary.

3. On or before 16 June 2022;

    a. On one or more occasions had to be prompted to adjust your communication according to the patient that was in your care at that time.
    b. Did not undertake hourly neuro observations on a patient who had suffered a fall.
    c. Having been explained on one or more occasions, did not recognise why Enoxaparin had been stopped for the patient.
    d. Having been explained on one or more occasions did not recognise that Enoxaparin could be administered after the CT scan indicated that the patient had not suffered a bleed.
    e. Provided incorrect information at handover indicating that the patient's Enoxaparin was on hold pending the results of the CT scan.
    f. Did not appreciate your surroundings and/or a patient's privacy by shouting words to the effect of, *'he is having a stroke'*.

4. On 18 June 2022 demonstrated poor hygiene and/or infection control by wearing your uniform outside of a hospital environment.

5. On 19 July 2022;

    a. Failed to recognise the importance of following infection control by wearing your uniform outside of the hospital environment.
    b. Failed to pay attention to a colleague when they were handing over to you.
    c. Provided incorrect information to the Echo department relating to a patient's medication.
    d. Failed to recognise why Alendronic Acid would not be the correct medication to use when a patient is suffering with nausea.
    e. Stated to a patient that you were going to give laxido for 'urine clearing' which was the incorrect medication to give.

f. Failed to provide comfort to a patient when they stated 'I'm afraid' or words to that effect.
g. Failed to recognise the importance of checking a diabetic patient's blood sugar prior to administering medication.
h. Failed to escalate a patient who had a high temperature and low blood pressure.
i. Failed to recognise that a patient's high temperature and/or low blood pressure may have been as a result of;
   i. The patient's bedding, and/or
   ii. The patient's clothing, and/or
   iii. There being a heatwave, and/or
   iv. The room temperature being 37C.

6. On 23 July 2022;

   a. When preparing medication for a patient;
      i. Failed to obtain the some of the required medication and/or
      ii. Obtained an incorrect dose.
   b. When providing care to a patient who was diabetic, failed to check;
      i. Their past medical history and/or
      ii. Their blood sugar levels and/or
      iii. Whether they required insulin.
   c. Having obtained medication to administer to a patient, had to be prompted to check a patient's Kardex because it was not the correct medication.
   d. Failed to contact and/or place the patient on the pharmacy list to request Tramadol.
   e. Failed to;
      i. Request the doctor to review whether a patient's Frusemide medication should be continued/discontinued, and/or.
      ii. Record in the patient's notes that the request had been made to the doctor.

f. Having been informed that a patient's blood sugar level was 13 did not recognise that you could;
    i. Check the patient's previous records to ascertain if the reading was normal for that patient and/or
    ii. Consider that if the reading was outside of the normal range that you should seek a further opinion from a senior nurse and/or doctor.
g. Failed to:
    i. Escalate a patient whose blood pressure reading was 199 systolic, and/or
    ii. Recognise when handing over the patient that they had a NEWS score when stating words to the effect of, *'he was not NEWSing'*.

7. On 24 July 2022;

    a. On one or more occasions failed to recognise the importance of maintaining a clean environment by discarding medication onto the floor.
    b. Had to be prompted to;
        i. Complete patients notes in a timely manner and/or tailor the notes according to the patient rather than copying and pasting them.
        ii. Use the correct sharps bin when disposing of medication.
        iii. Check IV medication against that on Kardex.
    c. On one or more occasions failed to update the SBAR handover for the patients in your care.

8. On 25 July 2022;

    a. Had to be prompted to reduce a patient's Isosorbide Mononitrate medication from 60mg to 30mg as prescribed.
    b. Failed to respond with urgency to an unresponsive patient when requested to get the blood sugar machine.

c. Whilst in the patient's room, ignored and/or failed to respond to the patient's buzzer.
d. Failed to recognise that leaving a commode by a patient's bedside could be hazardous.
e. Failed to recognise and/or accept that Salbutamol was not the correct medication when a patient's oxygen levels were 94%.
f. Had to be prompted on how to administer Frusemide IV medication to a patient.

9. On 27 July 2022;

a. Failed to recognise why a patient who suffered a fall required neuro observations.
b. Failed to recognise why a patient was prescribed Labetalol and/or what the medication was used for.
c. Failed to recognise that a patient required a nebuliser when short of breath.
d. Failed to recognise and/or provide reasons why you wanted to escalate a patient who had a low heart rate of 58bpm.
e. Incorrectly entered information relating to one patient into another patient's notes.

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

a. Check the patients' name on the medication chart and/or their wristband.
b. Check the patients date of birth matched with that on the medication chart.
c. Check whether a patient had any allergies.
d. Check the expiry date of the medication before administering it.
e. Check the medication chart in order to ascertain whether patients required antibiotics.
f. Recognise that Codeine was not a controlled drug and/or what it is used for.

g. Recognise the difference between medication that was PRN and regular medication.
h. Check the fluid balance charts.
i. Check a patient's diabetic chart to ascertain if they were prescribed insulin and/or whether the patient required their medication.

11. On 27 April 2022;

a. Failed to recognise the importance of following infection control by wearing your uniform to work and/or by wearing your jacket over your uniform whilst working.
b. Failed to undertake observations on a patient who had a NEWS score of 4.
c. Incorrectly declared that you had undertaken a patient's observations when you had not and/or failed to document the patient's observations.
d. Did not assist colleagues with doing personal care and/or changing and/or washing patients.

12. On 28 April 2022;

a. Had to be prompted to undertake checks during the medication round.
b. Failed to recognise that '*Sandoz*' was a brand name for medication and not Sando K the medication prescribed.

13. On or around 25 May 2022;

a. Failed to attend a patient who required assistance with personal care.
b. Failed to recognise that a patient who had an oxygen saturation level of 70% should have been administered oxygen using a non-rebreathe mask and not via nasal specs.
c. Attempted to escalate a patient with low blood pressure to a doctor without following the end of life care process.

d. Failed to recognise that a patient who had just died did not require further observations to be undertaken.
e. During a medication round took out the incorrect medication to administer to a patient in that you selected Ondansetron instead of Omeprazole.
f. Failed to recognise that potassium was required to be administered through a pump.

14. On 7 May 2022, failed to communicate effectively with patient in that you:

   a. Stood at the foot of the bed, and/or
   b. Waved your arms to get their attention.

15. On 7 May 2022 demonstrated poor infection control by taking off your mask when speaking to a patient.

16. On one or more occasions on 7 May 2022 did not check a patient's date of birth on their wristband.

17. On unknown dates in May 2022;

   a. Failed to escalate a patient who was NEWS scoring 3, and/or
   b. Failed to recognise why further observations were required.
   c. Failed to escalate a patient who was NEWS scoring 5 in relation to their blood pressure.
   d. Failed to act and/or assist with a patient who was attempting to stand up at the end of their bed.
   e. On one or more occasions during medication round/s failed to undertake any identity checks and/or checks for allergies;
      i. Verbally and/or
      ii. By checking the patient's wristband.

f. On one or more occasions obtained the wrong medication instead of checking the patient chart.

g. Was not aware;

i. Of the different clinical uses of Metoprolol and Lansoprazole

ii. That Ramipril is used to lower blood pressure.

18. On 20 June 2022, behaved in an inappropriate manner, when discovering that a patient was deceased, stated in a loud voice words to the effect of, *'It's my observation that the patient in bed 5 is dead'*.

19. On 20 June 2022, having discovered a patient was deceased, failed to;

a. Pull the emergency buzzer.
b. Lay the patient down.
c. Cover them from view with a bedsheet.
d. Pull the curtain around the bed.

And in light of the above, your fitness to practise is impaired by reason of your lack of competence.

That you a registered nurse;

1. Behaved in an unprofessional and/or inappropriate manner by stating to Colleague A words to the effect of;

a. *'I could kill someone here and I would still get a job at home'*.
b. *'If I disposed of my passport that has my visa attached, and not declare, they would not know, I would have to stay in the Country because of no passport'*.

2. Around January 2022 behaved inappropriately and/or unprofessionally by claiming that Colleague C and/or Colleague D had told you that they would clean the commode and/or bathroom when you knew that they had not.

3. Your actions in charge 2 lacked integrity in that you were attempting to blame Colleague C and/or Colleague D for not cleaning the commode and/or bathroom knowing that it was your responsibility.

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

Background

Ms George was referred to the NMC on 16 September 2022 by the Deputy Chief Nurse at North Cumbria Acute Hospital NHS Trust ('the Trust').

Ms George worked at the Trust as a supernumerary nurse from 20 December 2021. It was anticipated by the Trust that Ms George would work as a supernumerary nurse until she was able to complete the Objective Structured Clinical Examination (OSCE), which is necessary in order to obtain full registration with the NMC.

However, it is alleged that as early as January 2022, within a month of Ms George commencing her role at the Trust, concerns were being raised not only about Ms George's clinical abilities, but also about her behaviour and her attitude. These concerns were wide-ranging and covered competency, safely administering medication, communication and interpersonal skills, moving and handling techniques, compliance with uniform policy, retaining and applying information, and professionalism and trust.

Decision and reasons on amending the charges

After hearing live evidence from all of the NMC witnesses, the panel proposed a number of amendments to the wording of charges 3d, 5e, 6b, 6d, 6e(i), 8b, 9b, 13c, 17g, and 18. The panel determined that these amendments would fix the typographical and grammatical errors and would better reflect the evidence that it had heard from the witnesses.

Charge 3d

Proposed amendment

3. On or before 16 June 2022;
    d. Having been explained on one or more occasions did not recognise that Enoxaparin could be administered after the CT scan indicated that the patient had not suffered a ble**e**d, and/or

Charge 5e

Proposed amendment

5. On 19 July 2022;
    e. Stated to a patient that you were going to give laxido for 'urine ~~cleaning~~ **clearing**' which was the incorrect medication to give.

Charge 6b

Proposed amendment

6. On 23 July 2022;
    b. **When providing care to a** ~~A~~ patient who was diabetic**,** failed to check;
        i. Their past medical history and/or
        ii. Their blood sugar levels.

iii. Whether they required insulin.

…

Charge 6d

Proposed amendment

6. On 23 July 2022;
   d. Failed to contact and/or place the patient on the pharmacy list to request ~~tramadol~~ **Tramadol**.

…

Charge 6e(i)

Proposed amendment

6. On 23 July 2022;
   e. Failed to;
      i. Request the doctor to review whether a patient's ~~frusemide~~ **Frusemide** medication should be continued/discontinued, and/or.

…

Charge 8b

Proposed amendment

8. On 25 July 2022;
   b. ~~A patient who was unresponsive, failed~~ **Failed** to respond with urgency **to an unresponsive patient** when requested to get the blood sugar machine.

…

Charge 9b

Proposed amendment

9. On 27 July 2022;
    b. Failed to recognise why a patient was prescribed ~~labetalol~~ **Labetalol** and/or what the medication was used for.

    …

Charge 13c

Proposed amendment

13. On or around 25 May 2022;
    c. ~~Failed~~ **Attempted** to escalate **a** ~~an end of life~~ patient with low blood pressure to a doctor ~~for a review~~ **without following the end of life care process.**

    …

Charge 17g

Proposed amendment

17. On unknown dates in May 2022;
    g. ~~Failed to recognise that~~ **Was not aware**;

    i. **Of the different clinical uses of** Metoprolol **and Lansoprazole** ~~is used for high blood pressure~~.

    ~~ii. Lansoprazole is used for protecting the stomach.~~

    ii~~i~~. **That** Ramipril is used to lower blood pressure.

Charge 18

Proposed amendment

18. On 20 June 2022, behaved in an inappropriate manner, when discovering that a patient was deceased, stated in a loud voice words to the effect of, *'It's my observation that the patient in ~~bad~~* ***bed*** *5 is dead'*.

Ms Hussain submitted that she agreed with the panel's proposed amendments and proposed some additional amendments to charges 3b, 3c, 3d, 6b(ii), 9d, 10a, and misconduct charge 2.

Charges 3b, 3c, and 3d

Proposed amendment

3. On or before 16 June 2022;
b. Did not undertake hourly neuro observations on a patient who had suffered a fall, ~~and/or~~
c. Having been explained on one or more occasions, did not recognise why Enoxaparin had been stopped for the patient, ~~and/or~~
d. Having been explained on one or more occasions did not recognise that Enoxaparin could be administered after the CT scan indicated that the patient had not suffered a bleed, ~~and/or~~

…

Ms Hussain submitted that these amendments would simplify the charges and make it easier for the panel to make a determination in relation to the charges.

Charge 6b

Proposed amendment

6. On 23 July 2022;
    b. When providing care to a patient who was diabetic, failed to check;
        i. Their past medical history and/or
        ii. Their blood sugar levels~~.~~ **and/or**
        iii. Whether they required insulin.

    …

Charge 9d

Proposed amendment

9. On 27 July 2022;
    d. Failed to recognise and/or ~~providing~~ **provide** reasons why you wanted to escalate a patient who had a low heart rate of 58bpm.

    …

Charge 10a

Proposed amendment

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

a. Check **the** patients' name on the medication chart and/or their wristband.

…

Misconduct charge 2

Proposed amendment

2. Around January 2022 behaved ~~in an~~ inappropriate**ly** and/or unprofessional**ly** ~~manner~~ by ~~declaring to Colleague B that you had asked~~ **claiming that** Colleague C

and/or Colleague D ~~to~~ **had told you that they would** clean ~~a~~ **the** commode and/or bathroom when **you** knew ~~you~~ **that they had not.** ~~you had not asked them.~~

Ms Hussain submitted that the above amendments would more accurately reflect the evidence that the panel had heard. She submitted that it would be fair and just to make the proposed amendments.

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 amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Ms George and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to fix the typographical and grammatical errors and to better reflect the evidence that it had heard from the witnesses.

Decision and reasons on application to admit hearsay evidence

The panel heard an application from Ms Hussain to admit the evidence relied upon in respect of charge 1c as hearsay evidence. Ms Hussain submitted that this application is pursuant to Rule 31. She referred the panel to Witness 2's witness statement where she states that she was told by a healthcare assistant that Ms George had attempted to hoist a patient alone. Ms Hussain submitted that this information is clearly relevant, and the context in which this allegation was reported to Witness 2 must be taken into consideration.

Ms Hussain relied on the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that the panel should take into account the considerations set out at paragraph 56 of the judgment in *Thorneycroft*:

1) *whether the statement was the sole or decisive evidence in support of the charge;*

Ms Hussain submitted that this is not the sole evidence in support of charge 1 as a whole, as the panel have heard live evidence from two other witnesses regarding charge 1.

2) *the nature and extent of the challenges to the contents of the statement;*

Ms Hussain submitted that Ms George has not engaged with these proceedings and did not return the Case Management Form (CMF) therefore, it is unclear whether there is a challenge.

3) *whether there was any suggestion that the witness had reason to fabricate their allegations;*

Ms Hussain submitted that there is nothing to indicate that Witness 2 would have a reason to fabricate her evidence. Ms Hussain further submitted that there is no reason to suspect that the healthcare assistant would fabricate their allegation to Witness 2.

4) *the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

Ms Hussain submitted that the charges are serious, and in the event of adverse findings, there will be significant consequences for Ms George's career. Ms Hussain submitted that the seriousness of the allegations is why it is important that the panel has available to it all possible evidence in order to be able to come to a sound and reasoned determination.

5) *whether there was a good reason for the non-attendance of the witness;*

Ms Hussain submitted that this does not apply in this case.

6) *whether the NMC had taken reasonable steps to secure the attendance;*

Ms Hussain submitted that this does not apply in this case.

7) *the fact that the registrant did not have prior notice that the witness statement was to be read.*

Ms Hussain submitted that Ms George would have been aware of the evidence that the NMC seek to rely upon as she had been sent the hearing papers prior to the hearing commencing.

Ms Hussain submitted that it would be fair and in the interests of justice for the hearsay evidence to be admitted in this case.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the hearsay application serious consideration. The panel noted that Witness 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether Ms George would be disadvantaged by admitting the hearsay evidence in relation to charge 1c.

In making its decision, the panel had regard to the NMC guidance on hearsay evidence, DMA-6, and the case of *Thorneycroft*. The panel considered the seven factors of *Thorneycroft* in turn:

1) *whether the statement was the sole or decisive evidence in support of the charge;*

The panel determined that the evidence is the sole and decisive evidence in relation to charge 1c.

2) *the nature and extent of the challenges to the contents of the statement;*

The panel took into account that Ms George has not engaged with these proceedings, therefore it is unaware of the extent of the challenge.

3) *whether there was any suggestion that the witness had reason to fabricate their allegations;*

The panel determined that there is no evidence before it to indicate that Witness 2 has fabricated her evidence. However, the panel is concerned that the healthcare assistant has not been identified, and therefore it is unable to place any weight on this evidence as it has been unable to test it.

4) *the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

The panel determined that the charges are serious.

5) *whether there was a good reason for the non-attendance of the witness;*

The panel determined that it has not heard a good reason for the non-attendance of the healthcare assistant who reported to Witness 2.

6) *whether the NMC had taken reasonable steps to secure the attendance;*

The panel noted that it does not know if any steps were taken by the NMC to secure the attendance of the healthcare assistant.

7) *the fact that the registrant did not have prior notice that the witness statement was to be read.*

The panel determined that Ms George would have had prior knowledge of the charges as she was served with the hearing papers prior to the hearing commencing.

The panel determined that it would not be able to apply any meaningful weight to the evidence as it does not know who the healthcare assistant is, and cannot test the evidence, therefore making it difficult to rely on. The panel also heard evidence from two other witnesses regarding similar charges.

In these circumstances the panel refused the application.

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 Ms Hussain on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms George.

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

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

- Witness 1/Colleague B: Ward Manager at the time

- Witness 2/Colleague A: Deputy Manager of the Ward at the time

- Witness 3: Deputy Manager of the Ward at the time

- Witness 4: Deputy Manager of the Ward at the time

- Witness 5: Staff Nurse on the Ward at the time

- Witness 6 Staff Nurse on the Ward at the time

- Witness 7: Healthcare Assistant on the Ward at the time

- Witness 8/Colleague C: Healthcare Assistant on the Ward at the time

- Witness 9/Colleague D: Healthcare Assistant on the Ward at the time

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and Ms George.

The panel took into account the only information provided by Ms George, which was an email dated 26 September 2022 containing a counter complaint to the allegations, involving Witness 1. The email stated:

'…I would like to tell you that this is a counter complaint given by my previous employer to a finess [sic] *to practice complaint about my former ward manager* [Witness 1] *(…) because of the discrimination, racism, bullying & harassment & misguidance. They terminated me after failing me in the probation as well. I have forwarded the ongoing investigation about that case with this email as an attachment (…)'.*

The panel assessed all of the evidence of all witnesses to check for any possible discrimination, racism, bullying, harassment and misguidance.

During cross examination, the panel asked Witness 1 about the complaint made against her by Ms George. Witness 1 said that in retrospect, the allegations did not affect the support that she provided Ms George.

The panel considered all the support provided to Ms George during her employment at the Trust. The panel particularly took into account Witness 2's evidence and her contemporaneous statement dated 25 July 2022 in which she said, *'I have shared my personal experience of moving abroad with Nimmy* [PRIVATE], *but explained to Nimmy she should try her best for this opportunities she has been given and do her best to be pro-active.'*

The panel noted that Witness 2, who was also supernumerary whilst supervising Ms George on a one-to-one basis, was doing her best to be supportive and empathetic towards Ms George.

The panel also took into account the extensive training, supervision, mentorship, and occupational health input offered to Ms George during the seven months of her employment. It also considered the significantly reduced workload that was allocated to Ms George to support her. Ms George was often allocated only three patients to care for in order to allow her to focus on the aspects of her practice that needed improvement. The panel considered that the Trust, and the staff had taken significant steps to support Ms

George in her nursing role. Having assessed all of the evidence before it, the panel could find no evidence to support the allegations of discrimination, racism, bullying, harassment and misguidance.

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

Lack of competence charge 1a

1. On one or more occasions demonstrated poor moving and handling practice by attempting to hoist a patient on your own on or around;

    a. 2 May 2022.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 7's witness statement when she said, *'… I could see and hear the hoist being moved to the side of the bed as there is a gap in the curtains near the floor. As this was being done* [Ms 1] *came into the room to look for Ms George.* [Ms 1] *asked Ms George if she had requested assistance. Ms George replied that she was about to do so.'*

This is corroborated by Witness 7's contemporaneous statement dated 2 May 2022, which stated, *'… I could see her move the hoist to the side of the bed (…) she did not ask anybody for help. [Ms 1] came into the room and asked her if she had asked for any help and she said that she was about to'.*

This is further corroborated by Witness 7's oral evidence when she said, *"she didn't attempt to hoist because like I say, I would have (…) heard that* (the hoist) *move (…) had I thought she'd started to hoist, I would've went in there and stopped her…"*

The panel determined that whilst Ms George was moving the hoist to get it in position in preparation to hoist the patient, there is no evidence before it to support the allegation that Ms George attempted to hoist the patient on her own.

Charge 1b

1. On one or more occasions demonstrated poor moving and handling practice by attempting to hoist a patient on your own on or around;

    b. 7 May 2022.

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement when she said, *'… I went into the bed space that Ms George was in and saw that she was attempting to use the hoist alone. (…) When we saw that Ms George was trying to use the hoist alone, myself and* [Witness 8] *went to assist her.'*

This is corroborated by Witness 5's contemporaneous statement which stated, *'Nimmy was using a hoist on her own with a patient. Myself and a HCA* (healthcare assistant) *went to assist Nimmy to hoist the patient correctly. I spoke to Nimmy in the back office and explained that there must always be at least 2 members of staff to hoist patients. She said she was not aware this was the case, but knew for the future and wouldn't do it again on her own'*

This is further corroborated by Witness 5's oral evidence when she said, *"when I'd said to her about hoisting, did she know that she had to have two members of staff? She just shook her head at me."*

The panel accepted Witness 5's evidence. It determined that her evidence was clear, consistent, and reliable. She was a band 5 nurse who had worked alongside Ms George in

order to support her practice. She only knew Ms George in a professional capacity and the panel could identify no reason why she would fabricate this incident. It therefore finds this charge proved.

Charge 1c

1. On one or more occasions demonstrated poor moving and handling practice by attempting to hoist a patient on your own on or around;

    c. 8 May 2022.

This charge is found NOT proved.

The panel took into account Ms Hussain's submission that the NMC would not be making a comment on this charge, due to the panel rejecting the NMC's application to admit hearsay evidence in relation to this charge.

The panel determined that as the NMC are not advancing any evidence in relation to this charge, the panel find this charge not proved as there was a lack of evidence to suggest that Ms George attempted to hoist a patient on her own on 8 May 2022.

Charge 2

2. On 8 May 2022 did not record a patient's oral intake in their food diary and/or recognise the importance of completing the patient's food diary.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'… I told Nimmy that she needed to write in the food diary this information (since she fed the patient) and check/escalate any concerns. I returned after a couple of hours*

and Nimmy had not recorded any information regarding the patient's oral intake. Nimmy had not even started the food diary and put the date on it. I had to go and get a new sheet and fill it in retrospectively.'

This is corroborated by Witness 2's contemporaneous statement dated 8 May 2022, which stated, *'…Nimmy had a patient under her care with reduced appetite and was on a food diary. I had asked Nimmy if patient had lunch during 13h medication round. To what she replied "he is on a food diary". I have explained to Nimmy that doesn't tell me anything, I needed to know if he ate anything. She then proceeded to tell me he doesn't eat much, but she would assist him. I ordered to* [sic] *ice creams for the patient which he ate. I then reminded Nimmy to document in his food diary, when I checked this was not completed, there was not even a food diary for the day in place.'*

This is further corroborated by Witness 2's oral evidence when she said, *"She fed him and I then went back a couple of hours later, I believe nearly three hours later and there was nothing in there. When I checked again, there was not even a food diary started for that day…"*

The panel determined that Witness 2's evidence was credible as she provided very extensive contemporaneous documentation of her concerns which was consistent with her witness statement and her oral evidence. It took into account Witness 2's role as the deputy ward manager, who was working alongside Ms George in a supportive supernumerary capacity. It considered that she was well placed to comment on Ms George's practice, and the specific circumstances in relation to this charge. Overall, the panel found Witness 2's evidence to be balanced as she frequently identified positive aspects of Ms George's practice, as well as documenting concerns about deficiencies. Furthermore, she demonstrated empathy towards Ms George's circumstances as a new international nurse working in the United Kingdom, as she shared her own experience. The panel therefore accepted Witness 2's evidence and find this charge proved.

Charge 3a

3. On or before 16 June 2022;

a. On one or more occasions had to be prompted to adjust your communication according to the patient that was in your care at that time.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…During the medication round, Nimmy gave robotic answers and care that was not tailored to the patients. (…) when identifying the patient before administering mediation, Nimmy would repeat the same message along the lines of "My name is Nimmy" and then ask for the patient's date of birth. Some patients had dementia so did not reply however Nimmy repeatedly asked them their date of birth. Depending on level of dementia some patients are not able to engage or correctly answer a question even if asked repeatedly. In this case we have to proceed with other checks to confirm correct identification before administering any medication, such as wristband and patient board. Nimmy would do so after prompting, but then for the next shift or next medication round she would do the same thing and appeared to forget what I had told her. Would use the same robotic lines repeatedly.'*

This is corroborated by Witness 2's contemporaneous statement, which stated, *'Nimmy is still showing difficulties to adjust her communication to the patients she is looking after, she has a very automatic message and she seems unable to adjust her communication to meet the patient needs. I have explained this to Nimmy in every shift and medication round, but no change.'*

The panel determined that Witness 2's evidence is consistent with evidence from other witnesses in terms of Ms George's failure to understand and act on feedback. The panel also noted that a number of witnesses have raised concerns regarding Ms George's inappropriate and unprofessional communication with patients.

Charge 3b

3. On or before 16 June 2022;
b. Did not undertake hourly neuro observations on a patient who had suffered a fall.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'The doctor advised that neuro observations be taken for the patient and explained this to Nimmy and the patient. The patient was also on an anti-coagulant medication. I explained to Nimmy that the anti-coagulant had to be stopped/hold until we had a confirmation that there was no bleed. If the patient remained on their anti-coagulant medication it would increase the risk of bleeding. Nimmy failed to do the neurological observations every hour. There is a policy for suspected head injury and neuro observations.'*

This is corroborated by Witness 2's contemporaneous statement, which stated, *'We had a fall one shift and she was able to correctly complete framp, post falls and incident form. Unfortunately, she did not follow any of the doctor advice for neuro observations…'*

Charge 3c

3. On or before 16 June 2022;
c. Having been explained on one or more occasions, did not recognise why Enoxaparin had been stopped for the patient.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's contemporaneous statement, which stated, '[Ms George] *couldn't understand why enoxaparin was on hold until CT head. I have continuously explained to her that this was because of risk of*

haemorrhage and need a ct to rull [sic] *out and review before we give any anticoagulants, but she still did not understand…'*

The panel put more weight on Witness 2's contemporaneous statement than her witness statement as the relevant detail was in the contemporaneous statement and was not covered fully in Witness 2's witness statement.

Charge 3d

3. On or before 16 June 2022;

d. Having been explained on one or more occasions did not recognise that Enoxaparin could be administered after the CT scan indicated that the patient had not suffered a bleed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'When the medication was due at 17:00, the doctor had reviewed the CT scan and said that there was no bleed so we can safely give the patient the anticoagulant. I explained this to Nimmy and reiterated it to her several times. At the handover, Nimmy handed over that we were still waiting for the results from the CT scan and that the medication was on hold which was incorrect. Nimmy and I had just given the medication to the patient and the doctor had said that the CT scan was clear.'*

This is corroborated by Witness 2's oral evidence when she said, *"And she says, so we don't need to wait for the CT and I said 'no, she's already had it. So, because the CT didn't show any bleed, she'll be able to have her anticoagulation tablet'."*

The panel concluded that Ms George did not recognise that Enoxaparin could be administered after the CT scan indicated that the patient had not suffered a bleed, as she

had to be told a number of times, but still appeared not to understand. The panel therefore find this charge proved.

Charge 3e

3. On or before 16 June 2022;

e. Provided incorrect information at handover indicating that the patient’s Enoxaparin was on hold pending the results of the CT scan.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2’s witness statement when she said, *‘At the handover, Nimmy handed over that we were still waiting for the results from the CT scan and that the medication was on hold which was incorrect. Nimmy and I had just given the medication to the patient and the doctor had said that the CT scan was clear.’*

This is corroborated by Witness 2’s contemporaneous statement, which stated, *‘…During handover passed on wrong information. (…) the impression I got is that every day is a ‘first day’ and nothing from what she did previously gets carried on onto the next shift. I found myself repeating the same information over and over and over again.’*

Charge 3f

3. On or before 16 June 2022;

f. Did not appreciate your surroundings and/or a patient’s privacy by shouting words to the effect of, *‘he is having a stroke’*.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During one shift, Nimmy shouted at me while pointing at a patient "is he having a stroke?", because patient was drooling asleep. Nimmy should not have made this comment. Nimmy did not take into consideration her surroundings and that comment in such high tone can be frightening to patients. There was a disregard to patient's privacy and respect...'*

This is corroborated by Witness 2's contemporaneous statement, which stated, *'One of her patients was drooling due to being sit to forward* [sic] *in bed and she shouted at me saying "The patient is drooling is he having a stroke?". This is not a very professional and private way to communicate any concerns in regard to patient.'*

This is further corroborated by Witness 2's oral evidence when she said, *"Nimmy shouted at me and pointed at the patient and said, "is he having a stroke?" The patients got alarmed. I pulled Nimmy to the side and said, you know, if you do have concerns there is a way of escalating this. (…) We shouldn't be shouting. That's not a mean of communication. By all means, not between me and any of my staff and it certainly shouldn't be between any of the nurses and their patients either. (…) She wasn't very accountable to the situation or very aware of the how the situation was inappropriate."*

The panel determined that this charge is similar to charge 18 in that Ms George was using unprofessional communication and did not demonstrate an understanding of patient confidentiality and dignity.

Charge 4

4. On 18 June 2022 demonstrated poor hygiene and/or infection control by wearing your uniform outside of a hospital environment.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement when she said, *'On 18 June 2022, I witnessed Nimmy exhibiting strange behaviour and wearing her unfriform* [sic] *outside of the hospital. (…) After I saw Nimmy on 18 June 2022, I checked the Ward Rota and discovered that Nimmy had been on night shift on 17/18 June 2022. This made me think that she was wearing her unfirmao* [sic] *outside the hospital following her shift. Other members of staff and I had informed her not to wear uniform outside of the hospital. Uniform should not be worn due to infection control as staff can pick things up on uniform inside and outside of the hospital…'*

This is corroborated by Witness 1's contemporaneous statement, which stated, *'On Saturday morning, the 18th June at approximately 10am while in my car on* [PRIVATE] *I witnessed Nimmy in her uniform walking along the pavement adjacent to the road. She had an open jacket on with her hands in the pockets holding her arms out straight as a child would do when they are making an aeroplane.'*

This is further corroborated by Witness 1's oral evidence when she said, *"…I was sitting in traffic (…) Nimmy came along the road with her uniform under her coat (…) with her arms, you know, spread eagle walking along…"*

The panel took into account that Witness 1 was not the only witness to raise the issue of Ms George wearing her uniform outside of the work environment.

Charge 5a

5. On 19 July 2022;
a. Failed to recognise the importance of following infection control by wearing your uniform outside of the hospital environment.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At the beginning of the shift, Nimmy came to work in uniform with her trousers rolled up to her knees and wearing her tunic. I asked Nimmy to roll her trousers down. The uniform policy requires that staff should only wear their uniform at the hospital and trousers to cover the length of the leg. Covid was still very active in hospital and wearing uniform outside of the hospital increased the risk of spreading covid and any other infection. Staff are required to change into uniform at hospital and then change before going home.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'walked to work in uniform + pants pulled up to knees (Reinforced: that is not hospital policy)'.*

The panel took into account that a number of other witnesses have reported seeing Ms George wearing her uniform outside of the hospital environment.

Charge 5b

5. On 19 July 2022;
b. Failed to pay attention to a colleague when they were handing over to you.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…Nimmy received handover at the desk from another nurse (…) I listened in to the handover but explained to Nimmy that it was her handover so she needed to pay attention.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'Distracted during handover (looking around)…'*

The panel determined that it is more likely than not that Ms George was not paying attention when receiving a handover on 19 July 2022. The panel therefore find this charge proved.

Charge 5c

5. On 19 July 2022;

c. Provided incorrect information to the Echo department relating to a patient's medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'Subsequently, I overheard Nimmy talking on the telephone. I do not know who she was speaking to. Nimmy told someone that they have not sent a patient down because they have been sick, so they have given the patient Alendronic acid to settle. This is incorrect. Alendronic acid is not used for sickness/nausea/vomiting. The patient was actually on ondansetron. During handover, Nimmy was shown the patient file and what medication the patient was on. However, Nimmy passed on the wrong information on the phone.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…Echo department phoned (wrong information given about patient)…'*

Charge 5d

5. On 19 July 2022;

d. Failed to recognise why Alendronic Acid would not be the correct medication to use when a patient is suffering with nausea.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'I looked at Nimmy and asked her what she was saying. Nimmy said it was the Echo department and that she said we were giving Alendronic acid for sickness/vomiting. I asked if the handover nurse had said we had given Alendronic. I believe Nimmy had heard the handover incorrectly and then passed on the wrong information without questioning because Nimmy did not know what alendronic acid was.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…Echo department phoned (wrong information given about patient) I have questioned her, she did not understand patient was having ondansetron for sickness, thought she heard she was having Alendronic Acid. I have questioned how does she think Alendronic acid would help nausea, Nimmy does not know or understand why, and again she thought she heard Alendronic Acid. Did not understand, but also did not ask me to explain.'*

The panel noted that there were a number of charges that related to Ms George's inability to identify the correct clinical use of different medications.

Charge 5e

5. On 19 July 2022;

e. Stated to a patient that you were going to give laxido for 'urine clearing' which was the incorrect medication to give.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'Nimmy told a patient who had dementia that she was giving laxido for "urine clearing". This is incorrect and I told Nimmy that laxido is a laxative. Nimmy just said 'ok' in response.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…When explaining what some medication are to patient gave wrong info. Told Laxido was for urine clearing. (I have rectified)'*

The panel considered that this was another example of Ms George's basic failure to identify the correct use of a medication.

Charge 5f

5. On 19 July 2022;

f. Failed to provide comfort to a patient when they stated 'I'm afraid' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…This was a patient that had dementia and repeatedly kept saying 'I'm afraid'. Nimmy ignored that and made no attempt to comfort patient or explaining what she was doing/actions, just kept trying to offer the medication. I had to intervene and to reassure patient myself.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…Patient with dementia kept saying 'she was frightened'. Nimmy has made no attempt to comfort patient.'*

Charge 5g

5. On 19 July 2022;

g. Failed to recognise the importance of checking a diabetic patient's blood sugar prior to administering medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'Nimmy did not recognise the importance of checking a diabetic patient's blood sugar. I had not spoken to Nimmy about the importance of checking blood sugar and that we do not want to cause the patient to have a hypo or hyper glycaemic episode, especially when patient is on insulin. Nimmy could not understand the importance of this. I expected Nimmy to have this level of knowledge from her nursing degree and to be aware of the side effects of administering as part of training as a nurse. If you do not know the outcome of the medication, then should not give it. If Nimmy did not know, she could have checked with me or any other colleague or any other sources of medication administration such as BNF* (British National Formulary). *She did not attempt to do any of this.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…Did not check blood sugar on diabetic patient. When I asked why would it be important to check if patient has insulin prescribed, could not recognise why. Did not know different types of insulin (fast acting from long acting).'*

The panel noted that this is one of a number of charges that relate to the basic fundamentals of nursing knowledge and the proper and correct administration of medications.

Charge 5h

5. On 19 July 2022;
h. Failed to escalate a patient who had a high temperature and low blood pressure.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…Nimmy identified that one patient had a high temperature and low blood pressure. However, Nimmy did not escalate this and instead expected the next shift to look into it.'*

This is corroborated by Witness 2's contemporaneous note dated 19 July 2022, which stated, *'…She proceeded to say patient BP* (blood pressure) *was low and temperature 38.2°C. I have asked Nimmy what did she do about it. To what she told me nothing yet, that she was going to tell the next shift staff to redo observations and inform doctor.'*

Charges 5i(i), 5i(ii), 5i(iii), and 5i(iv)

5. On 19 July 2022;

i. Failed to recognise that a patient's high temperature and/or low blood pressure may have been as a result of;
    - i. The patient's bedding, and/or
    - ii. The patient's clothing, and/or
    - iii. There being a heatwave, and/or
    - iv. The room temperature being 37C.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'I went to the patient and saw that the patient was sitting in bed with flannelette pyjamas and four or five blankets on her. At the time, there was a heatwave and the room temperature was 37c. Nimmy failed to recognise that she should have taken the blankets off and put fresh clothing on the patient as this may be causing her increased temperature. If Nimmy suspected that the increase in temperature was due to infection or sepsis, Nimmy did not pass on that concern to me or a doctor. Nimmy expected the next shift to look into it. I was concerned that Nimmy could read a temperature but could not interpret what she was reading…'*

This is corroborated by Witness 2's contemporaneous statement dated 19 July 2022, which stated, *'I have explained to Nimmy this is one of the hottest days of heatwave if it could be that patient was just too covered up. Nimmy had looked at me like she was not understanding what I was saying. To what I asked if Nimmy had considered the environment could be affecting the temperature rise on patient. I have looked at patient and the patient had 4 blankets + flannel pyjamas in a 34°C heatwave. Again I asked Nimmy if she considered removing some of the blankets, to what her reply was 'I didn't thought of that'.*

Charges 6a(i) and 6a(ii)

6. On 23 July 2022;
   a. When preparing medication for a patient;
      i. Failed to obtain the some of the required medication and/or
      ii. Obtained an incorrect dose.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…When taking medication out, Nimmy should go through the checklist on the patient's Kardex. However Nimmy missed some medications and had to go back, or she would get the wrong dose which I would correct.'*

This is corroborated by Witness 2's contemporaneous note dated 23 July 2022, which stated, *'…07:35 – started medication round until 08:35. Forgot some tablets (wrong dose)…'*

Charges 6b(i), 6b(ii), and 6b(iii)

6. On 23 July 2022;

b. When providing care to a patient who was diabetic, failed to check;
    i. Their past medical history and/or
    ii. Their blood sugar levels and/or
    iii. Whether they required insulin.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'I asked if she needed to check anything else and Nimmy said no. I asked her again if she was sure and she gave me the same response. I advised her to check the patient's past medical history because during the handover it was handed over that the patient is diabetic. Nimmy said there was nothing else so I had to say that the patient is diabetic and that we need to check blood sugar, and whether he needs insulin.'*

This is corroborated by Witness 2's contemporaneous note dated 23 July 2022, which stated, *'…forgot insulin (required several prompts)…'*

Charge 6c

6. On 23 July 2022;
c. Having obtained medication to administer to a patient, had to be prompted to check a patient's Kardex because it was not the correct medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…When taking medication out, Nimmy should go through the checklist on the patient's Kardex. However Nimmy missed some medications and had to go back, or she would get the wrong dose which I would correct. (…) Nimmy needed a second person to counter check, and check against Kardex. I was present and noticed that Nimmy had*

taken out the wrong medication. I asked Nimmy if it was the correct medication and to check the Kardex. Nimmy then corrected her mistake.'

This is corroborated by Witness 2's oral evidence when she said, *"So she never actively committed a medication error because she had that supervision…"*

Charge 6d

6. On 23 July 2022;

d. Failed to contact and/or place the patient on the pharmacy list to request Tramadol.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During Nimmy's break, I was looking through the patient's record as the patient had requested tramadol at 12:50. I had asked Nimmy to put the patient on the list for pharmacy to supply the tramadol so that it could be administered during the next medication round. I noticed that Nimmy had not contact the pharmacy. Nimmy was on her break so I ordered the tramadol from the pharmacy.'*

This is corroborated by Witness 2's contemporaneous note dated 23 July 2022, which stated, *'…14:40 – patient requested for Tramadol during previous med round. Nimmy assured me she would try and order. I have confirmed, nothing was done post near 3 hrs, so I ordered this…'*

Charge 6e(i)

6. On 23 July 2022;

e. Failed to;

    i. Request the doctor to review whether a patient's Frusemide medication should be continued/discontinued, and/or.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During the morning medication round, Nimmy was due to administer frusemide to a patient. The doctor on the Ward put a review on the patient's medication so I said to Nimmy that we need to ask the doctor if they want to continue or discontinue the patient frusemide. I asked Nimmy if she could ask the doctor to review. I subsequently checked the patient records and there was no record by Nimmy as to whether or not she had asked the doctor to review the medication. I went and asked doctor to do the review myself.'*

This is corroborated by Witness 2's contemporary note dated 23 July 2022, which stated, *'…was supposed to request Dr to RV* (review) *patient's furosemide in a.m. – has not followed on task (I have requested this from doctor)…'*

The panel determined that Ms George should have requested the doctor to review the patient's Frusemide and therefore found this charge proved.

Charge 6e(ii)

6. On 23 July 2022;

e. Failed to;

    ii. Record in the patient's notes that the request had been made to the doctor.

This charge is found proved.

The panel determined that this charge is proved on the basis that Ms George did not make the request for the Frusemide to be reviewed, therefore it is more likely than not that she did not record the request in the patient's notes.

Charge 6f(i)

6. On 23 July 2022;

f. Having been informed that a patient's blood sugar level was 13 did not recognise that you could;

    i. Check the patient's previous records to ascertain if the reading was normal for that patient and/or

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During the shift a healthcare assistant, reported a patient under Nimmy's care had a blood sugar level of 13. The normal range for a patient is 4 to 11. Nimmy looked at me like she did not know what to make of it. I tried to prompt Nimmy's clinical judgement. Nimmy should be aware of what she needed to do as nurses are told how to assess blood sugar during their nursing training. (…) Nimmy could have checked the previous records of the patient to see what had been the normal reading on the blood sugar level of the patient on previous days.'*

Charge 6f(ii)

6. On 23 July 2022;

f. Having been informed that a patient's blood sugar level was 13 did not recognise that you could;

    ii. Consider that if the reading was outside of the normal range that you should seek a further opinion from a senior nurse and/or doctor.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, '*Nimmy looked at me like she did not know what to make of it. I tried to prompt*

Nimmy's clinical judgement. Nimmy should be aware of what she needed to do as nurses are told how to assess blood sugar during their nursing training. (…) Given that it was not much outside normality we would just monitor, but if the result was completely outside the normal value and she was concerned she should and could have escalated to a senior nurse for further opinion or to a doctor for review.'

This is corroborated by Witness 2's contemporaneous note dated 23 July 2022, which stated, *'…Escalated by HCA BM* (blood sugar) *13.0 does not recognise if need for escalation to doctor or not…'*

Charge 6g(i)

6. On 23 July 2022;

g. Failed to:

i. Escalate a patient whose blood pressure reading was 199 systolic, and/or

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During this shift, Nimmy recorded that a patient had a blood pressure of 199 systolic. If patient has a certain blood pressure range and then had 199, there is a risk to the patient's health as this is a very high blood pressure. A high blood pressure places a consistent strain on blood vessels. Nimmy did not escalate the patient's high blood pressure and could not recognise why she should have escalated.'*

This is corroborated by Witness 2's contemporaneous statement dated 23 July 2022, which stated, *'…(Pt BP 199 sys, Nimmy says patient not newsing so did not see need to report to doctor). (…) She has recorded patient systolic of 199 as BP and was handing this over to night staff (again) to monitor. I have advised Nimmy again why she did not informed* [sic] *someone of this, me or doctor, to what Nimmy does not seem to think it was an issue, since it did not score on NEWS.'*

Charge 6g(ii)

6. On 23 July 2022;

g. Failed to:

ii. Recognise when handing over the patient that they had a NEWS score when stating words to the effect of, *'he was not NEWSing'*.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'If Nimmy was working by herself, she should report it to the doctor on the Ward. I was there to support her and she could have reported the high blood pressure to me. Nimmy did neither and even during the handover when she was passing on high blood pressure she raised no concern and just said that 'he was not NEWSing'. This meant that he did not have a high NEWS score on the monitor…'*

This is corroborated by Witness 2's contemporaneous statement dated 23 July 2022, which stated, '*She has recorded patient systolic of 199 as BP and was handing this over to night staff (again) to monitor. I have advised Nimmy again why she did not informed* [sic] *someone of this, me or doctor, to what Nimmy does not seem to think it was an issue, since it did not score on NEWS.'*

The panel noted that this is one of the occasions when Ms George appears to have failed to prioritise patient needs by passing responsibility for their care to another member of staff when she herself should have taken action.

Charge 7a

7. On 24 July 2022;

a. On one or more occasions failed to recognise the importance of maintaining a clean environment by discarding medication onto the floor.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'When Nimmy was prefilling the needle, Nimmy wrongly discarded the two units of insulin for prefill onto the middle of the floor. Disposing of medication is part of your medication administration e-learning. Although it is only a small amount, patients could have slipped on it and it created an extra potential hazard. Also, nurses should try to maintain a clean environment on the Ward and discarding substances on the floor does not help maintaining* [sic] *this. (…) When administering the IV* (intravenous) *medication, Nimmy kept spilling it. Nimmy needed to take the air out of the syringe, when pressing liquid up of syringe. However, Nimmy discarded medication onto floor when taking air out. This created another potential hazardous environment.'*

This is corroborated by Witness 2's contemporaneous note dated 24 July 2022, which stated, *'…During med round disposed + prepared insulin pen for administration correctly, but when prefilling needle with 2 units ejected into* [sic] *floor (primed into floor) – I have explained this is a hazard and that is not how we dispose/prime medicine (…) During preparation kept spilling liquid onto floor (same this a.m with insulin) I have again told Nimmy this spills could cause a hazard incident.'*

The panel considered that Ms George repeated this error again in the afternoon after being asked not to in the morning by Witness 2. The panel determined that there appears to be a pattern of behaviour in which Ms George is unfamiliar with the process of safely disposing of medication.

Charge 7b(i)

7. On 24 July 2022;

b. Had to be prompted to;

i. Complete patients notes in a timely manner and/or tailor the notes according to the patient rather than copying and pasting them.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2’s witness statement when she said, *‘Nimmy needed a lot of prompts to organise her time, including what she needed to do next, how to organise her actions, and whether she should be doing notes or observations. A registered nurse should know how to prioritise and organise their own work load. Furthermore, Nimmy had been on the Ward since December 2021 so I expected her to be able to organise her time and integrate with the ward routines. (…) at 10:40, I asked Nimmy about her documentation including nursing records, falls risk assessment and any documentation for her shift because I wanted to check it. I had asked on three occasions and Nimmy always said “I’ll have it done” but at some point, she should have given me a time of when she would do it so I could then go check. (…) At 13:40, Nimmy had still not completed her documentation so I had to set a timeframe. At 14:30, I had to step aware from Nimmy to do a one to one with a patient. Nimmy was at the computer and I told her to do her documentation. Nimmy was sitting on the nurse’s station at the desk looking through her phone, giggling, instead of doing the patient’s notes. (…) Nimmy used the example I gave her for one patient and wrote it on all her notes for all her patients. This did not give me tailored information on the patient’s needs.’*

This is corroborated by Witness 2’s contemporaneous note dated 24 July 2022, which stated, *‘…I had to prompt all actions and organise her time (…) I have asked how document + records were going and when she would have it done reply ‘I will get it done’ (…) 13:40 Asked about records + documents – Answered me still going. I have set her a time to have this completed and will check. (…) 14:30 – 15:30 sitting next to computer at bottom desk playing with mobile phone, while I was 1:1 with patient (…) ? looks like copy + paste for all 3 patients’*

The panel also took into account Witness 2's contemporaneous note dated 24 July 2022 when comparing Ms George's shift notes to her goals, Witness 2 recorded, *'…still requiring several prompts to complete notes and records, but able to do it, missing consistency in organising shift and notes…'*

Charge 7b(ii)

7. On 24 July 2022;

b. Had to be prompted to;

ii. Use the correct sharps bin when disposing of medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'The Ward has a yellow bin for sharps disposal and a blue bin for vial disposal. There is a guide which says what goes in which one. Nimmy was putting vial that goes on blue top bin, into the yellow bin. I had to remind Nimmy to use correct bin. There are different costs and methods of disposal for each bin, so it is important to follow the correct disposal. If you put a vial into needle bin, it would not be possible to retrieve it.'*

This is corroborated by Witness 2's contemporaneous note dated 24 July 2022, which stated, *'…Does not dispose of vials + sharps correctly…'*

Charge 7b(iii)

7. On 24 July 2022;

b. Had to be prompted to;

iii. Check IV medication against that on Kardex.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At 12:30, Nimmy need prompts to check IV medication on Kardex. The patient's antibiotics were prescribed on the back of the Kardex. I had to remind Nimmy to check and Nimmy then noticed there was an IV med.'*

This is corroborated by Witness 2's contemporaneous note dated 24 July 2022, which stated, *'…12:30-13:10 Medication round. Needed prompts to remember to check IV medication…'*

The panel noted that this is an example of Ms George failing to check medication and patient information during her shift.

Charge 7c

7. On 24 July 2022;

c. On one or more occasions failed to update the SBAR handover for the patients in your care.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'…I asked Nimmy to update the SBAR* (Situation, Background, Assessment and Recommendation) *handover throughout the day to make sure that she passed on the information to the night shift. However, Nimmy had not updated it for any of her three patients. The information was available from previous day.'*

This is corroborated by Witness 2's contemporaneous note dated 24 July 2022, which stated, *'Handover has not been updated (I had previous reminded Nimmy to do so)…'*

The panel noted that Ms George was only allocated three patients and was not required to look after as many patients as the other nurses on the Ward. It considered therefore that

there was no reason why the SBAR handover was not completed in a timely manner. It noted that there were other charges that related to delayed completion of tasks.

Charge 8a

8. On 25 July 2022;
a. Had to be prompted to reduce a patient's Isosorbide Mononitrate medication from 60mg to 30mg as prescribed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During the morning medication round, Nimmy forgot Isosorbide mononitrate ("ISMN") for a patient. (…) Nimmy did not put the medication in the paper container. Nimmy noticed that she forgot the tablet. She then got the tablet out and because the blister in the drawer was a 60mg but patient was prescribed 30mg, she nearly forgot to cut it in half. I noticed it and called it to her attention before she gave it.'*

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'… Forgot ISMN tablet for 1 patient…'*

The panel noted again that this is one of a number of charges that relate to medication errors. The panel noted that if Witness 2 had not intervened, this may well have led to an incorrect dose of medication being administered which may have resulted in patient harm.

Charge 8b

8. On 25 July 2022;
b. Failed to respond with urgency to an unresponsive patient when requested to get the blood sugar machine.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At 12:00 I was with another patient which appeared to be very sleepy, unresponsive. (…) We asked Nimmy to get the blood sugar machine urgently for the patient, which took her 15 minutes. Nimmy had to walk to top of the ward and back down which should take about two minutes. (…) There was no sense of urgency.'*

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'…Doctor requested for urgent blood sugar, I have asked Nimmy if she could do this urgently, but took near to 15 min for Nimmy to actually do this (seen very casually walking to get machine) – No sense of urgency.'*

Charge 8c

8. On 25 July 2022;

c. Whilst in the patient's room, ignored and/or failed to respond to the patient's buzzer.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'A patient was requesting to go to the toilet. Nimmy was in the room and ignoring the patient's buzzer. If Nimmy was aware that a patient is asking for help, she should go and help. (…) I had to prompt Nimmy to take patient to toilet which she did. When Nimmy came back, I told Nimmy that she needed to take patient off the toilet as well. Nimmy asked to delegate this task to a HCA. However, you cannot pass on tasks just because you do not want to do them.'*

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'…Patient requesting toilet in room Nimmy was, she ignored this and when I asked her to take this patient off toilet, she asked if she could delegate to HCA…'*

The panel determined that Ms George displayed a highly concerning disregard for patients and her fellow colleagues.

Charge 8d

8. On 25 July 2022;
d. Failed to recognise that leaving a commode by a patient's bedside could be hazardous.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'Nimmy asked if she could leave the commode by the bedside so that if the patient buzzed again it was by the bed ready to use. This is not appropriate because it could be a hazard for patients. Also when a commode has been used, it should be cleaned and store in the commode room so others know where to find them if needed.'*

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'…Nimmy also asked if she could leave commode in middle/side of bed for next time – to what I said 'no' and explained IP guidelines again and the hazard this would be for wandering patients.'*

The panel considered that this was one of a number of charges in which Ms George demonstrated a lack of understanding of the needs of this patient group.

Charge 8e

8. On 25 July 2022;
e. Failed to recognise and/or accept that Salbutamol was not the correct medication when a patient's oxygen levels were 94%.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At 13:00, a patient had oxygen levels of 94 per cent. Most patients are above 96 per cent. Nimmy asked whether patient needed salbutamol because patient had oxygen level of 94 per cent. Salbutamol was prescribed on 'in case needed medication' via a nebuliser or inhaler for when patient is short of breath. This patient was not short of breath and was talking in full sentences with no struggle, had oxygen levels of 94, 95 and 96 per cent so they appeared within a normal range. I used my judgement, and decided that salbutamol was not necessary at the time but Nimmy wanted to ask a doctor. It showed again a lack of clinical decision making and interpretation.'*

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'…Asked if she should give PRN salbutamol inhaler to patient because O2 saturation 94%. I have explained as written in prescription indication this is for SOB (shortness of breath) and currently patient is not SOB, plus doctor was not concerned with sat O2 94%, so in this instance it would not be required (again seems unaware of what should be escalated)…'*

Charge 8f

8. On 25 July 2022;

f. Had to be prompted on how to administer Frusemide IV medication to a patient.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'One of Nimmy's patient was prescribed frusemide, which is an IV medication. Nimmy went to prepare the frusemide but did not know how to do it. I reminded her that two days ago we had done an IV antibiotic and where to look. I showed her again where*

the medication was and referred her to the BNF. (…) Nimmy was dismissing the information I was giving in a very rude tone. I told Nimmy that I was there to help her and I did not appreciate the tone or way she made me feel. Nimmy apologised but then she turned around and laughed or giggled. This made me feel that it was not a sincere apology.'

This is corroborated by Witness 2's contemporaneous note dated 25 July 2022, which stated, *'…I have explained six times how to prepare + administer and side effects of furosemide, showed where to look for this information too. During preparation of IV Nimmy as commented to me in a very rude tone of voice "what do we need that for?!" while I was trying to show her how to prepare something and open ampoules. I explained to Nimmy did this not* [sic] *make me feel appreciated when I was just trying to help. She apologised, but then turned around and giggled. (did not feel like an honest/heartfelt apology)…'*

The panel noted the poor response of Ms George to the support being provided to her. The panel was of the view that the Trust had directed considerable resource to support Ms George in her nursing practice and was concerned that this incident indicated that Ms George did not value that support or recognise its potential benefit to her. The panel noted that Ms George demonstrated unprofessional behaviour towards a colleague.

Charge 9a

9. On 27 July 2022;
   a. Failed to recognise why a patient who suffered a fall required neuro observations.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'During a medication round, a patient required neuro observations following a fall. Nimmy could not understand the reasoning why she needed to do this.'*

This is corroborated by Witness 2's contemporaneous note dated 27 July 2022, which stated, *'…(Does not know why neuro obs* (observations) *were implemented on patient or how to complete it if needed)…'*

The panel noted that this was a similar charge to 3b and occurred over a month later. The panel was concerned that this demonstrated that Ms George was not applying previous learning. The panel considered that the need for neuro observations after a fall was well understood, even by those with no medical training.

Charge 9b

9. On 27 July 2022;

b. Failed to recognise why a patient was prescribed Labetalol and/or what the medication was used for.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At 16:50, a doctor on the Ward prescribed labetalol for a patient who had raised blood pressure. I asked Nimmy about the medication but she did not look at the BNF or on the information leaflet. Instead, Nimmy appeared to be guessing what the medication was and saying random things.'*

This is corroborated by Witness 2's contemporaneous note dated 27 July 2022, which stated, *'…16:50 Doctor prescribed Labetalol for patient with raised BP. Nimmy collected from pharmacy. Before administration I have enquired to Nimmy onset action of medication to which she stated guessing. I have advised she looks for answer, instead of guessing. She did this.'*

The panel considered that this charge reflected the previously identified pattern of Ms George being unaware of the clinical use of different medications.

Charge 9c

9. On 27 July 2022;
c. Failed to recognise that a patient required a nebuliser when short of breath.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At 18:20, Nimmy did not realise that a patient needed a nebuliser when the patient was short of breath. Nimmy's response to this patient did not match with a patient from previous day who she wanted to give salbutamol to.'*

This is corroborated by Witness 2's contemporaneous note dated 27 July 2022, which stated, *'…18:20 – patient SOB did not recognise need for nebuliser on PRN…'*

Charge 9d

9. On 27 July 2022;
d. Failed to recognise and/or provide reasons why you wanted to escalate a patient who had a low heart rate of 58bpm.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'Another patient had a heart rate of 58bpm* (beats per minute) *and Nimmy wanted to escalate the patient to a doctor. However, Nimmy did not know why she wanted to escalate the patient. Nimmy asked me "should I escalate?", I asked her what was the reason for escalating and Nimmy said "I don't know". I asked why Nimmy wanted to escalate because the patient's heart rate was within their normal range. The heart rate was normal for the individual.'*

This is corroborated by Witness 2's contemporaneous note dated 27 July 2022, which stated, *'…wanted to escalate HR* (heart rate) *of 58bpm to doctor when I asked normal the value – was 64bpm. I have asked what would be rationale for escalation – no answer'*

Charge 9e

9. On 27 July 2022;

e. Incorrectly entered information relating to one patient into another patient's notes.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's contemporaneous note dated 27 July 2022, which stated, *'…Wrote wrong information of patient in other patient's notes. Pt with* [increased] *BP documented (…) I have asked Nimmy about this "it was in error"…'*

Charges 10a, 10b, 10c, and 10d

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

a. Check the patients' name on the medication chart and/or their wristband.
b. Check the patients date of birth matched with that on the medication chart.
c. Check whether a patient had any allergies.
d. Check the expiry date of the medication before administering it.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said *'When Nimmy approached the first patient, I had to prompt her to check the patient's name on the medication chard and their wristband. I also had to prompt Nimmy*

to check that their date of birth matched the medication chart and whether they had any allergies. Nimmy did not check the expiry date on medication before administering unless I promoted her to do so. Nimmy did not do any checks before she started administering medication until I prompted her.'

The panel noted that Witness 3's witness statement was consistent with her contemporaneous note of the medication round on 20 April 2022.

The panel considered that Ms George appeared always to need to be prompted to do the essential checks to ensure she was giving the correct medication to patients. It further noted that this is basic nursing practice that Ms George did not appear to understand.

The panel took into account that Witness 3 was a senior nurse and deputy ward manager and that she was supervising and supporting band 5 nurses in a supernumerary role. The panel determined that Witness 3's oral evidence was clear and consistent with her written statement and contemporaneous record and determined that her evidence was reliable when making decisions on the facts in this case.

Charge 10e

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

e. Check the medication chart in order to ascertain whether patients required antibiotics.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'…Nimmy did not check the medication chart and completely missed the section for antibiotics. Nimmy would not have administered the patients' antibiotics unless I had prompted her to do so.'*

This is corroborated by Witness 3's contemporaneous note dated 20 April 2022 which stated, *'Medication chart not checked correctly, some of the medication prescribed was missed Pivmecilin* [sic]*'*

Charge 10f

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

f. Recognise that Codeine was not a controlled drug and/or what it is used for.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'During the medication round, Nimmy looked at a patient's medication chart and I asked her what the patient's next medication is. Nimmy said that the patient is prescribed codeine. Nimmy said that codeine is an opioid narcotic and that she would not administer it. (…) Nimmy did not appear to know what codeine is and what it is administered for.'*

This is corroborated by Witness 3's contemporaneous note dated 20 April 2022 which stated, *'noted that codeine is an opioid narcotic and would not administer that…'*

Charge 10g

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

g. Recognise the difference between medication that was PRN and regular medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'Nimmy could not tell the difference between regular medication and PRN medication. PRN medication means that it is administered to patients as required…'*

This is corroborated by Witness 3's contemporaneous note dated 20 April 2022 which stated, *'could not make the difference between regular medication and PRN…'*

Charge 10h

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

h. Check the fluid balance charts.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'…Nimmy did not check the fluid balance charts to see whether the patients were prescribed any IV fluids...'*

This is corroborated by Witness 3's contemporaneous note dated 20 April 2022 which stated, *'fluid balance chart not checked…'*

Charge 10i

10. On 20 April 2022, on one or more occasions, had to be prompted to and/or failed to:

i. Check a patient's diabetic chart to ascertain if they were prescribed insulin and/or whether the patient required their medication.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'…Nimmy did not check the patient's diabetic chart to see whether insulin was prescribed and whether it was due. Nimmy also needed to check the patient's blood sugar levels and record these on the diabetic chart. However, I had to prompt Nimmy to do so.'*

This is corroborated by Witness 3's contemporaneous note dated 20 April 2022, which stated, *'… patient with T2DM* (Type 2 Diabetes Mellitus)*, diabetic chart not checked…'*

Charge 11a

11. On 27 April 2022;
    a. Failed to recognise the importance of following infection control by wearing your uniform to work and/or by wearing your jacket over your uniform whilst working.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'At the beginning of the shift, Nimmy arrived to work in her uniform wearing a black puffer jacket over her uniform. Nimmy continued wearing her jacket over her uniform while working. I told Nimmy that she needed to remove her jacket. (…) Nimmy wore her uniform to and from work which placed patients at risk because it was against the Hospital's infection control procedures…'*

This is corroborated by Witness 3's contemporaneous note dated 27 April 2022, which stated, *'walked with jacket on the corridor walked to go to check obs for patient with the jacket on, asked to remove it'.*

The panel noted that this is not the only charge in relation to Ms George failing to recognise the importance of infection control in relation to her clothing.

Charge 11b

11. On 27 April 2022;

b. Failed to undertake observations on a patient who had a NEWS score of 4.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'At the start of the shift, the patient had a NEWS score of four. The patient's blood pressure was 87 which is too low. I asked Nimmy to check the patient's observations in four hours. Later on in the shift, I asked Nimmy whether she had checked the patient's observation but she said that she had forgotten.'*

This is corroborated by Witness 3's contemporaneous note dated 27 April 2022, which stated, *'… NEWS 4 at the start of the shift. Told to recheck obs in 4 hours as BP 87 (…) forgot to check when asked…'*

The panel noted that this is an example where Ms George fails to follow instructions from a senior colleague.

Charge 11c

11. On 27 April 2022;

c. Incorrectly declared that you had undertaken a patient's observations when you had not and/or failed to document the patient's observations.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'I asked Nimmy again whether she had checked the patient's observations and she said that she had. However, when I checked the patient's observations chart there were no observations recorded…'*

This is corroborated by Witness 3's contemporaneous note dated 27 April 2022, which stated, *'… forgot to check when asked, stated that she checked but she didn't.'*

The panel noted that this is not the only charge relating to Ms George failing to record patient observations but declaring that she had.

Charge 11d

11. On 27 April 2022;

d. Did not assist colleagues with doing personal care and/or changing and/or washing patients.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'Nimmy did not help others by doing personal care and was not changing or washing patients. I spoke to Nimmy and told her that she needed to do personal care. Nimmy never said anything and just looked at me.'*

This is corroborated by Witness 3's contemporaneous note dated 27 April 2022, which stated, *'… not doing personal care…'*

Charge 12a

12. On 28 April 2022;

a. Had to be prompted to undertake checks during the medication round.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'On 28 April 2022, I worked my third and final shift with Nimmy. I had to prompt her during the medication round to do all the checks. It appeared as though Nimmy had not remembered anything from the previous two shifts and that we were back to the beginning.'*

The panel were satisfied with Witness 3's recollection of the incident, as explained in her live evidence that she had to prompt Ms George and that Ms George was not retaining information and was repeating errors. The panel noted that this incident occurred just one week after the incidents referred to in charge 10, and that Ms George was repeating the same mistakes.

Charge 12b

12. On 28 April 2022;

b. Failed to recognise that '*Sandoz*' was a brand name for medication and not Sando K the medication prescribed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement when she said, *'… The patient was prescribed Sando K which is a potassium replacement. However, when checking the patient's medication Nimmy wanted to give the patient Bisoprolol because the box had Sandoz written on it. (…) Sando K and Bisoprolol are medications that qualified nurses should be aware of and medication that is often administered on the Ward.'*

This is corroborated by Witness 3's contemporaneous note dated 28 April 2022, which stated, *'patient (…) prescribed Sando K, she wanted to give Bisoprolol…'*

Charge 13a

13. On or around 25 May 2022;

a. Failed to attend a patient who required assistance with personal care.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'… Ms George was sat in a chair between bed 3 and 4. On Ms George's left hand side, the patient in bed 4 had stripped naked and was covered in urine. I asked Ms George what was she doing? I pulled the curtain round the patient to give them privacy. Ms George said that "it's not my patient". I told Ms George that she cannot choose who she nurses as and when. I told her that she had a responsibility to look after all patients on the Ward. The patient needed help and assistance. I was flabbergasted by Ms George's response. (…) If she saw something untoward or a risk, such as a patient trying to get out of bed, Ms George would not stop them because it was not her patient.'*

This is corroborated by Witness 4's oral evidence when she confirmed that she had told Ms George that there is a responsibility to look after all the patients on the ward. Witness 4 said that Ms George *"shrugged it off (…) as though it didn't matter because it was not her patient."*

The panel determined that Witness 4's witness statement was clear and was supported by her oral evidence. Furthermore, Witness 4 is a registered nurse who was a deputy ward manager at the time. She had been asked to supervise Ms George to support her nursing practice and the panel considered that this close supervision meant that Witness 4 would be well placed to provide reliable detail in relation to the charges. The panel took into account that it has been mentioned in other charges that Ms George has failed to intervene when she believes the patient is not hers to care for.

Charge 13b

13. On or around 25 May 2022;

b. Failed to recognise that a patient who had an oxygen saturation level of 70% should have been administered oxygen using a non-rebreathe mask and not via nasal specs.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'…The patient's oxygen saturation level was 70 per cent. Ms George asked if she should administer 3 litres of oxygen via nasal specs. This was totally inappropriate as it was not an adequate amount of oxygen for the patient to increase their oxygen saturation levels. while at bed side, Ms George should have got a non re-breath mask out, and attached it to the oxygen at the bedside and turned it up to 15 litres and applied the mask to the patient's face. Ms George should have been taught how to do this through the Trust's intermediate life support and basic life support training…'*

This is supported by Witness 4's contemporaneous statement dated 25 May 2022, which stated, *'On one occasion a patient with saturations of 70% she asked if she should put oxygen on and proceeded to administer oxygen through the nasal specs on 3 litres.'*

Charge 13c

13. On or around 25 May 2022;

c. Attempted to escalate a patient with low blood pressure to a doctor without following the end of life care process.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'Ms George identified that the patient had a low blood pressure, 84 systolic, and wanted to give fluids to the patient. Ms George knew what to do in* [sic] *when a patient had*

low blood pressure. However, as the patient was end of life this should have been discussed with the doctor. (…) Generally, when a patient is on end of life it means no more observations because we are not going to react to the finding and treat the cause as this can cause more distress to the patient and the family, and as long as the patient is comfortable free from pain or distress we would just observe, and ensure the patients dignity was maintained and they were not in distress.'

This is corroborated by Witness 4's contemporaneous statement dated 25 May 2022, which stated, *'…Another occasion she did highlight a patient had low blood pressure 84 systolic and bleeped the Dr to prescribe IV Fluids however, the patient was nearing the end of life a matter of days/weeks as a result of multiple metastases.'*

This is further corroborated by Witness 4's oral evidence when she said, *"…on this occasion because the patient was end of life, it was put down that no further observation because it causes the patient distress (…) it's a pathway that we put in the patient's end of bed notes (…) and it would be on the handover as well…"*

Charge 13d

13. On or around 25 May 2022;
   d. Failed to recognise that a patient who had just died did not require further observations to be undertaken.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'…I informed her* (Ms George) *that the patient had died and Ms George then asked me whether I wanted her to do the patient's observations. I told Ms George that observations were not needed as the patient had died. Ms George asked again whether she should do the patient's observations. Ms George did not understand that observations were not needed. I told Ms George no and she walked away.'*

The panel were satisfied on the basis of the description of the interaction in Witness 4's witness statement that it is clear that Ms George did not understand that observations are not required after a patient has died.

Charge 13e

13. On or around 25 May 2022;

e. During a medication round took out the incorrect medication to administer to a patient in that you selected Ondansetron instead of Omeprazole.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'During the medication round, Ms George got ondansetron out instead of omeprazole. These medications have different spellings and come in different colour boxes. One is yellow and one is white and red. Ms George should be reading the name of the medication and the doses. I had to step in and tell Ms George that she had the wrong medication and got her to check medication. I asked Ms George to show me the boxes and check against the prescription. This is the same process that I do with a student nurse.'*

This is corroborated by Witness 4's contemporaneous statement dated 25 May 2022, which stated, *'…I believe she lacks understanding of Pharmaceutical medications, both oral and IV.'*

Charge 13f

13. On or around 25 May 2022;

f. Failed to recognise that potassium was required to be administered through a pump.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement when she said, *'On another occasion, Ms George was due to administer a bag of fluids containing potassium intravenously. Intravenous fluids containing potassium must be administered through an electronic pump which controls the amount of fluid administered over a set period, thus avoiding fluids being administered as a bolus which would potentially cause the patient harm. Ms George appeared not to know about needing to administer potassium through a pump. This is basic nursing practice and covered in medicine management, as part of nursing degree and training at the Trust. Ms George should know as a nurse that potassium affects the regularity of the heart. Too much potassium can cause cardiac arrythmias or arrest.'*

This is corroborated by Witness 4's contemporaneous statement dated 25 May 2022, which stated, *'…I believe she lacks understanding of Pharmaceutical medications, both oral and IV.'*

This is further corroborated by Witness 4's oral evidence when she confirmed that this would be covered in the medication policy and would have been covered during Ms George's induction with the Trust.

Charges 14a and 14b

14. On 7 May 2022, failed to communicate effectively with patient in that you:
  a. Stood at the foot of the bed, and/or
  b. Waved your arms to get their attention.

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement when she said, *'… During the medication round, Ms George stood by the bottom of the patient's bed, took her mask off and began waving at the patient to get their attention. (…) This was not best practice as the patients on the Ward are often elderly and may have difficulty hearing someone from that distance. Also, it is not professional bedside manner.'*

This is corroborated by Witness 5's contemporaneous statement, which stated, *'During the meds* (medication) *round Nimmy would stand at the end of the patient's bed, remove her mask and wave at the patient to get their attention…'*

This is further corroborated by Witness 5's oral evidence when she said, *"she removed her mask and then just shook her hand (…) like a little toddler kind of wave, which isn't appropriate…"*

Charge 15

15. On 7 May 2022 demonstrated poor infection control by taking off your mask when speaking to a patient.

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement when she said, *'… As covid policies were still in effect at this point, Ms George should not have removed her mask. This provided a risk to both herself and patients in that she might either catch covid from the patients or give it to patients by removing her mask…'*

This is corroborated by Witness 5's contemporaneous statement, which stated, '*During the meds round Nimmy would stand at the end of the patient's bed, remove her mask and wave at the patient to get their attention…'*

This is further corroborated by Witness 5's oral evidence when she said she *"possibly reminded her* (Ms George) *that we had to wear masks if we were in the middle of Covid and it was to protect herself."*

Charge 16

16. On one or more occasions on 7 May 2022 did not check a patient's date of birth on their wristband.

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement when she said, *'… Each patient has a wristband with information on. Ms George should have checked the wristband after asking the patient their name.'*

The panel determined that this is consistent with evidence from Witness 3 regarding charge 10b that this was an error that Ms George repeatedly made in terms of failing to make the correct safety checks before administering medication. The panel considered that this was particularly important when working in an environment where many patients suffered with dementia and might be confused when asked questions about their personal details.

Charge 17a

17. On unknown dates in May 2022;

a. Failed to escalate a patient who was NEWS scoring 3, and/or

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'If a patient does score a three in one category then staff will review their*

observations on an hourly basis (…) Ms George did not notify anyone that the patient had scored a three in one of the categories...'

This is corroborated by Witness 6's contemporaneous statement, which stated, *'Now she volunteers to do observations but has still not grasped the importance of reporting any issues or why observations are taken as determined by the NEWS score unless they are done more frequently due to issues arising e.g. a score of 3 in 1 parameter indicates 1 hourly recheck but she couldn't grasp why I wouldn't leave it for 4 hours as it was only a score of 3.'*

The panel accepted Witness 6's evidence in relation to this charge. Witness 6 is a registered nurse who was working alongside Ms George at the time of the incident. The panel considered that this charge is similar to previous charges in which Ms George had failed to interpret and escalate NEWS scores appropriately.

Charge 17b

17. On unknown dates in May 2022;

b. Failed to recognise why further observations were required.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'… I asked Ms George to repeat the observations as required but she could not understand why I was asking for this to be done.'*

This is corroborated by Witness 6's contemporaneous statement, which stated, '*Now she volunteers to do observations but has still not grasped the importance of reporting any issues or why observations are taken as determined by the NEWS score unless they are done more frequently due to issues arising e.g. a score of 3 in 1 parameter indicates 1*

hourly recheck but she couldn't grasp why I wouldn't leave it for 4 hours as it was only a score of 3.'

Charge 17c

17. On unknown dates in May 2022;

c. Failed to escalate a patient who was NEWS scoring 5 in relation to their blood pressure.

This charge is found NOT proved.

In reaching this decision, the panel considered that while the witness statement of Witness 6 indicated that this patient had a NEWS score of 5 in relation to blood pressure, when answering panel questions, it was not clear what this patient had actually scored on the NEWS score in relation to the blood pressure. The panel noted that there is no contemporaneous statement to support this charge.

The panel determined that there is insufficient evidence before it to find this charge proved.

Charge 17d

17. On unknown dates in May 2022;

d. Failed to act and/or assist with a patient who was attempting to stand up at the end of their bed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'Other members of staff and I went into the room to respond to the alarm and saw that the patient (…) had climbed to the bottom of their bed and was attempting to*

stand up from their bed. Upon entering the room, I saw Ms George sat watching the patient. Ms George made no effort to help the patient alone or assist the other staff. When I questioned Ms George as to the reasoning for her actions, she stated that she did not have to help as "he was not my patient"…'

This is corroborated by Witness 6's contemporaneous statement, which stated, *'… she will ignore fall sensors that are activated saying "they're not my patient"…'*

The panel determined that Witness 6's evidence is consistent with evidence in relation to other charges, namely charges relating to Ms George's failure to take responsibility and treat patients with respect and dignity.

Charges 17e(i) and 17e(ii)

17. On unknown dates in May 2022;
 e. On one or more occasions during medication round/s failed to undertake any identity checks and/or checks for allergies;
 i. Verbally and/or
 ii. By checking the patient's wristband.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'… When administering medication, I ask the patient their name and date of birth and then confirm this with the patient's chart. When Ms George was administering medication during the medication round, she looked at the medication chart and then proceeded to get the patient's medication. Ms George did not carry out any identity checks or check for any allergies either verbally or by checking the wristband.'*

This is corroborated by Witness 6's contemporaneous statement, which stated, *'… She did look at the expiry dates but had to be reminded to check patient ID.'*

The panel determined that Witness 6's evidence is consistent with evidence provided by Witness 3 and Witness 5. The panel determined that Ms George was being repeatedly reminded about necessary safety checks before administering medication, and that Ms George was failing to do this.

Charge 17f

17. On unknown dates in May 2022;

f. On one or more occasions obtained the wrong medication instead of checking the patient chart.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'On several occasions, Ms George went to the medication area and pulled out the wrong box of medication, rather than check the patient chart, Ms George asked me whether it was the same as the medication she was meant to be administering.'*

The panel considered that there are multiple charges relating to Ms George's inability to select the correct medication and failing to make basic safety checks before administering medication.

Charge 17g(i)

17. On unknown dates in May 2022;

g. Was not aware of;

    i. The different clinical uses of Metoprolol and Lansoprazole.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'… Ms George found a box or* [sic] *metoprolol and asked if it was the same as lansoprazole…'*

This is corroborated by Witness 6's contemporaneous statement, which stated, *'Doing medication for 2 patients took over 30 minutes as Nimmy looked at the boxes and put them back numerous times. She did look at the expiry dates but had to be reminded to check patient ID. On one occasion she pulled metoprolol out of the drawer and asked if it was the same as lansoprazole. She doesn't seem to know what the drugs are for or the side effects.'*

This is further corroborated by Witness 6's oral evidence when she said, *"she kept picking boxes out of the drawer, having a look at them, putting them back, picking another box up, and it was as if she didn't know what the drugs were. I don't know whether she wasn't reading them properly…"*

The panel considered that this was part of a pattern of failure on the part of Ms George, as a number of charges relate to her inability to identify the correct clinical use of different medications.

Charge 17g(ii)

17. On unknown dates in May 2022;

g. Was not aware of;

ii. Ramipril is used to lower blood pressure.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'Some patients are also prescribed Ramipril which has the effect of lowering blood pressure, so nurses should be aware of the patient's current blood pressure. Ms*

George was not aware of this when administering Ramipril which could make a patient's condition worse if they patient already has a low blood pressure.'

This is corroborated by Witness 6's contemporaneous statement, which stated, *'… I don't feel she would use her professional judgement i.e. not giving hypotensive medication to a patient with a low blood pressure. (…) Unfortunately I have worked with first/second year students who have more idea about medications than Nimmy does.'*

This is further corroborated by Witness 6's oral evidence when she confirmed that Ms George was not aware of the effects of Ramipril lowering a patient's blood pressure.

Charge 18

18. On 20 June 2022, behaved in an inappropriate manner, when discovering that a patient was deceased, stated in a loud voice words to the effect of, *'It's my observation that the patient in bed 5 is dead'*.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'…Ms George was sauntering up the corridor from the direction of room 26. Ms George was in room 26 as she was carrying out patient observations while I was filling out the paperwork for the observations. In a loud voice Ms George stated "It is my observation that the patient in bed 5 is dead". Myself and the HCAs were stunned at this as it was deeply inappropriate to state that information at such a volume given that there were patients' family members in the ward next to us. There was also no sense of urgency to her actions which was also concerning.'*

This is corroborated by Witness 6's contemporaneous statement dated 20 June 2022, which stated, *'…Nimmy came sauntering up the ward from Room 26. She said to me in a loud voice "it is my observation that (…) in bed 5 is dead…'*

The panel took into account that this is not the only charge that has been found proved in relation to Ms George communicating inappropriately and unprofessionally, showing little regard for patient dignity and confidentiality.

Charge 19a

19. On 20 June 2022, having discovered a patient was deceased, failed to;

a. Pull the emergency buzzer.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'upon finding the deceased patient, Ms George should have pulled the emergency buzzer rather than walking up the corridor and declaring the death in such a loud manner as the buzzer would have alerted us at the desk and we would have come running down the hall anyway. All Ms George did was potentially delay the time of us getting to the patient's bed if a DNAR* (Do Not Attempt Resuscitation) *has not been in place by walking over to us.'*

Charges 19b, 19c, and 19d

19. On 20 June 2022, having discovered a patient was deceased, failed to;

b. Lay the patient down.
c. Cover them from view with a bedsheet.
d. Pull the curtain around the bed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement when she said, *'…the patient was sat uncovered in an upright position in their bed, the patient*

did not have the curtain pulled round the bedside and they were not covered up by a bedsheet. (…) If Ms George was certain the patient was deceased with a DNAR then she should have laid the patient down and covered them from view with the bedsheet. If resuscitation was to be attempted then she would have needed to lay the patient flat anyway. I spoke to Ms George after the incident; I told her that the correct course of action was to pull the emergency buzzer. Ms George just stared at me blankly and then walked away after I finished speaking. This was a common occurrence when speaking to Ms George in that she would just stare blankly and not respond or acknowledge that she had taken information on board. As such I do not believe there was any insight into her actions.'

This is corroborated by Witness 6's contemporaneous statement, which stated, *'…As I laid him down the HCA's pulled the curtains round.'*

The panel noted that this is an inference by Witness 6 that the appropriate response would have been for Ms George to pull the curtains round to preserve the patient's dignity. The panel bore in mind that the deceased patient was in a room with four other patients who may have well been distressed by the death. It considered that Ms George should have understood that it would be appropriate to draw the curtains and therefore found all elements of this charge proved.

Misconduct charge 1a

1. Behaved in an unprofessional and/or inappropriate manner by stating to Colleague A words to the effect of;

a. 'I could kill someone here and I would still get a job at home'.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'I asking* [sic] *Nimmy whether she would need reference if she went back to*

India. Nimmy said "I could kill someone here and I would still have a job at home." I told Nimmy that this was not right attitude and that it was not appropriate to joke about this to a manger on probationary period. I found this comment very concerning, especially for a nurse. (…) Following my conversation with Nimmy the previous day and my concerns with her comments, I raised them during the meeting. (…) Nimmy said comments about killing someone were a joke, and that she meant that they were so desperate for nurses in India that they would still employ her.'

This is corroborated by Witness 2's contemporaneous statement dated 25 July 2022, which stated, *'…I have asked Nimmy if she would not need like a court record clear to see that she has no convictions for any future employment even her country, to what she said clearly "I could kill someone here and I would still have a job at home".'*

The panel took into account Witness 2's oral evidence when she said that Ms George's comments rang alarm bells for her and that it showed *"a lack of accountability".*

The panel also took into account Witness 2's oral evidence that Ms George accepted that she made this comment in a meeting with the matron. It determined that this was an unprofessional and inappropriate way for a nurse to communicate, even if it was intended as a joke.

Charge 1b

1. Behaved in an unprofessional and/or inappropriate manner by stating to Colleague A words to the effect of;

b. 'If I disposed of my passport that has my visa attached, and not declare, they would not know, I would have to stay in the Country because of no passport'.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement when she said, *'At the end of shift, I had a conversation with Nimmy and prepared a separate note of my conversation. (…) I was concerned with comments made by Nimmy during our conversation. Nimmy, who originally came from India, said that she would dispose of her visa so that officials in India would never know that she had been abroad. (…) Following my conversation with Nimmy the previous day and my concerns with her comments, I raised them during the meeting. Nimmy said that she would never burn her passport and accused me of lying…'*

This is corroborated by Witness 2's contemporaneous statement dated 25 July 2022, which stated, *'…I have asked Nimmy what would she do if she does not have a favorable* [sic] *reference from this employment and goes back home. Nimmy has replied that if she disposes of her passport that has her visa attached and not declare they would not know, but she would have to stay in Country because of no passport.'*

The panel took into account that Ms George had said that she would never burn her passport and accused Witness 2 of lying. The panel determined that there was no reason for Witness 2 to lie and determined that Witness 2's account is an accurate and reliable account of the conversation she had with Ms George.

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The panel noted that these remarks were made at about the same time that Ms George said to Witness 4 *'that she did not want to come to the UK and did not want to be a nurse…'*

The panel noted that Ms George also said to Witness 2 that *'nursing was a choice in career not necessarily a vocation and she came to the UK for the salary…'*

Charge 2

2. Around January 2022 behaved inappropriately and/or unprofessionally by claiming that Colleague C and/or Colleague D had told you that they would clean the commode and/or bathroom when you knew that they had not.

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's witness statement when she said, *'I heard Ms George say that I had told her that I would clean the bathroom (…) Ms George then said that* [Witness 9] *had told her that she would clean it up.'* This is corroborated by Witness 8's contemporaneous statement which stated, *'the nurse* (Ms George) *tried to blame other members of staff and said she was told to leave it & that someone else would clear it up'.*

The panel determined that this is corroborated by Witness 9's oral evidence. Although Witness 9 confirmed in oral evidence that she did not witness this incident directly, she had heard about it from Witness 1 and was present at the time. In her contemporaneous handwritten statement, Witness 9 confirmed that she did not tell Ms George that she would clean the soiled commode. The panel was satisfied from the evidence of Witnesses 8 and 9 that Ms George behaved inappropriately and unprofessionally in failing to clean the commode and/or bathroom by asserting that Witnesses 8 and 9 told her that they would clean it when she knew that they had not.

Charge 3

3. Your actions in charge 2 lacked integrity in that you were attempting to blame Colleague C and/or Colleague D for not cleaning the commode and/or bathroom knowing that it was your responsibility.

This charge is found proved.

The panel determined that this was a deliberate attempt to conceal a failure on Ms George's part by attempting to blame other colleagues for not doing something that she should have done herself.

The panel took into account that Colleague C and Colleague D were junior members of staff and that Ms George was senior to them and therefore should promote trust at all times. The panel determined that Ms George attempted to pass blame and responsibility onto these colleagues which could have had professional implications for them. The panel determined that, even though this was an isolated incident, deflecting blame for something that would have implications for colleagues C and D is poor and lacks integrity.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved in relation to the lack of competence charges amount to a lack of competence and whether the facts found proved in relation to the misconduct charges amount to misconduct, and, if so, whether Ms George's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely, kindly and professionally.

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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, Ms George's

fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

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 Hussain invited the panel to take the view that the facts found proved amount to a lack of competence. She submitted that the charges found proved provide a holistic view of Ms George's nursing practice during a defined period and that during this period, Ms George demonstrated a very serious lack of knowledge and skill, and questionable judgement which put patients at a real risk of harm. Ms Hussain further submitted that a number of the charges relate to the basic fundamentals of nursing knowledge that are expected of a registered nurse to ensure that they can provide safe and effective care to patients.

The panel was directed to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") in making its decision.

Ms Hussain identified the specific, relevant standards where Ms George's actions amounted to a lack of competence. She submitted that the breaches of the code amount to an unacceptably low standard of professional performance.

Ms Hussain submitted that the facts found proved show that Ms George's competence at the time was below the standard expected of a band 5 registered nurse and invited the panel to conclude that it constitutes to a lack of competence.

Submissions on misconduct

The panel was directed 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 Hussain invited the panel to take the view that the facts found proved in relation to the misconduct charges amount to misconduct. The panel was directed to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Hussain submitted that the conduct found proved in misconduct charges 1-3 constitutes a fundamental breach of the NMC Code. She submitted that Ms George's behaviour falls far short of the standards expected of a registered nurse, and that her actions were a significant departure from the NMC's principles of promoting professionalism and trust and could be seen as deplorable.

Submissions on impairment

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

Ms Hussain referred the panel to Dame Janet Smith's "test" in the Fifth Shipman Report and submitted that the first three limbs are relevant in this case. Ms Hussain submitted that Ms George's fitness to practise is impaired in the sense that she acted and is liable to act in the future in a way that puts patients at risk of harm.

Ms Hussain submitted that Ms George has failed to engage in these proceedings, and that there is no evidence before the panel to suggest any intention on Ms George's part to address any of the concerns that have been raised. Ms Hussain submitted that these concerns are multifaceted and affect multiple areas of Ms George's clinical practice.

Ms Hussain submitted that there are deep-seated attitudinal concerns, in that the Trust went to great lengths to support Ms George's practice, and she did not appear to accept the support provided. Ms Hussain referred to Ms George's email dated 26 September 2022 which contained counter complaints regarding Witness 1 and submitted that this suggests a lack of insight and Ms George's inability to reflect on her actions.

Regarding misconduct, Ms Hussain submitted that the panel have already heard how extensive support and supervision was put in place for Ms George but that she seemed unwilling to engage meaningfully in any way. She further submitted that Ms George's lack of engagement suggests that she has demonstrated no insight into the concerns regarding her practice, and that there is no evidence as to how these concerns may be addressed going forward.

Ms Hussain submitted that in the absence of any evidence of any desire for Ms George to improve her practice, there is a very real risk that Ms George's actions could put patients at risk of harm, if repeated in the future. Ms Hussain submitted that a finding of impairment is necessary on the grounds of public protection.

Ms Hussain submitted that there is also a public interest in the finding of impairment in this case. She submitted that an informed member of the public would be extremely concerned to hear that a finding of impairment has not been made in a case such as this. She submitted that a finding of impairment is necessary in the public interest, and to uphold the standards of the nursing profession and maintain the trust and confidence in the NMC as the regulator.

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 General Medical Council v Meadow [2007] QB 462 (Admin).

Decision and reasons on lack of competence

The panel firstly determined that it has seen a fair and representative sample of Ms George's clinical practice which had been supervised and comprehensively documented throughout her employment. The panel noted that Ms George never worked in anything other than a supervised capacity whilst employed within the Trust.

The panel heard from nine witnesses, all of whom the panel found to be credible and reliable in terms of assessing Ms George's clinical competency. It noted that there was no evidence provided by Ms George regarding this case.

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

> '***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *1.5 respect and uphold people's human rights*
>
> ***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*

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

5 Respect people's rights to privacy and confidentiality

To achieve this, you must, as appropriate

5.1 respect a person's right to privacy in all aspects of their care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

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

7 Communicate clearly

To achieve this, you must:

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

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

8.4 work with colleagues to evaluate the quality of your work…

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if (…) an incident has happened which had the potential for harm

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 …provide medicines (…) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

To achieve this, you must:

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

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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 bore in mind, when reaching its decision, that Ms George should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel determined that there were several themes that emerged from the facts in Ms George's case. The panel has already heard how extensive support and supervision was put in place for Ms George to improve her practice which was significantly below the standard and competency expected of a registered nurse. Her workload was reduced to three patients so she could have more time to improve. However, the panel noted that Ms George's colleagues compared her practice to that of a first or second-year student.

In evidence, the panel heard of Ms George's repeated failures to follow the correct medication administration procedures. Ms George demonstrated a lack of knowledge and skill regarding identifying patients prior to administering medication, such as checking the patient's wristband or determining if the patient had allergies.

Ms George demonstrated a poor understanding of the drugs she was administering. Ms George had to be reminded frequently how to administer medication safely. She failed to identify the correct drug, the dose, the frequency of the medication, or whether the drug had expired. Without the intervention of her supervisor, she may have administered an incorrect drug or dose to patients, placing them at risk of harm. Medication was stored in an untidy state and was spilt when administered. Ms George did not maintain a clean environment, which may have led to a safety hazard in the workplace.

Ms George was unable to undertake basic observations and interpret their meaning. She could not assess, plan, and care for patients as she did not understand the clinical

conditions and the care required. She could not identify when care was normal or a patient was deteriorating. As a result, she was unable to understand when to escalate issues relating to patient care to a colleague for further advice. She was, therefore, unable to take responsibility for the care of patients without supervision as a qualified nurse, as to do so may lead to a risk of harm to patients.

One of the essential requirements of the nursing role is good written and verbal communication and the timely handover of information at key points in the day to colleagues and other departments in the Trust. Ms George's failure to record or alert her colleagues of changes in the patient's condition on several occasions, despite numerous prompts and advice from colleagues, was a significant breach of this requirement. This failure not only hindered the continuity of patient care but also underscored the importance of effective communication and teamwork in the nursing profession.

Ms George was not able to follow essential infection control and prevention guidelines. She was observed wearing her uniform outside of work and attending work with clothes over her uniform, and repeatedly rolled her trouser legs up, which breached the guidelines as it could cause cross-infection.

Ms George failed to treat patients with kindness, privacy, and dignity. She ignored a call buzzer when a patient required the toilet and had to be prompted to respond to the patient's needs. She failed to offer reassurance to patients suffering from dementia when they were afraid. She did not assist a patient who was standing on their bed naked and soaked in urine. She failed to attend to a deceased patient appropriately.

Ms George failed to preserve patients' safety and follow the correct procedures. She was unable to maintain a safe environment when moving and handling patients and was observed using a hoist by herself. She failed to assist a patient who was standing by their bed and at risk of falling and sustaining an injury.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Ms George's practice was below the standard that one would expect of the average registered nurse acting in Ms George's role.

In all the circumstances, the panel determined that Ms George's performance was a serious departure from good professional practice, demonstrating a lack of basic knowledge, skill, and judgement, showing that she was incapable of safe and effective practice and, as such, amounts to serious lack of competence.

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 Ms George's actions did fall significantly short of the standards expected of a registered nurse, and that Ms George's actions amounted to breaches of the Code. Specifically:

> ***'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*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*
>
> ***24 Respond to any complaints made against you professionally'***

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 the statements that Ms George made to a senior nurse who was supervising her were serious and highly inappropriate and unprofessional, demonstrating a complete lack of accountability, irrespective of whether they were intended as a joke or not. [PRIVATE].

The panel further considered that Ms George's attempt to cover up her own failure to clean a commode after patient use, and instead lay the blame on HCA colleagues fell far below the standard of behaviour required of a registered nurse. A nurse should set a model of professional behaviour to less senior colleagues. Ms George failed to do this by trying to implicate other colleagues in her own failure, and thereby breaching the duty of candour. The panel considered that such behaviour might rightly be termed *"deplorable".*

The panel determined that Ms George's behaviour demonstrates a complete lack of professional judgement and a lack of integrity.

The panel found that Ms George's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment in relation to lack of competence

The panel next went on to decide if as a result of the lack of competence, Ms George's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

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

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

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) …'

The panel determined that limbs a-c of the '*test'* are relevant in this case. The panel found that patients were put at risk of harm as a result of Ms George's lack of competence. Ms George's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel determined that there was a pattern of behaviour, including a very concerning and deep level of lack of competence that has been established. The panel has given careful thought to the future risk of allowing Ms George to practise unrestricted. It determined that although these are areas of clinical practice that could, in theory, be remediable, it is concerned that Ms George has been unable to satisfactorily remedy the areas of concern despite extensive support and considerable input by colleagues. The panel determined that there is evidence of attitudinal concerns and a lack of preparedness by Ms George to engage with support from her colleagues.

The panel determined that Ms George has not demonstrated any insight, remorse, or remediation, and that the only information she has provided for this case is her email dated 26 September 2022 which contained counter allegations of discrimination against her, which the panel has found no evidence to support.

The panel determined that even when Ms George was offered specific support, she was unable to retain information and repeated the same concerns. The panel is concerned that in the future, Ms George would repeat the same mistakes, therefore indicating a high risk

of repetition. The panel decided that a finding of impairment in relation to Ms George's lack of competence is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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, in this case, a finding of impairment on public interest grounds was also required. The panel determined that the public would lose confidence in the nursing profession and the NMC as the regulator if a nurse with this level of incompetence was permitted to practise unrestricted. The panel noted Witness 2's contemporaneous statement when she explained that every day working with Ms George was like a first day and that she found herself *'repeating the same information over and over and over again.'*

The panel drew the conclusion that even when support was put in place, including one-to-one supernumerary supervision, Ms George was unable to make use of it to improve her practice.

Having regard to all of the above, the panel was satisfied that Ms George's fitness to practise is currently impaired by reason of her lack of competence.

Decision and reasons on impairment in relation to misconduct

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:
"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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 again determined that limbs a-c are relevant in this case. The panel found that patients were put at risk of harm as a result of Ms George's misconduct. Ms George's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel determined that the comments Ms George made in charges 1a, and 1b indicates a dangerous attitude and a disregard to the laws of the United Kingdom. The panel determined that Ms George demonstrated deep-seated attitudinal concerns that are not easily remediable. The panel noted that Ms George has shown no remorse, and no evidence of empathy or insight.

The panel determined that the charges relating to Ms George's lack of integrity also amount to impairment. The panel determined that Ms George's colleagues would have found her conduct deplorable and took into account the potential repercussions for her colleagues. The panel also noted that a lack of integrity impacts trust between colleagues, which directly impacts patient safety.

The panel again determined that Ms George has demonstrated no insight, remorse, or remediation into the concerns regarding her nursing practice. The panel determined that

there are concerns regarding patient care due to Ms George's comments of being able to *'kill someone here and still get a job at home'*. It determined that this shows a complete disregard for patient safety, lack of accountability, and unprofessionalism. The panel decided that a finding of impairment in relation to Ms George's misconduct is necessary on the grounds of public protection.

The panel bore in mind 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 a finding of impairment on public interest grounds is also required as a member of the public would be very concerned by Ms George's comments and her lack of integrity, given that she has shown a complete lack of insight and remorse.

The panel determined that patients should always be treated with dignity and respect, and that Ms George's misconduct falls far below the standards expected of a registered nurse and would be seen as deplorable.

Having regard to all of the above, the panel was satisfied that Ms George's fitness to practise is currently impaired by reason of her misconduct.

Sanction

The panel has considered this case very carefully and has 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 Ms George's 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 Hussain informed the panel that the original NMC sanction bid was an 18-month conditions of practice order, if the panel found Ms George's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that an 18-month suspension order is more appropriate in light of the panel's findings.

Ms Hussain submitted that Ms George has not engaged with these proceedings, nor has she indicated that she would be willing to attempt to take any further training and supervision to improve her nursing practice.

Ms Hussain submitted that Ms George's lack of competence is at the higher end of the spectrum, and that Ms George poses a very real risk of harm to the public should her practice not be restricted.

Ms Hussain identified the following aggravating features in this case:

- Abject lack of insight, remorse, and remediation in relation to the concerns
- The issues in this case relate to fundamental areas of nursing practice
- The issues in this case involve conduct which puts patients at risk of suffering harm
- Ms George failed to demonstrate competency despite extensive support, enhanced supervision, and mentorship being put in place
- No evidence before the panel of any remorse or any recognition of the lack of competence or misconduct

Ms Hussain did not identify any mitigating factors in this case.

Ms Hussain submitted that Ms George would require significant supervision before she could return to the nursing profession, and that an 18-month suspension order is the only appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms George's 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:

- Complete lack of insight into lack of competence and misconduct
- A pattern of lack of competence over a period of time
- Conduct which put patients at risk of suffering harm
- Lack of remorse and remediation
- Deep seated attitudinal concerns
- Failure to interact respectfully with colleagues providing support
- Ms George sought to blame colleagues for her failings
- Very limited engagement with the regulatory process

The panel also took into account the following mitigating feature:

- Ms George was new to the country which was a significant personal change for her

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 Ms George's 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 Ms George's 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 Ms George's 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;*
- *…*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel noted that the above factors are relevant in this case and determined that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Ms George has not responded or made any attempt to engage with any support that has been offered. The panel determined that Ms George has already had a significant period of supervision including one-to-one supernumerary support and did not show any signs of improvement regarding her clinical practice. The panel has seen no evidence from Ms George of any intention to improve her practice and determined that her lack of competence is serious as it relates to the fundamentals of nursing care, is generic and does not relate to specific areas of her nursing practice which might be strengthened with continued supervision.

Furthermore, the panel concluded that the placing of conditions on Ms George's registration would not adequately address the seriousness of this case and would not protect the public as the panel was concerned that actual patient harm was only avoided in this case due to the stringent one-to-one supervision the Trust had put in place.

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:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *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 determined that the above factors are relevant in this case and was satisfied that the misconduct was not fundamentally incompatible with remaining on the register.

The panel determined that this was not a single incident of misconduct or lack of competence, but that Ms George showed a wide range of repeated lack of basic competence despite being provided with extensive support and supervision. The panel determined that there was evidence of deep-seated attitudinal concerns and that Ms George breached some of the fundamental tenets of the nursing profession, as well as the trust of her colleagues. The panel noted that it does not know if the behaviour has been repeated since Ms George's employment was terminated but noted that the lack of competence was repeated throughout her employment at the Trust. The panel determined that Ms George has shown a complete lack of any insight and found a high risk of repetition of the facts found proved in this case.

As such, the panel determined that a suspension order is appropriate and proportionate in the circumstances of this case.

The panel 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, the panel concluded that it would be disproportionate in relation to the misconduct charges. The panel noted that this is predominantly a lack of competence case, therefore a striking-off order is not available in those circumstances despite the panel's concerns that Ms George's attitude to the support provided, and her approach to the difficulties she faced might indicate that she is not suitable to remain on the register.

The panel looked carefully at the charges and was of the view that the misconduct charges arose as a result of Ms George's lack of competence. The panel determined that the public would be protected and the public interest would be engaged if it imposed a suspension order as a result of Ms George's lack of competence and misconduct. Whilst the panel acknowledges that a suspension may have a punitive effect upon Ms George, no lesser sanction would be appropriate 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 noted the hardship such an order will inevitably cause Ms George. However, this is outweighed by 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 12 months was appropriate in this case to mark the seriousness of the lack of competence and 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:

- Ms George's attendance and engagement with the regulatory process
- References and/or testimonials from colleagues in nursing or any other work Ms George has undertaken in a healthcare setting
- Evidence of how Ms George has kept her nursing knowledge and skills up to date
- A comprehensive reflective piece demonstrating insight into both her misconduct and lack of competence

This will be confirmed to Ms George in writing.

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 Ms George's 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 Hussain. She invited the panel to impose an interim suspension order for 28 days to allow time for any possible appeal. Ms Hussain submitted that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that 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 allow time for any possible appeal.

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

That concludes this determination.