Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 6 August – Wednesday, 14 August 2024

Virtual Hearing

Name of Registrant:	Janice Kirsty Maclean
NMC PIN	88E0089S
Part(s) of the register:	Registered Nurse - Sub Part 1 Adult (5 July 1991) V300: Nurse Independent/Supplementary Prescriber (28 October 2009)
Relevant Location:	Glasgow
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair Lay member) Mary Karasu (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	Natalie Byrne
Hearings Coordinator:	Claire Stevenson (6 August 2024) Sharmilla Nanan (7 – 14 August 2024)
Nursing and Midwifery Council:	Represented by Omar Soliman, Case Presenter
Ms Maclean:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7 and 8
Facts not proved:	Charge 9
Fitness to practise:	Impaired
Sanction:	**Suspension order (9 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 Maclean was not in attendance and that the Notice of Hearing letter had been sent to Ms Maclean's registered email address by secure email on 24 June 2024.

Further, the panel noted that the Notice of Hearing was also sent to Ms Maclean's representative, Mr Chris Weir of Anderson Strathern, on 24 June 2024. He informed the NMC that he is not instructed to represent Ms Maclean at this hearing.

Mr Soliman, 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 Maclean'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 Maclean 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 Maclean

The panel next considered whether it should proceed in the absence of Ms Maclean. It had regard to Rule 21 and heard the submissions of Mr Soliman who invited the panel to continue in the absence of Ms Maclean. He submitted that Ms Maclean had not responded, therefore she had voluntarily absented herself.

Mr Soliman submitted that there had been no engagement at all by Ms Maclean with the NMC in relation to these proceedings. Mr Soliman submitted that as recently as 2 August 2024 the NMC had attempted to contact Ms Maclean by telephone, without success. As a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

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'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5).

The panel has decided to proceed in the absence of Ms Maclean. In reaching this decision, the panel has considered the submissions of Mr Soliman, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *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 Maclean;
- Ms Maclean has not engaged with the NMC 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;
- 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 2020;
- 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 Maclean 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 no 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. The panel noted that Ms Maclean had elected to engage only to a very limited extent with the early stages of the regulatory process and provide some limited documentation. However, in the panel's judgement, her non-attendance 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 Maclean's decisions 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 Maclean. The panel will draw no adverse inference from Ms Maclean's absence in its findings of fact.

Details of charge

That you, a registered nurse:

On 24th August 2020, at Northgate House Care Home:

1. Attended work whilst under influence of alcohol and/or otherwise unfit.

2. Failed to administer medication in a timely manner, in that you started the round at approximately 8:20 and at handover at approximately 11.00 you had only given medication to four out of the ten residents.

3. Administered the incorrect dose of Colecaciferol to Resident A, in that you administered double the prescribed dose.

4. Documented that you had administered metformin 500mg to Resident A on 25th August 2020, when you had administered it on 24th August 2020.

On 10th October 2020, at Kyle Court Nursing Home:

5. Attended work whilst under influence of alcohol and/or otherwise unfit.

6. Did not administer 10mg atorvastatin to Resident B.

7. Did not administer 50mg Thiamine to Resident C.

8. Did not administer 40mg Atorvastatin and/or 15mg Mirtazapine to Resident D.

9. Did not administer 10mg Miconazole to Resident E.

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

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

At the outset of the hearing, Mr Soliman made a request that this case be held partly in private on the basis that proper exploration of Ms Maclean's case involves [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised in order to protect her privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Soliman under Rule 31 to allow the hearsay accounts of Ms 6 as referred to in Witness 5's NMC witness statement and exhibits into evidence. He submitted that the panel heard oral evidence from Witness 5 that she relied on Ms 6's account at the material time. He submitted that the NMC made several attempts to contact Ms 6 from 19 August 2021 to 17 June 2024 to give evidence in relation to charges 5-9. He noted that the NMC made efforts to contact Ms 6 via telephone, email and letter. He submitted that Ms 6 discovered the medications errors and that she speaks to Ms Maclean's appearance on the evening of 10 October 2020. He submitted that Ms 6's account goes toward the panel's consideration as to whether Ms Maclean was under the influence of alcohol or drugs on this date. He submitted that the local statement of Ms 6, as exhibited by Witness 5, is sometimes illegible and it would have assisted the panel if she could have confirmed exactly what her initial account was. However, he submitted that she has not engaged with the NMC and that Ms 6 did not believe in the authenticity of the NMC's telephone calls and that she thought it was a scam. Further, he noted that Ms 6 had been a registered nurse whose nursing registration lapsed in December 2022 and he submitted that her ongoing duty to assist the NMC in its regulatory proceedings even after she no longer remains in practice had been highlighted to her in a letter dated 17 June 2024.

Mr Soliman submitted that Ms 6's hearsay account was not the sole and decisive evidence in respect of charges 5-9. He submitted that the panel had the evidence of Witness 2 and Witness 5 which supports Ms 6's account. Further, he submitted that Ms 6's evidence is demonstrably reliable and is capable of being tested. He submitted that the content of the hearsay evidence has been thoroughly tested by virtue of the other witnesses who have appeared. He submitted that Ms 6's hearsay account is admissible and should admitted into evidence in these proceedings.

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 application in regard to the hearsay account of Ms 6 serious consideration. Whilst there was no question about the relevance of the evidence, the panel considered whether Ms Maclean would be disadvantaged by allowing the hearsay testimony into evidence. It took into consideration the principles as outlined in the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) in relation to admitting hearsay evidence.

The panel took into account that Ms Maclean had been provided with a copy of Ms 6’s hearsay account and, as the panel had already determined that Ms Maclean had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

The panel took into consideration that the NMC’s sanction bid sent to Ms Maclean, in this case, is a suspension order for a period of 12 months. It bore in mind that this sanction would have a significant impact on Ms Maclean’s life and nursing career.

The panel bore in mind that it had not been provided with a cogent reason for Ms 6’s non-attendance. However, the panel took into account that the NMC had made significant attempts to secure Ms 6’s attendance with no success.

In addition, the panel had no reason to believe that Ms 6 would fabricate her account, and it noted that Ms 6’s account is consistent with the evidence it had heard from other witnesses. It concluded that Ms 6’s hearsay account was not sole or decisive.

The panel took into consideration the nature and extent of the challenge by Ms Maclean and bore in mind that Ms Maclean has not engaged with the NMC and has not attended the hearing.

The panel concluded that there is also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

Weighing all these factors, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay account of Ms 6, but it would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Background

The charges arose whilst Ms Maclean was employed as a registered agency nurse by Robinson Medical Recruitment Agency (the Agency). Ms Maclean had been employed with the Agency since 17 June 2020.

On 24 August 2020, Ms Maclean attended Northgate House for her shift. During the morning of this this shift, Witness 4 raised concerns to Witness 1 regarding Ms Maclean's presentation. It was suspected that Ms Maclean was unfit to work and that she might be under the influence of alcohol.

It is also alleged during this shift, that Ms Maclean had started the medication round at approximately 8am but did not finish it until after 11am. It is alleged that Ms Maclean made medication administration errors when giving medication to Resident A.

Ms Maclean denies that she consumed any alcohol either prior to or during this shift. She states she had [PRIVATE] Witness 1 called a taxi for Ms Maclean, and she left the Home.

On 10 October 2020, during a nightshift at Kyle Court Nursing Home, it is alleged that there was a concern from Witness 2 that Ms Maclean was intoxicated due to her presentation. Witness 2 alleges that Ms Maclean was unsteady on her feet and lacking concentration. Witness 2 states that she could not smell any alcohol on Ms Maclean at the material time.

During the same shift, it is alleged that Ms Maclean made medication errors whereby medication for four residents had not been administered.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel also had regard to the submissions made by Mr Soliman on behalf of the NMC and the limited documentation provided by Ms Maclean at the early stages of the regulatory process.

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

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 only 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: At the material time was the Deputy Manager at Northgate House.
- Witness 2: At the material time was employed as a Care Assistant at Kyle Court.
- Witness 3: At the material time was employed as a Care Assistant at Northgate House.
- Witness 4: At the material time was employed as a Staff Nurse at Northgate House.
- Witness 5: At the material time was employed as the Home Manager at Kyle Court.

She qualified as a registered nurse
in 1994.

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

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

Charge 1

"That you, a registered nurse:

On 24th August 2020, at Northgate House Care Home:

1.Attended work whilst under influence of alcohol and/or otherwise unfit"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 3 and Witness 4. Further, it considered that 'attended' as used in this charge had the ordinary meaning as defined in the Oxford English dictionary, 'to be present'. In the circumstances of this case, it took 'attended' to mean that Ms Maclean was present at work.

The panel considered Witness 1's evidence. She said in her local statement, dated 24 August 2020, *"... she appeared to be struggling to concentrate and staggering/unsteady on her feet."* In her NMC statement she stated *"To me, she just seemed to be drunk. Her physical movements and the way she was interacting all made it seem that way"* and in her oral evidence she said that Ms Maclean was unsteady on her feet, trying not to speak and incoherent.

The panel took into account the evidence of Witness 3. In her local statement dated 24 August 2020, she stated that *"[Ms Maclean] didn't look herself, she looked off. [PRIVATE],*

very white." In her NMC witness statement she stated, *"On this shift, the registrant looked a bit away with it, as if she was drunk or had taken something."* During her oral evidence she was consistent in her account and said that Ms Maclean looked 'dead off, glazed, pale, off balance' and 'if she was drunk or had taken something'.

The panel took into consideration the evidence of Witness 4. She stated in her local statement, 24 August 2020, that *"Janice then turned around and hit the wall, locked her trolley then came to the treatment room walking quite unsteadily."* Her NMC statement stated *"[..] I do feel that the registrant was under the influence of something. Whether this was medication that she had reacted to or something else, I have no idea. However, she was behaving in a really strange and unusual way, so I just feel like something was wrong."* She said in her oral evidence that Ms Maclean seemed quite vague as if she didn't know what she was doing. She stated that she saw Ms Maclean going into the treatment room several times but accepted that she did not know what the registrant was doing in the treatment room.

The panel had regard to Ms Maclean's reflective statement dated 29 September 2020. She stated *"On reflection I shouldn't have attended my shift as I was in a lot of pain on the day however I did and [PRIVATE]."*

The panel considered the evidence before it and accepted Ms Maclean's reflective statement in which she stated that she should not have attended her shift as [PRIVATE]. The panel bore in mind that it had no evidence before it that anyone had witnessed Ms Maclean consuming alcohol. Witness 1 thought that some of the bottles in the treatment room might be emptier than previously but could not be completely sure. The panel was satisfied that Ms Maclean became unfit for duty during the shift but it was not clear that this was due to the influence of alcohol. The panel was therefore not satisfied that the NMC has discharged its burden of proof that Ms Maclean had been under the influence of alcohol at the material time. It bore in mind Ms Maclean's admission and the evidence of the witnesses it had heard and concluded that on 24 August 2020, at Northgate House Care Home, Ms Maclean attended work whilst otherwise unfit. The panel therefore found charge 1 proved.

Charge 2

> "2. Failed to administer medication in a timely manner, in that you started the round at approximately 8:20 and at handover at approximately 11.00 you had only given medication to four out of the ten residents."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 4.

The panel considered the evidence of Witness 4. It took into account that in her local statement, dated 24 August 2020, she stated *"I established that in the previous two-hour period Janice had only administered four residents' medication"*. Witness 4 stated in her NMC statement that *"When I took over the medication round, I noticed that only 4 patients had their medication signed for, despite their being 10 who needed medication. This was unusual, as the registrant had been completing the round for a long time."* Witness 4 said in her oral evidence that four out of 10 residents had had their medicine administered to them, between 8:20 and 11am, which was unusual as 10 residents would usually take from 45 minutes to an hour and half.

The panel considered the evidence of Witness 1. In Witness 1's local statement, dated 24 August 2020, she stated *"At approximately 11:00hrs I was informed that there was concern re the registrant. She was not finished her medication round, appeared to be struggling to concentrate and staggering/unsteady on her feet."* In her NMC witness statement, she stated *"… the medication round was still not completed by around 11am, even though she had started at around 8am and it usually only takes a couple of hours."* During Witness 1's oral evidence, she said Ms Maclean should have been finished her medication round at approximately 10am (if not before).

The panel took into account that there was a slight time difference as to when Ms Maclean was reported to have started the medication administration round. Despite this, the panel

concluded that Witness 1 and Witness 4 were consistent in their accounts and were corroborated by each other.

The panel considered the evidence before it. It bore in mind that Witness 1 and Witness 4 were registered nurses who explained that the medication round completed by Ms Maclean took longer than reasonably expected. The panel bore in mind that there was no reason as to why the medication round completed by Ms Maclean for four of the 10 residents took this long. The panel therefore determined that Ms Maclean failed to administer medication in a timely manner, in that she started the round at approximately 8:20 and at handover, at approximately 11.00, and had only given medication to four out of the 10 residents. The panel therefore found charge 2 proved.

Charge 3

> "3. Administered the incorrect dose of Colecaciferol to Resident A, in that you administered double the prescribed dose."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4, Witness 1 and Ms Maclean.

The panel had regard to the MAR chart for Resident A for the start day of 'Friday' and the end date of '10/09/2020'. It noted that the signatures for 24 August 2020 and 25 August 2020 were the same. The following note had also been handwritten on Resident A's MAR chart *"Double signed, two tablets given. On 24th count now 16"*. The panel took into account that the count for Colecaciferol should have been 17, if the correct dose of one capsule had been administered. The panel was of the view that two capsules had been administered on 24 August 2020.

The panel considered the evidence of Witness 4. In her NMC witness statement she stated *"…this patient was prescribed one Colecalciferol capsule however, the registrant has also signed for this medication on both 24 and 25 August. When I looked at the medication count it was evident that the registrant had given two of these tablets, so this resident ended up having a double dose of this medication. Colecalciferol is a Vitamin D medication so the risk of patient harm, to the best of my knowledge, is low and I can confirm there was no actual harm. However, were it another drug i.e. Metformin, the potential harm could have been a lot worse."* In her oral evidence she said depending on the medication, the error could have been very harmful. She accepted that there was no harm caused in this instance.

The panel considered the evidence of Witness 1. During her oral evidence, Witness 1 said that they had found the incorrect counts and that medication had possibly been signed for that hadn't been given to the resident.

The panel also took account of Ms Maclean's reflective statement dated 29 September 2020 in which she said, *"I do realise now that I should have Asked for help and told the deputy manager how I was feeling as it ultimately lead to a drug error which I am extremely sorry for…"*, although the panel noted that the drug error was not specified.

The panel considered the evidence before it. The panel took into consideration that Witness 4 was a direct witness to this incident. It was of the view that Witness 4's evidence had been corroborated by Witness 1's oral evidence. The panel therefore concluded that Ms Maclean administered the incorrect dose of Colecaciferol to Resident A, in that she administered double the prescribed dose. The panel therefore found charge 3 proved.

Charge 4

> "4.Documented that you had administered metformin 500mg to Resident A on 25th August 2020, when you had administered it on 24th August 2020."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4, Witness 1 and Ms Maclean.

The panel considered the evidence of Witness 4. In Witness 4's NMC statement, she stated "*The first medication error was that the registrant had signed to say she had administered Resident A's prescribed dose of two tablets of Metformin (500mg) tablets however, what the registrant had actually done is signed for this on both 24 and 25 August. Fortunately, the registrant had only given half the dose for both of these entries, so the resident actually ended up having his correct dose. I knew this from the drug count. Essentially, the registrant had signed to say she had given 4 tablets across two days but had actually given the two tablets as prescribed, signed across two days. Metformin is a medicine used to treat Diabetes which reduces the sugar levels so there is a real risk of harm if the resident had been given the incorrect dose as he may have been Hypoglycaemic were he given a double dose. As the correct dose was actually given, there was no actual patient harm."*

During Witness 5's oral evidence, she clarified that Resident A needed two (500mg) tablets every morning. She stated that two tablets had been administered to Resident A but had been incorrectly recorded, one on 24 August 2020 and the other on the wrong date (namely 25 August 2020).

The panel had regard to the MAR chart for Resident A with the end date of '10/9/2020'. The panel noted that the prescription for Metformin tablets 500mg stated *"Take TWO tablets once daily"*. It noted that signatures, for both dates 24 August 2020 and 25 August 2020, on the MAR for the Metformin tablets were the same. It also took into consideration the handwritten note on the MAR chart made by Witness 1 which explained her findings when subsequently checking the medication.

The panel also took account of Ms Maclean's reflective statement dated 29 September 2020 in which she said, *"I do realise now that I should have Asked for help and told the deputy manager how I was feeling as it ultimately lead to a drug error which I am extremely sorry for…"*, although the panel noted that the drug error was not specified.

The panel considered the evidence before it. It bore in mind that Witness 4's evidence was corroborated by Witness 1. It therefore concluded that Ms Maclean documented that she had administered metformin 500mg to Resident A on 25 August 2020, when she had administered it on 24 August 2020. The panel therefore found charge 4 proved.

Charge 5

"On 10th October 2020, at Kyle Court Nursing Home:

5. Attended work whilst under influence of alcohol and/or otherwise unfit"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and Witness 5. Further, it applied the same definition of 'attended' as outlined in charge 1 to this charge.

The panel considered that Witness 2 stated in her local statement, made at the material time, that *"At about 10:30pm I noticed the nurse was acting strange. I was worried and asked [if] nurse [Ms Maclean] had been drinking. She told me no and she was just tired."* She stated in her NMC statement *"[…] after a couple of hours or so, I started to notice that she was behaving oddly. She kept banging the medicine trolley against the wall and was acting uncoordinated. She seemed unstable on her feet. I asked her if she had been drinking, as the lack of coordination made it seem like she could be drunk."* During her oral evidence, Witness 2 said she was actually scared for Ms Maclean as she was staggering and hitting off every wall, not able to stand up straight. Witness 2 said that it looked like Ms Maclean was 'on some sort of drug'.

The panel took into account Witness 5's evidence. She stated in her NMC statement *"The registrant was working as the nurse in charge on the nightshift of Saturday 10 October 2020 alongside HCA's [Witness 2] and [Mr 7]. There were concerns that the registrant was intoxicated and under the influence of either alcohol or drugs although she was not presenting like this at the start of the shift. [Ms 6], the Nurse in Charge was notified and asked to come and check on the registrant, [Ms 6] agreed that the registrant appeared intoxicated and unfit to be on shift."* Witness 5 said during her oral evidence that Ms 6 phoned her just before midnight to say that Ms Maclean seemed to be intoxicated. Ms 6 told Witness 5 that Ms Maclean was slumped over a chair in a resident's room. Ms 6 had said to her that staff had heard a resident shouting for help. The resident appeared

distressed, as Ms Maclean's speech was slurred, and the resident's wheelchair had been up against the door.

The panel took into consideration that Witness 5 exhibited the undated local statement of Ms 6. Ms 6 stated in her local statement *"the registrant's behaviour had become erratic, and they had noticed her to be unsteady and staggering and her speech had become slurred."* The panel noted that this statement was made at the material time of the incident.

The panel bore in mind that Ms Maclean has not provided a further reflective statement to the NMC since her initial statement dated 29 September 2020 which preceded this second incident.

The panel considered the evidence before it. It took into consideration that the witnesses it had heard from in respect of this charge had not smelt alcohol on Ms Maclean during the shift nor had they seen her take any alcohol or any other drug from the unit. The panel was of the view that the NMC has not provided sufficient evidence that Ms Maclean attended work whilst under influence of alcohol. The panel took into consideration that Ms Maclean became unfit during this shift as she had been slumped over a chair in a resident's room and her speech was slurred. It concluded that on 10 October 2020, at Kyle Court Nursing Home, Ms Maclean had attended work whilst otherwise unfit. The panel therefore found charge 5 proved.

Charge 6

"6. Did not administer 10mg atorvastatin to Resident B"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5.

The panel had regard to the MAR chart for Resident B, with the start date of 24 September 2020, exhibited by Witness 5. The panel took into consideration that there is

no signature for the Atorvastatin on 10 October 2020. The panel concluded that the prescribed dose of “one at night” was not administered.

The panel considered Witness 5’s NMC statement. She stated *“Resident B should have been administered 1 x 10mg atorvastatin which is a statin medication used to lower cholesterol for high cholesterol or high blood pressure. The risk of harm of this medication being omitted is that the patient’s cholesterol may have increased which could in turn potentially increase the risk of a heart attack and/or a stroke.”*

During Witness 5’s oral evidence, she confirmed that the drug count should have gone down to 24, were it correctly administered on 10 October 2020.

The panel considered the evidence before it. The panel determined that on 10 October 2020, at Kyle Court Nursing Home, Ms Maclean did not administer 10mg atorvastatin to Resident B. The panel therefore found charge 6 proved.

Charge 7

“7. Did not administer 50mg Thiamine to Resident C”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5.

The panel had regard to the MAR chart for Resident C exhibited by Witness 5. The panel took into consideration that Resident C was prescribed Thiamine tablets (50mg) and should take one tablet four times a day and there is no signature for the night dose of Thiamine on 10 October 2020 on the MAR chart. The panel concluded that the prescribed dose of “one at night” was not administered.

The panel considered Witness 5’s NMC statement. She stated “*Resident C should have been administered 1 x 50g Thiamine which is Vitamin B. The risk of omitting this is that it*

can cause tiredness and muscle weakness as the Vitamin B converts food into energy." Witness 5 repeated this in her oral evidence.

The panel considered the evidence before it and it determined that on 10 October 2020, at Kyle Court Nursing Home, Ms Maclean did not administer 50mg Thiamine to Resident C. The panel therefore found charge 7 proved.

Charge 8

> "8. Did not administer 40mg Atorvastatin and/or 15mg Mirtazapine to Resident D"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5.

The panel had regard to the MAR chart for Resident D, with the start date of 24 September 2020, exhibited by Witness 5. The panel took into consideration that Resident D was prescribed Atorvastatin tablets (40mg) and should take one tablet daily. Resident D was also prescribed Mirtazapine tablets (15mg) and should take one tablet at night. The panel took into account that there was no signature on the MAR chart for Atorvastatin on 10 October 2020 or Mirtazapine on 10 October 2020.

The panel considered Witness 5's NMC statement. She stated *"Resident D should also have been administered 1 x 40mg atorvastatin and 1 x 15mg Mirtazapine which is an anti-depressant. Atorvastatin could have increased cholesterol levels. Mirtazapine can cause withdrawals, irritability, poor sleep relapse, insomnia and depression."* Witness 5 was consistent in her oral evidence in relation to the account she provided in her NMC witness statement in respect of this charge.

The panel considered the evidence before it. The panel determined that on 10 October 2020, at Kyle Court Nursing Home, Ms Maclean did not administer 40mg Atorvastatin and 15mg Mirtazapine to Resident D. The panel therefore found charge 8 proved.

Charge 9

"9. Did not administer 10mg Miconazole to Resident E"

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's evidence.

The panel took into consideration that it did not have a complete MAR chart for Resident E. The panel noted that the MAR chart appeared to be four pages in length and that it only had pages two and three of the four pages.

In her NMC witness statement Witness 5 stated *"Resident E should have been administered 1 x 10mg Miconazole which is an anti-fungal medication. Omitting this medication can cause skin irritation, itching and burning sensation in the skin."* In her oral evidence, Witness 5 stated that Ms 6 had administered some medication to Resident E but was adamant that Ms Maclean had not signed the MAR chart to say she administered 10mg Miconazole. She said that she would not have put it in her statement if she had not seen the MAR chart. The panel found Witness 5 to be a reliable and credible witness, but noted that she could not now say with certainty from memory that the Miconazole should have been administered to Resident E.

The panel considered the evidence before it and, in the absence of the complete MAR chart for Resident E, it concluded that it was not satisfied that the NMC had discharged the burden of proof in respect of this charge. The panel determined that on 10 October 2020, at Kyle Court Nursing Home, it was unclear whether or not Ms Maclean had administered 10mg of Miconazole to Resident E. The panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Maclean'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 kindly, safely 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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Maclean's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Soliman invited the panel to take the view that the facts found proved amount to misconduct. He submitted that Ms Maclean repeated the nature of her misconduct despite reflecting on the initial incident that took place. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where he submitted that Ms Maclean's actions amounted to misconduct.

Submissions on impairment

Mr Soliman 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 application of the principles outlined in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery*

Council (2) and Grant [2011] EWHC 927 (Admin) to the circumstances of this case. He referred the panel to the relevant NMC guidance.

Mr Soliman submitted that Ms Maclean is not currently working as a nurse and there is no way of knowing if her practice would raise any concerns. He submitted that today's panel does not have any evidence of any relevant training completed by Ms Maclean since these incidents. He referred the panel to Ms Maclean's reflective statement dated 29 September 2020. He acknowledged that Ms Maclean had made some attempt initially to reflect and remediate on her behaviour, but then there had been a further incident. He submitted that there is no information before today's panel to show that Ms Maclean has strengthened her practice regarding the areas of regulatory concern identified. He submitted that there is a risk of repetition and a consequent risk of harm. He invited the panel to make a finding of impairment on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Maclean's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code, specifically the following:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.3 complete records accurately …

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.9 maintain the level of health you need to carry out your professional role'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered the two incidents which took place on 24 August 2020 and 10 October 2020 respectively.

The panel bore in mind that Ms Maclean's actions on 24 August 2020 had the potential to cause harm. It took into consideration that in her reflective statement she stated that she was unfit to go into work that day. The panel noted that attending work whilst she was unfit to do so led to the medication administration errors that occurred. The panel took into consideration that Ms Maclean is an experienced nurse. The panel concluded that Ms Maclean's actions on this date were sufficiently serious to amount to misconduct.

The panel considered that Ms Maclean's actions on 10 October 2020 were similar in nature to the incidents which took place on 24 August 2020. The panel bore in mind the reflective statement from Ms Maclean, dated 29 September 2020, for the incident that took place on 24 August 2020 and that it was approximately two weeks later (from the date of the reflective statement) when she repeated the nature of the misconduct on 10 October 2020. The panel bore in mind that Ms Maclean had seemingly not addressed the root cause that affected her nursing practice on 24 August 2020 and that it recurred on 10 October 2020. The panel concluded that Ms Maclean's actions on 10 October 2020 were sufficiently serious to amount to misconduct as she had not demonstrated sufficient insight and reflection to address the root cause of why she was unfit to work on 24 August 2020 and this led to a similar incident on 10 October 2020.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC's Fitness to Practise Library, updated on 27 March 2023, 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. 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 determined that limbs a, b and c of Dame Janet Smith's "test" were engaged.

The panel finds that patients were put at risk of harm as a result of Ms Maclean's misconduct. The panel was of the view that there is no evidence before it to indicate that the risks identified in Ms Maclean's practice have been addressed or reduced. Ms Maclean's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel bore in mind that it had no evidence before it that Ms Maclean has taken steps to strengthen her practice.

Regarding insight, the panel considered Ms Maclean's reflective statement dated 29 September 2020. The panel took into account Ms Maclean's admissions in relation to the incident on 24 August 2020 and that she said she was unfit to practise on this date. It considered that her reflective statement did not demonstrate a full understanding of how her actions put patients at a risk of harm nor has she demonstrated an understanding of how this could negatively impact on her colleagues and the reputation of the nursing profession. It noted Ms Maclean's apology for this incident. However, she did not demonstrate how she would handle a similar situation differently in the future, and indeed went on to be involved in a very similar situation shortly afterwards. The panel took into consideration that Ms Maclean did not provide a reflective statement which addressed the similar incident which took place on 10 October 2020. The panel concluded that Ms Maclean's insight was very limited.

The panel is of the view that there is a risk of repetition based on Ms Maclean's very limited insight and lack of evidence to show her strengthened practice. It bore in mind that it had no information that Ms Maclean has dealt with the root cause that made her unfit to practise on both 24 August 2020 and 10 October 2020. The panel took into consideration that it did not have any information from Ms Maclean which demonstrates her learning from these incidents and that she would not attend work in the knowledge that she is unfit to do so. The panel therefore decided that a finding of impairment 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 an informed member of the public would be concerned to learn that a registrant was allowed to practise with no restrictions in light of the findings made in this case. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Maclean's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Maclean's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of nine months. The effect of this order is that the NMC register will show that Ms Maclean'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 the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Soliman invited the panel to impose a suspension order for a period of 12 months in light of its finding that Ms Maclean's fitness to practise is currently impaired. He referred the panel to the relevant NMC guidance. He provided the panel with what he said were aggravating and mitigating features of the case. He reminded the panel of the sanctions available to it and made submissions on their appropriateness in this case. He submitted that a 12 month suspension order was the most appropriate and proportionate sanction to adequately protect the public and serve the public interest.

Decision and reasons on sanction

Having found Ms Maclean'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:

- Ms Maclean's very limited insight.
- Conduct which put patients at risk of harm.
- Despite Ms Maclean's apology and reflection dated 29 September 2020 in relation to the first incident, two weeks later she repeated her conduct. The panel determined that this amounted to a pattern of misconduct.

The panel also took into account the following mitigating features:

- [PRIVATE].

- Witnesses spoke highly of Ms Maclean's nursing practise prior to these incidents.

The panel bore in mind that [PRIVATE] in regulatory proceedings than in criminal proceedings.

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 Maclean'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 Maclean'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 Maclean'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 is of the view that there are no practicable or workable conditions that could be formulated, given the nature of the misconduct in this case. It was of the view that Ms Maclean's misconduct was attitudinal in that she appeared to be unaware of when it is appropriate to attend work or [PRIVATE]. The misconduct identified in this case was not something that can be addressed solely through retraining. It also took into consideration that Ms Maclean has not recently engaged with the regulatory proceedings, and it concluded that there was nothing to suggest that she would engage with any conditions imposed on her nursing practice.

Furthermore, the panel concluded that the placing of conditions on Ms Maclean's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. It considered the SG and that it highlights some of the factors which would make a suspension order appropriate in the circumstances. The panel bore in mind that this case did not relate to a single instance of misconduct but that the misconduct related to two occasions of the same type of behaviour and a lesser sanction is not sufficient. It bore in mind Ms Maclean's very limited insight. The panel was of the view that Ms Maclean's repeated behaviour was attitudinal in nature but did not cross the bar to constitute a deep seated personality or attitudinal problem. It bore in mind that since these incidents on 24 August 2020 and 10 October 2020, it had no further information that Ms Maclean had repeated this misconduct. In light of these findings, the panel was satisfied that in this case, the misconduct was not fundamentally incompatible with her remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel was of the view that whilst there are questions about Ms Maclean's professionalism, public confidence in the nursing profession could be maintained through the imposition of a suspension order. The panel determined that a suspension order would protect patients, members of the public and maintain professional standards and confidence in the NMC as regulator. The panel acknowledges that a period of suspension may have a punitive effect but considered that it would be unduly punitive in Ms Maclean's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Ms Maclean. 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 nine months was appropriate in this case to mark the seriousness of the misconduct. Further, the panel was of the view that this would provide Ms Maclean the opportunity to reflect on what she would like to do with her future nursing career and provide this information to the NMC.

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 Maclean's attendance and engagement at any review hearing.
- A reflective statement which addresses the following:
    - Full and in-depth reflections on the incidents.
    - A full understanding of how Ms Maclean's actions put patients at a risk of harm.
    - A full understanding of how Ms Maclean's actions could negatively impact on her colleagues and the reputation of the nursing profession.
    - How Ms Maclean would handle a similar situation differently in the future.
- Evidence that Ms Maclean has kept up to date with current nursing practice.
- Testimonials from any paid or unpaid work that detail Ms Maclean's attendance and current work practices.

This will be confirmed to Ms Maclean 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 Maclean'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 Mr Soliman. He submitted that an interim suspension order was necessary for a period of 18 months on the grounds of public protection and public interest. He submitted that this interim order would cover any period of appeal.

Decision and reasons on interim order

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

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

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

That concludes this determination.