Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
12-13 August 2024

Virtual Hearing

Name of Registrant:	Stephen Ward
NMC PIN	06I0195E
Part(s) of the register:	V300: Nurse independent/supplementary prescriber (30 September 2015)
Relevant Location:	Belfast
Type of case:	Misconduct
Panel members:	Susan Thomas (Chair – Lay member) Patience McNay (Registrant member) Jennifer Portway (Lay member)
Legal Assessor:	Fiona Barnett
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Rory Gordon, Case Presenter
Mr Ward:	Present and represented by Thomas Buxton, Counsel, instructed by the Royal College of Nursing
Consensual Panel Determination:	Accepted
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered nurse:

1) In relation to Patient 1, on 24 February 2019:
   a) Failed to undertake a full set of observations in that you did not carry out and/or record:
      i) Oxygen saturation measurements and/or;
      ii) Pulse rate measurements and/or;
      iii) Respiratory rate measurements and/or;
      iv) Urine dip testing.
   b) Prescribed Penicillin when it was not clinically necessary.

2) On or before 3 March 2019, in relation to an unknown patient:
   a) Called an ambulance when there was no clinical need;
   b) Failed to carry out an ECG.

3) In relation to Patient 2, between 3 and 8 March 2019:
   a) Advised them to take 1mg of Colchicine in the first instance and then a further 500mcg one hour later contrary to British National Formulary's dosing recommendations;
   b) Issued an excess of tablets for Colchicine when there was no clinical need;
   c) Prescribed Codeine without clinical justification;
   d) Prescribed Allopurinol for maintenance at a dose of 200mg daily with advice that this could be increased if needed, without first checking their liver and/or renal function;
   e) Failed to escalate blood tests results in light of the clinical concerns displayed in the blood results and/or informed them that their "bloods were largely normal" or words to that effect.

4) In relation to Patient 3, between 4 and 5 March 2019, failed to write any notes on the system regarding a consultation and/or what was discussed.

5) In relation to Patient 4, on 4 March 2019, failed to undertake and/or record observations.

6) In relation to Patient 5, on 4 March 2019:
   a) Failed to undertake a full set of observations in that you did not carry out and/or record;
      i) Oxygen saturation measurements and/or;
      ii) Pulse rate measurements and/or;
      iii) Urine dip testing.
   b) Failed to record your rationale for prescribing Zithromax as opposed to using Penicillin when they had no known allergy;
   c) Prescribed the incorrect dosage for their weight of 2.25ml of Zithromax once daily, when the correct dosage for their weight is 2.7ml once daily.

7) In relation to Patient 6, between 5 and 7 March 2019:
   a) Failed to undertake and/or record observations;
   b) Failed to provide a record of history taking and/or examination;
   c) Failed to provide a justification for the blood tests that had been ordered;
   d) Failed to escalate blood tests results in light of the clinical concerns displayed in the blood results;
   e) advised to book an appointment with Colleague A, knowing that Colleague A was unavailable from 8-16 March 2019.

8) In relation to Patient 7, on 5 March 2019:
   a) Failed to advise that a chest Xray and/or CT scan and/or blood tests may be necessary in the first instance;
   b) Prescribed Codeine without clinical justification.

9) In relation to Patient 8, on 5 March 2019, failed to:
   a) Undertake and/or record observations;
   b) Undertake and/or record an abdominal check;
   c) Record any red flag checks.

10) In relation to Patient 9, on 5 March 2019:
    a) Failed to undertake and/or record a Ketone check;
    b) Failed to ensure an adequate medical assessment of Patient 9 was completed in that insufficient information was obtained from them about their symptoms to enable a comprehensive medical assessment to be undertaken.
    c) Failed to advise follow up by stool check;
    d) Failed to advise about taking MST Continus and Co-Codamol 30/500 together;
    e) Prescribed Nitrofurantoin when a safer alternative would have been Pivmecillinam;
    f) Advised them to stop taking blood pressure medication despite their blood pressure being high;
    g) Did not recommend any further investigation.

11) In relation to Patient 10, on 5 March 2019, failed to:
    a) Advise how to bring their temperature down;
    b) Further investigate symptoms;
    c) Undertake a pregnancy test and/or abdominal examination before prescribing antiemetic medication;
    d) Record any safety netting advice.

12) In relation to Patient 11, between 8 and 16 March 2019, failed to:
    a) Explain your rationale for taking bloods;
    b) Record any previous medical history and/or previous medications;
    c) Interpret their blood results correctly;
    d) Recommend any further investigations.

13) In relation to Patient 12, on 8 March 2019, failed to:
    a) Record information about consent;
    b) Give advice about side effects.

14) In relation to Patient 13, on 9 March 2019:
    a) Failed to record any safety netting advice;

b) Prescribed Codeine without clinical justification;
c) Failed to undertake and/or record observations.

15) In relation to Patient 14, on 9 March 2019:
a) Sent them to Accident and Emergency when observations appeared normal;
b) Prescribed Co-codamol without clinical justification.

16) In relation to Patient 15, on 10 March 2019:
a) Failed to undertake and/or record observations;
b) Failed to undertake and/or record an abdominal examination;
c) Failed to undertake and/or record a pregnancy test;
d) Failed to refer to a gynaecology department;
e) Failed to record any safety netting advice;
f) Prescribed Tranexamic Acid without clinical justification.

17) In relation to Patient 16, on 12 March 2019:
a) Failed to undertake a full set of observations in that you did not carry out and/or record;
i) A temperature reading and/or;
ii) Urine dip testing.
b) Prescribed Codeine without clinical justification.

18) In relation to Patient 17, on 12 March 2019:
a) Failed to undertake a full set of observations in that you did not carry out and/or record;
i) Temperature reading and/or;
ii) Pulse rate measurements and/or;
iii) Respiratory rate measurements and/or;
iv) Urine dip testing.
b) Failed to refer them for a CT scan of the chest and/or X-ray.

19) In relation to Patient 18, on 12 March 2019:
a) Failed to undertake and/or record an abdominal and/or a rectal examination;

b) Failed to arrange for a faecal occult blood test;
c) Failed to record any safety netting advice.

20) In relation to Patient 20, on 12 March 2019, did not record observations of their throat.

21) In relation to patient 21, on 12 March 2019:
a) Failed to record any safety netting advice;
b) Prescribed Codeine without clinical justification;
c) Did not make recommendations for a mild muscle relaxant and/or neck care exercises.

22) On 16 March 2019, shared over Skype messaging service confidential information relating to an unknown patient.

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

Consensual Panel Determination

At the outset of this hearing, Mr Gordon informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between you and the NMC.

The agreement, which was put before the panel, sets out your full admissions to the facts alleged in the charges, that your actions amounted to misconduct, and that your fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a conditions of practice order for a period of 18 months with a review hearing.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council ("the NMC") and Stephen Ward, PIN 06I0195E ("the Parties") agree as follows:

1. *Stephen Ward ('Mr Ward') is aware of the CPD hearing. Mr Ward does not intend on attending the hearing and is content for it to proceed in his and his representative's absence. Mr Ward will endeavour to be available by telephone should clarification on any point be required, or should the panel wish to make other amendments to the provisional agreement that are not agreed by Mr Ward.*

2. *Mr Ward understands that if the panel proposes to impose a greater sanction or make other amendments to the provisional agreement that are not agreed by Mr Ward, the panel will refer the matter to a further substantive hearing.*

The charge

3. *Mr Ward admits the following charges:*

That you, a registered nurse:

1) In relation to Patient 1, on 24 February 2019:
   a) Failed to undertake a full set of observations in that you did not carry out and/or record:
      i) Oxygen saturation measurements and/or;
      ii) Pulse rate measurements and/or;
      iii) Respiratory rate measurements and/or;
      iv) Urine dip testing.
   b) Prescribed Penicillin when it was not clinically necessary.

2) On or before 3 March 2019, in relation to an unknown patient:
   a) Called an ambulance when there was no clinical need;
   b) Failed to carry out an ECG.

3) In relation to Patient 2, between 3 and 8 March 2019:

a) *Advised them to take 1mg of Colchicine in the first instance and then a further 500mcg one hour later contrary to British National Formulary's dosing recommendations;*
b) *Issued an excess of tablets for Colchicine when there was no clinical need;*
c) *Prescribed Codeine without clinical justification;*
d) *Prescribed Allopurinol for maintenance at a dose of 200mg daily with advice that this could be increased if needed, without first checking their liver and/or renal function;*
e) *Failed to escalate blood tests results in light of the clinical concerns displayed in the blood results and/or informed them that their "bloods were largely normal" or words to that effect.*

4) *In relation to Patient 3, between 4 and 5 March 2019, failed to write any notes on the system regarding a consultation and/or what was discussed.*

5) *In relation to Patient 4, on 4 March 2019, failed to undertake and/or record observations.*

6) *In relation to Patient 5, on 4 March 2019:*
   a) *Failed to undertake a full set of observations in that you did not carry out and/or record;*
      i) *Oxygen saturation measurements and/or;*
      ii) *Pulse rate measurements and/or;*
      iii) *Urine dip testing.*
   b) *Failed to record your rationale for prescribing Zithromax as opposed to using Penicillin when they had no known allergy;*
   c) *Prescribed the incorrect dosage for their weight of 2.25ml of Zithromax once daily, when the correct dosage for their weight is 2.7ml once daily.*

7) *In relation to Patient 6, between 5 and 7 March 2019:*
   a) *Failed to undertake and/or record observations;*
   b) *Failed to provide a record of history taking and/or examination;*

c) *Failed to provide a justification for the blood tests that had been ordered;*
d) *Failed to escalate blood tests results in light of the clinical concerns displayed in the blood results;*
e) *advised to book an appointment with Colleague A, knowing that Colleague A was unavailable from 8-16 March 2019.*

8) *In relation to Patient 7, on 5 March 2019:*
   a) *Failed to advise that a chest Xray and/or CT scan and/or blood tests may be necessary in the first instance;*
   b) *Prescribed Codeine without clinical justification.*

9) *In relation to Patient 8, on 5 March 2019, failed to:*
   a) *Undertake and/or record observations;*
   b) *Undertake and/or record an abdominal check;*
   c) *Record any red flag checks.*

10) *In relation to Patient 9, on 5 March 2019:*
   a) *Failed to undertake and/or record a Ketone check;*
   b) *Failed to ensure an adequate medical assessment of Patient 9 was completed in that insufficient information was obtained from them about their symptoms to enable a comprehensive medical assessment to be undertaken.*
   c) *Failed to advise follow up by stool check;*
   d) *Failed to advise about taking MST Continus and Co-Codamol 30/500 together;*
   e) *Prescribed Nitrofurantoin when a safer alternative would have been Pivmecillinam;*
   f) *Advised them to stop taking blood pressure medication despite their blood pressure being high;*
   g) *Did not recommend any further investigation.*

11) *In relation to Patient 10, on 5 March 2019, failed to:*
   a) *Advise how to bring their temperature down;*

b) *Further investigate symptoms;*
c) *Undertake a pregnancy test and/or abdominal examination before prescribing antiemetic medication;*
d) *Record any safety netting advice.*

12) *In relation to Patient 11, between 8 and 16 March 2019, failed to:*
a) *Explain your rationale for taking bloods;*
b) *Record any previous medical history and/or previous medications;*
c) *Interpret their blood results correctly;*
d) *Recommend any further investigations.*

13) *In relation to Patient 12, on 8 March 2019, failed to:*
a) *Record information about consent;*
b) *Give advice about side effects.*

14) *In relation to Patient 13, on 9 March 2019:*
a) *Failed to record any safety netting advice;*
b) *Prescribed Codeine without clinical justification;*
c) *Failed to undertake and/or record observations.*

15) *In relation to Patient 14, on 9 March 2019:*
a) *Sent them to Accident and Emergency when observations appeared normal;*
b) *Prescribed Co-codamol without clinical justification.*

16) *In relation to Patient 15, on 10 March 2019:*
a) *Failed to undertake and/or record observations;*
b) *Failed to undertake and/or record an abdominal examination;*
c) *Failed to undertake and/or record a pregnancy test;*
d) *Failed to refer to a gynaecology department;*
e) *Failed to record any safety netting advice;*
f) *Prescribed Tranexamic Acid without clinical justification.*

17) In relation to Patient 16, on 12 March 2019:

- *a) Failed to undertake a full set of observations in that you did not carry out and/or record;*
  - *i) A temperature reading and/or;*
  - *ii) Urine dip testing.*
- *b) Prescribed Codeine without clinical justification.*

18) In relation to Patient 17, on 12 March 2019:

- *a) Failed to undertake a full set of observations in that you did not carry out and/or record;*
  - *v) Temperature reading and/or;*
  - *vi) Pulse rate measurements and/or;*
  - *vii) Respiratory rate measurements and/or;*
  - *viii) Urine dip testing.*
- *b) Failed to refer them for a CT scan of the chest and/or X-ray.*

19) In relation to Patient 18, on 12 March 2019:

- *a) Failed to undertake and/or record an abdominal and/or a rectal examination;*
- *b) Failed to arrange for a faecal occult blood test;*
- *c) Failed to record any safety netting advice.*

20) In relation to Patient 20, on 12 March 2019, did not record observations of their throat.

21) In relation to patient 21, on 12 March 2019:

- *a) Failed to record any safety netting advice;*
- *b) Prescribed Codeine without clinical justification;*
- *c) Did not make recommendations for a mild muscle relaxant and/or neck care exercises.*

22) On 16 March 2019, shared over Skype messaging service confidential information relating to an unknown patient.

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

The facts

4. *Mr Ward appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse – Adult and a Nurse Independent/ Supplementary Prescriber and has been on the NMC register since 21 September 2006 and 30 September 2015 respectively.*

5. *The NMC received the referral on 28 March 2019 from Chantal Edwards, the co-owner of Duality Health. The incidents are said to have taken place when Mr Ward was working as a locum Advanced Nurse Practitioner at the Newry Clinic ('the Clinic'). This clinic operates as a private GP service, run by Duality Health.*

6. *Following an incident on 6 March 2019 (which is referred to in more detail below at paragraph 14), an audit was carried out on Mr Ward's files and various issues were flagged relating to his provision of care for a large number of patients, some vulnerable. There was also a concern raised relating to Mr Ward's inappropriate sharing of patient confidential information over the surgery wide Skype system during consultation. Below are the findings from the audit that took place over a two week period from 24 February 2019 to 12 March 2019:*

7. *(Charge 1): On 24 February 2019, Patient 1 attended for a consultation presenting with a sore throat. The patient had left it for 10 days and then a few days later the patient's wife had noticed some white streaks on his tonsils. The patient was seen by an out of hours doctor and given a Difflam spray and then antibiotics. His throat had settled but he had started waking in pain and his tonsils felt swollen and he was taking 30/500 Co-codamol. Mr Ward examined the patient's throat and took his temperature but he failed to undertake and record a full set of observations - he did not carry out and record the patient's oxygen saturation measurements, pulse rate measurements, respiratory rate measurements and did not do a urine dip testing. Mr Ward then went on to*

prescribe Penicillin when it was not clinically necessary – he failed to consider that the patient still had symptoms which were prolonged, despite antibiotic therapy and perhaps the issue was therefore viral in origin.

8. *(Charge 2): On or before 3 March 2019, a patient attended for a consultation presenting with an exacerbation of her Chronic Obstructive Pulmonary Disease ('COPD'). Her cough, sputum colour and upper right lung discomfort and shortness of breath were all pointing to an acute infection. The patient was able to climb the stairs unaided to the consultation rooms. Th patient was not clammy or expressing any chest pains, she had a mild temperature and her pulse was raised a bit after climbing the stairs. Mr Ward carried out observations and sprayed Glyceryl trinitrate('GTN') under her tongue but did not assess the patient's chest and instead requested an ambulance. Mr Ward felt that her pain was cardiac related. The patient did not understand why an ambulance had been called. When the ambulance arrived they asked for a copy of the ECG, but Mr Ward had failed to carry out one. The ambulance crew did an ECG which was normal.*

9. *(Charge 3): Between 2 and 8 March 2019, Patient 2 attended for a consultation as he had run out of his daily medication to prevent Gout. Mr Ward prescribed Colchicine 500mcg, one hundred tablets, advising the patient to take 1mg initially and then a further 500mcg 1 hour later which is not listed as a dosing recommendation for acute Gout in the British National Formulary. Despite Mr Ward advising 6mg max per course, he issued 100 tablets which was excessive, especially as he was unaware of the patient's renal function as Duality Health did not have access to the NHS blood test results. He also prescribed Codeine Phosphate and did not provide any clinical reason for doing so. Opioid analgesics are not recommended for the treatment of pain caused by Gout as they do not affect the inflammatory cause of pain and can cause severe side effects at a high dose. The Colchicine would manage pain better as would Ibuprofen. Mr Ward also prescribed 200mg daily for Allopurinol for maintenance of Gout with advice that this could be further increased if needed but the correct dose is 100mg daily and he had no evidence of the patient's liver or renal function.*

10. *Furthermore, during the consultation which took place on 3 March, Mr Ward took bloods which were received back on 6 March. On 8 March, Mr Ward emailed the patient to say the bloods were largely normal but this was not the case. Whist the blood results were mostly within normal range, closer analysis and understanding of the results should have prompted a more appropriate outcome. The blood tests indicated a raised LDH (322IU/L, normal range 135 – 225) which can be caused by a possibility of liver disease, kidney disease or tissue damage which given the presentation is the most likely cause as the other liver tests were within a normal range. Hepatic impairment is a side effect of overdose with Colchicine and an abnormal result should prompt the prescriber to advise stopping this medication as it is contraindicated with severe hepatic impairment. The usual prophylaxis treatment taken long term for Gout is Allopurinol. Colchicine can be taken for acute exacerbations or for short term prophylaxis when starting Allopurinol but then stopped as Allopurinol continues. The treatment with Colchicine is 500mcg 2-4 times a day for a total of 6mg per course, and not to be repeated within 3 days. 12 tablets would usually constitute the short course. As per paragraph 9 above, as Duality Health did not have access to the NHS blood test results, there was no way for Mr Ward to know if this patient was stable or already compromised. His prescription of 100 tablets of Colchicine was therefore dangerous and excessive. The blood tests which Mr Ward took at that appointment also showed a normal uric acid level (377 µmol/L, normal range 266 - 474) indicating that there was a strong likelihood of no acute Gout flare up at that time of the appointment, and further confirms that the Gout prophylaxis that the patient was missing was likely to be Allopurinol as the notes indicate that the patient ran out only 7 days previously. These result should have been reported to the patient, should have prompted a repeat test, cessation of Colchicine, and involvement of the patients GP for appropriate shared care, but Mr Ward informed the patient that his blood test was normal and raised no concerns.*

11. *(Charge 4): Between 4 and 5 March 2019, Mr Ward failed to write any notes on the system regarding a consultation he had, or what was discussed, with Patient 3.*

12. *(Charge 5): On 4 March 2019, Patient 4 attended for a consultation to be seen for a urticaria rash. Mr Ward failed to undertake and record any observations for this patient which would be standard practice for a patient presenting with a possible anaphylactic reaction. The recording of these observations would indicate the current systemic effect that the reaction may be having on the patient's body, and not recording these leaves the notes lacking evidence of risk assessment.*

13. *(Charge 6): On 4 March 2019, Patient 5, a baby, attended for a consultation with their dad who advised that the patient had been unsettled, feverish and had rapid respirations earlier that day. Although Mr Ward carried out some examinations on the baby and took their temperature and respiration rate, Mr Ward failed to undertake and record a full set of observations as he did not carry out and record the patient's oxygen saturation measurements, pulse rate measurements and carry out urine dip testing which all would have been able to provide a baseline for worsening symptoms to be compared to. Mr Ward also failed to record his rationale for prescribing Zithromax as opposed to Penicillin when the patient had no known allergy to Penicillin. Furthermore, Mr Ward prescribed the incorrect dosage for the patient's weight of 2.25ml of Zithromax once daily, when the correct dosage for the patient's weight was 2.7ml once daily.*

14. *(Charge 7): Between 5 and 7 March 2019, during a consultation with Patient 6, the patient had blood tests which were returned from the laboratory on 7 March with very concerning results, particularly related to the patient's pro-BNP levels which is a test carried out to determine heart failure. Normal levels are between 0-400 and the patient's levels came back at 1556 which is excessively elevated. The results had been shared to the patient's notes on 7 March by Mr Ward. Mr Ward failed to interpret the blood test results appropriately and failed to recognise the seriousness and therefore appropriately action them accordingly. The patient's wife emailed the Clinic on 19 March to say she was concerned as she had not received a response regarding the patient's blood tests which had been taken on 6 March and her husband was short of breath, with no energy and complaining of severe stomach cramps and cold sweats when he walked a short distance. The blood tests results where then checked and they were found to be*

very concerning. The patient and his wife were visited at home by the Clinic's locum, [Ms 1], and the patient was advised to attend hospital immediately. Mr Ward has simply sent a summary which had been emailed to the patient (on an unknown date) which said "please book an appointment with Dr Morgan to discuss your blood results". However, Mr Ward was aware that Dr Morgan was on holiday from 8 March until 16 March. On review of the patient's records there was no detail of the consultation, no record of history taking , observations or examination – there was also no justification for the blood tests that had been ordered, only a consultation note which read "bloods, was booked in to be seen assessed and treated".

15. *(Charge 8): On 5 March 2019, Patient 7 attended for a consultation presenting with a fever, an ongoing dry cough and with weakness and lethargy. The patient had presented to Accident and Emergency 6 weeks prior with flu-like illness and was given medication which he had completed 1 week before this appointment. Mr Ward diagnosed this patient with a viral cough. Mr Ward failed to advise that a chest Xray and/or CT scan and/or blood tests may be necessary due to the patient's lethargy and prolonged symptoms and to check for underlying inflammatory markers or anaemia. Instead, he prescribed Codeine which has a side effect of respiratory suppression and was not a recommended treatment for a patient with such presentation. If this viral infection required treatment prescribed, then a simple expectorant to loosen the chest may have been indicated, and not Codeine.*

16. *(Charge 9): On 5 March 2019, Patient 8, a child, attended for a consultation having already been prescribed Laxido for constipation. Mr Ward prescribed Movicol and Senokot. As Mr Ward failed to carry out any observations or do an abdominal check he could not know if the causes was constipation over any other diagnosis. Mr Ward also did not record any checks for red flags such as bowel obstruction, intussusception or a hernia.*

17. *(Charge 10): On 5 March 2019, Patient 9 attended for a consultation. The patient was overweight with no history of diabetes and presented with ongoing diarrhoea and vomiting which had been recurrent for 7 months. The patient's blood sugar reading was 7.4mmols and she was not eating. Mr Ward failed to undertake and*

record a Ketone check. It would have been appropriate for him to do one despite the patient not having a formal diagnosis of diabetes, as she had not eaten, was dehydrated and was overweight and therefor at a higher risk of type 2 diabetes. He also failed to ensure an adequate medical assessment of the patient was completed in that he did not query any symptoms of melaena, haematemesis, lethargy symptoms, stool colour change, sweats, recent weight changes or advise follow up by stool check. Mr Ward then failed to advise the patient not to take MST Continus and Co-Codomal 30/500 together which could be contributing to the symptoms of nausea and vomiting. Mr Ward also prescribed Nitrofurantoin, which is normally given to treat urine infections, but he did not indicate any working diagnosis for this patient and without access to the patient's NHS bloods there was no way to know the patient's kidneys were working before prescribing this. Nitrofurantoin is a nephrotoxic medication which means it could have put the patient's kidneys under further distress. A safer alternative would have been to prescribe Pivmecillinam for a short course of treatment if a urine infection was suspected. Mr Ward also advised the patient to stop taking blood pressure medication despite her blood pressure being high. Finally, Mr Ward also failed to carry out any safety netting and to recommend any further investigation to check if there were any bowel obstruction, infection or underlying blood in the stools.

18. *(Charge 11): On 5 March 2019, Patient 10 attended for a consultation presenting with flu like symptoms which had been ongoing since 22 February. The patient's observations included a high temperature and high heart rate of 107 indicating a possibility of sepsis which needed to be further explored for a possible alternative diagnosis. Mr Ward failed to advise the patient how to bring their temperature down and did not further investigate symptoms. Mr Ward recorded that the patient had been vomiting bile that day but does not appear to consider alternative differential diagnoses for vomiting bile – that the patient could be pregnant or diabetic for example. He failed to carry out a pregnancy test and an abdominal examination and prescribed the patient an anti-emetic medication which is acceptable for her symptoms as long as pregnancy had been excluded. Mr Ward also did not record any safety netting advice and guidance of who and when to contact and in what circumstances.*

19. *(Charge 12): Between 8 and 16 March 2019, Patient 11 attended for a consultation on 8 March and had blood tests done. Mr Ward did not explain his rationale for taking bloods and did not record any previous medical history and previous medications. The blood test results came back on 12 March. Mr Ward did not process them until 16 March whereby Mr Ward failed to interpret the patient's blood results correctly and did not recommend any further investigations. The bloods indicated that the patient has or could have the indicators for haemochromatosis, possible liver disease, hypothyroidism, and also indicated a possible infection with a slightly raised white cell count. The patient's liver function tests indicated that further investigation was needed in the form of a liver scan and also in relation to her thyroid and ferritin levels.*

20. *(Charge 13): On 8 March 2019, Patient 12 attended for a consultation for his monthly Sandostatin injection which should be given by rotating site of administration. Mr Ward failed to provide any information about consent to an invasive procedure and did not give any advice in relation to side effects.*

21. *(Charge 14): On 9 March 2019, Patient 13 attended for a consultation presenting with lower back pain and informed Mr Ward that an anti-inflammatory he had been taking had worked. Mr Ward failed to record any safety netting advice and did not undertake and record observations. Instead, Mr Ward prescribed Codeine without any clinical justification as the patient had tolerated Ibuprofen. In this case, prescribing a muscle relaxant and a topical or oral anti-inflammatory medication with a suitable gastric protectant, would have been appropriate, and furthermore, giving the patient some back exercises to do, as well as anticipated timeline of recovery to manage patient expectations.*

22. *(Charge 15): On 9 March 2019, Patient 14 attended a consultation presenting with a sore throat. The patient had been on a course of Amoxicillin. Mr Ward could have changed her medication to Phenoxymethylpenicillin as the patient had not improved. Instead, he sent them to Accident and Emergency to be treated for quinsy (a rare complication of tonsilitis) despite observations appearing normal and prescribed Co-codamol despite the fact the patient was sent to Accident and Emergency.*

23. *(Charge 16): On 10 March 2019, Patient 15 attended a consultation at 16 weeks post-partum for treatment for continued vaginal discharge. The patient had been treated for vaginal infection using three different antibiotics after giving birth and she stated that she was supposed to go back to hospital for a scan due to products being retained internally. Mr Ward failed to undertake any observations, carry out an abdominal examination or carry out a pregnancy test. He also prescribed Tranexamic acid without clinical justification - it is dangerous to have given this patient this medication as she had retained products of her pregnancy and this could have led to further gynaecology complications. Mr Ward failed to realise with the symptoms the patient was presenting with to refer her to a gynaecology department. He also failed to add safety-netting advice to escalate her symptoms to whom, where and when.*

24. *(Charge 17): On 12 March 2019, Patient 16 attended for a consultation presenting with viral cold infection symptoms, muscle pain in her abdomen when coughing and coryza. Mr Ward took some observations (heart rate, blood pressure and SpO2 levels) but failed to undertake a full set of observation because he did not carry out and record a temperature reading and a urine dip testing. Mr Ward also prescribed Codeine without clinical justification. The correct course of action would have been to tell the patient to take over-the-counter medicines for the cold symptoms and for the muscle pains, as viral infections are self-limiting.*

25. *(Charge 18): On 12 March 2019, Patient 17 attended for a consultation presenting with a persistent cough. Mr Ward carried out some examinations to the chest and took some observations (SpO2 and blood pressure) but failed to undertake a full set of observations because he did not carry out and record a temperature reading, pulse rate measurements, respiratory measurements and urine dip testing. Given the persistent nature of the patient's cough, it would be following guidance to refer for a CT chest or X-ray but Mr Ward failed to do this.*

26. *(Charge 19): On 12 March 2019, Patient 18 attended a consultation presenting with abdominal pain and diarrhoea for 2 weeks. Mr Ward failed to undertake and record an abdominal and rectal examination which may have shown organomegaly or guarding/ change in bowel sounds/ rectal or abdominal mass.*

He also failed to arrange for a faecal occult blood test and failed to record any safety netting advice.

27. *(Charge 20): On 12 March 2019, Patient 20, a child, attended for a consultation with their parents for a review appointment and Mr Ward failed to record observations of the patient's throat.*

28. *(Charge 21): On 12 March 2019, Patient 21 attended for a consultation presenting with tender left cervical neck region, combined with radiating pains to the forehead. The patient had said the pain was controlled by Ibuprofen and Paracetamol yet Mr Ward prescribed him with Codeine and did not make recommendations for a mild muscle relaxant and neck care exercises. Mr Ward also failed to record any safety netting advice.*

29. *(Charge 22): On 16 March 2019, a female patient attended a consultation requesting a sexual infection check. In order to communicate between the floors in the Clinic and between staff members, the Clinic used Skype messaging service. On this occasion, Mr Ward shared over Skype confidential information relation to this patient such as that she was very anxious and asking where the Herpes test kits were.*

30. *On 2 August 2019 a panel of the NMC's Investigating Committee imposed an interim conditions of practice order ('ICOPO') on Mr Ward's registration. The ICOPO was varied to an interim suspension order ('ISO') on 5 September 2019. He has since been unable to practise as a nurse and Independent/Supplementary Prescriber.*

31. *On 17 June 2024 and 27 June 2024, through Mr Ward's representative, the Royal College of Nursing ('RCN'), he admitted the charges and impairment in full.*

Misconduct

32. *The facts amount to misconduct.*

33. *Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 provides guidance when considering what could amount to misconduct:*

'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.

34. *Further assistance may be found in the comments of Jackson J in R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin) respectively:*

'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.

And

'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.

35. *At the relevant time, Mr Ward was subject to the provision of* ***The Code: Professional standards of practice and behaviour for nurses and midwives (2018)*** *('the Code'). It is agreed that the following provisions of the Code have been breached in this case:*

Prioritise people

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*

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

To achieve this, you must:

3.3 *act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

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

Practise effectively

6 Always practise in line with the best available evidence

To achieve this, you must:

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

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

8 Work cooperatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

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

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 *complete 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*

Preserve safety

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*

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

18.3 *make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines*

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*

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

36. *In 2018 the NMC adopted the Royal Pharmaceutical Society's ('RPS') Prescribing Competency Framework (2016) as the standards of competence for prescribing practice. The RPS refreshed the framework in September 2021, which the NMC adopted in November 2021. The relevant sections of both frameworks include (as per the numbering in the September 2021 framework):*

4 Prescribe

4.1. *Prescribes a medicine or device[a] with up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions and adverse effects.*

4.2. *Understands the potential for adverse effects and takes steps to recognise, and manage them, whilst minimising risk.*

4.3. *Understands and uses relevant national, regional and local frameworks[b] for the use of medicines.*

5 Provide information

5.1. *Assesses health literacy of the patient/carer and adapts appropriately to provide clear, understandable and accessible information[a].*

5.2. *Checks the patient's/carer's understanding of the discussions had, actions needed and their commitment to the management plan[b].*

5.3. *Guides the patient/carer on how to identify reliable sources[c] of information about their condition, medicines and treatment.*

5.4. *Ensures the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific timeframe[d]*

5.5. *Encourages and supports the patient/carer to take responsibility for their medicines and self-manage their condition.*

6 Monitor and review

6.1. *Establishes and maintains a plan for reviewing[a] the patient's treatment.*

6.2. *Establishes and maintains a plan to monitor[b] the effectiveness of treatment and potential unwanted effects.*

7 Prescribe safely

7.1. *Prescribes within own scope of practice, and recognises the limits of own knowledge and skill.*

7.2. *Knows about common types and causes of medication and prescribing errors, and knows how to minimise their risk.*

7.3. *Identifies and minimises potential risks associated with prescribing via remote methods[a].*

8 Prescribe professionally

8.2. *Accepts personal responsibility and accountability for prescribing[a] and clinical decisions, and understands the legal and ethical implications.*

8.3. *Knows and works within legal and regulatory frameworks[b] affecting prescribing practice.*

8.4. *Makes prescribing decisions based on the needs of patients and not the prescriber's personal views.*

8.6. *Works within the NHS, organisational, regulatory and other codes of conduct when interacting with the pharmaceutical industry*

10 Prescribe as part of a team

10.1. *Works collaboratively[a] as part of a multidisciplinary team to ensure that the transfer and continuity of care (within and across all care settings) is developed and not compromised*

37. *The Parties agree that the facts amount to misconduct. The misconduct in this case relates to failure in patient assessments and management, poor record keeping, patient confidentaily and a failure to follow guidelines for advanced or prescribing practice. Mr Ward's misconduct spanned a large number of patients, some, vulnerable. Mr Ward's actions and omissions were a serious departure from the standards expected of a registered nurse and independent/supplmentary prescriber and demonstrate failings in fundamental nursing practice. These failings are likely to present a risk to patients in the future if they are not addressed.*

Impairment

38. *Mr Ward's fitness to practise is currently impaired by reason of his misconduct.*

39. *The NMC's guidance[1] explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. This involves a consideration of both the nature of the concern and the public interest.*

[1] DMA-1

40. *The Parties agree that consideration of the nature of the concern involves looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;*

    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 professions 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 professions; and/or*

    d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

41. *The Parties have also considered the comments of Cox J in Grant at paragraph 101:*

"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."

42. *In this case, limbs a) b) and c) are engaged. Taking each limb in turn:*

Limb a

43. *The conduct in question relates to patient care. There are real concerns with the safety of any patients in Mr Ward's care. His conduct involved a serious departure from the provisions of the Code. The charges are wide ranging and cover 21 different patients in which Mr Ward has placed them at unwarranted risk of harm either through failures in patient assessments, poor record keeping and failures to follow guidelines for advanced or prescribing practice. Mr Ward's conduct and failings have put patients at unwarranted risk of harm and indeed*

are likely to cause future risks to patients if his behaviour is not addressed. As such, there is a real public protection risk present here.

Limb b

44. Mr Ward's misconduct both in terms of his clinical failings and his breach of confidentiality has brought the profession into disrepute. The incidents in this case are serious. The public has the right to expect high standards of registered professionals. The seriousness of the misconduct is such that it calls into question the safety of any patient under Mr Ward's care. This therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute. There is a need to take action now on a public interest ground because the public may not feel able to trust nurses and as a result the public might take risks with their own health and wellbeing so as to avoid receiving treatment or care from nurses.

Limb c

45. The provisions of the Code constitute fundamental tenets of the profession and Mr Ward's actions have clearly breached these in so far as they relate to prioritising people, practising effectively, preserving safety and promoting professionalism and trust. They also relate to basic nursing knowledge.

46. The fact that Mr Ward's actions in charge 6,9 and 20 were directed to vulnerable patients aggravates the incidents. This makes the concerns particularly serious. Mr Ward's actions demonstrate a flagrant departure from the standards expected of a registered nurse and independent/supplementary nurse prescriber and a breach of the fundamental tenets of the professions.

47. The parties note that impairment is a forward-thinking exercise.

48. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

49. *Having regard to the NMC's guidance 'Can the concern be addressed?' (FTP-14A), The Parties agree that the misconduct in this case is remediable. The misconduct involved safety of clinical practice and related to failings in discrete and easily identifiable areas.*

Remorse, reflection, insight, training and strengthening practice

50. *The Parties next considered if Mr Ward has reflected and taken opportunities to show insight into what happened.*

51. *In Mr Ward's reflective response dated 18 June 2024 (note that Mr Ward's full reflective response is annexed to this CPD provisional agreement), it states:*

Reflection on record keeping and documentation

'…The patient was a gentleman who I recall presented with fatigue and feeling generally unwell. I remember I was feeling under pressure, I was running late in the clinic and had other patients waiting. I decided that I would handwrite my notes and later transcribe them onto the system as I felt this would save time. I took a history, and clinical observations, and examined the patient. I decided that I would take blood tests and include a B – Type Natriuretic Peptide blood test (BNP) as I wanted to rule out heart failure. The patient was not clinically unwell, nor did he warrant admission to the hospital at this point, I gave my usual safety net advice to the patient and his wife explaining if worsening symptoms then in hours to contact me or his GP otherwise he should attend the Emergency Department.

That day I did not record on the computer system any of my clinical history taking, examination, rationale for tests, or safety netting advice. The patient's blood test came back a few days later at 1556ng/L which was elevated. I followed the NICE Guidance on heart failure which states "If the NT-pro-BNP level is between 400–2000 ng/L (47–236 pmol/L), refer for specialist assessment and echocardiography to be seen within 6 weeks. (al-Mohamed, 2020)

As there wasn't an NHS heart failure pathway at this time in our local area, I decided to refer the patient to my supervisor Dr Morgan for a review and for further tests to be organised. At the time I wasn't sure of what other tests may have been required

or my authority for onward referral. I have since undertaken training on heart failure by reading the NICE guidance, attending a webinar on heart failure, and reviewing local referral pathways. Evidence of this can be seen in my record of Continuous Professional Development (CPD) which will be before the panel.

It was common practice in the organisation to email the blood results to the patient. I did this and advised them to book an appointment with our private GP for a review. At the time, I did not believe there was an urgency as the NICE Guidance stated that the patient should be seen within 6 weeks. Dr Morgan was on leave for a further ten days. In hindsight, reflecting now, I should have contacted the patient by phone to ensure that he was clear with the plan and to enquire that his symptoms had not worsened. I did, however, write to his NHS GP asking for any recent blood results and medical history, which I believed would assist the private GP (Dr Morgan) in gathering a more substantial history.

I fully understand the concerns of my colleagues who discovered the BNP blood result when the patient contacted the surgery, and that there was no context to this blood test being taken due to no documentation being recorded on the electronic system. I fully accept that this standard of care fell well below what is expected of a Registered Nurse practicing at an Advanced Level. I refer to the NMC code of conduct which states nurses should "Complete records at the time or as soon as possible after an event, recording if notes are written sometime after the event, also nurses should identify any risks or problems that have arisen and take steps to deal with them so colleagues who use the records have all the information they need. (NMC 2018). I have reflected at length on this incident, and I am deeply remorseful that my record keeping did not meet the required standard. I wish to express my sincere and deep apology to all concerned. I hope that I am able demonstrate to the panel that I have taken steps to update my knowledge, with additional CPD and through reflection to ensure that this type of incident will never happen in the future. I am grateful that no harm came to the patient because of my omission in record keeping and documentation. I failed to demonstrate section 1.16 of proficiencies for Registered Nurses in that I failed to demonstrate the ability to keep complete, clear, and timely records (NMC 2018).'

Mr Ward goes on to say:

'…I have identified that I would, on occasion, if under pressure, make handwritten notes to transcribe these onto the computer at the end of the shift. I acknowledge that this is poor practice and allows room for error. In the case of one patient, I had only recorded the fact that I had requested blood tests, resulting in my colleague following the patient up with an abnormal blood result with no background available in the way of clinical notes. I accept this falls well below the standard expected of a registered nurse. The approach to record-keeping that the courts adopt is that "if it's not recorded, it has not been done". The NMC code advises that nurses should keep clear and accurate records relevant to their practice and complete records at the time or as soon as possible after an event (NMC 2018).

I now have heightened awareness that record keeping is important because it enhances care and safety, communicates to others a patient's progress or deterioration. It also ensures nurses are practicing in line with their professional responsibilities. Clear and concise records will also support the nurse in the case of a complaint, or investigation.'

Training and strengthening practice on record keeping and documentation

'…To address my failings in this area I have undertaken professional discussions with other clinicians around the topic and the revised NMC code section 10 which relates to record keeping. I have also reflected upon several academic articles listed below and have attached a separate reflection in my CPD log.

Royal Collage of Nursing. (2023). Record keeping the facts. RCN Publications. 2023, pp.1-8.

Kent P, Morrow K. (2014). Better documentation improves patient care. Nursing Standard. 29(14), pp.44-51.

Beach J, Oates J. (2014). Maintaining best practices in record keeping and documentation. Nursing Standard. 28(36), pp.45-50.

Brooks N. (2021). How to undertake effective record keeping and documentation. Nursing Standard. 00(0), pp.1-3.

I have attended a Webinar through GP – NI, which is an educational website and resource for those working in general practice in Northern Ireland. Update and Tips on Good Medical Notes and Record-Keeping was an hour-long presentation from a medical doctor and a medico-legal expert from the Medical Protection Society. I was able to complete a reflection on this learning, please see my CPD log. As Nursing as a profession, I am aware of the standards of record keeping expected of me including notes being succinct, factual, accurate, and concise. In addition, the vital recording of clinical observations and full examinations, allergy status, pregnancy status, the reasoning for prescribing, and clear and contemporaneous notes written at the time of the patient event.'

Reflections on documenting clinical findings and clinical observations

'…My usual practice would be to document both positive and negative examination findings. However, I accept that I was inconsistent with this practice over the 2 weeks audit of my Patient's notes. I admit that on occasions I failed to document sometimes in full, or not at all, the clinical observations and examinations in my consultations. Taking and recording clinical observations even when the results are normal can help to reassure patients and their relatives that nothing has been missed (Mein, 2019). Abnormal clinical observations and examinations can assist nurses in reaching a diagnosis. It is essential for patient safety that clinical observations such as temperature, pulse, blood pressure, respiratory rate, and oxygen saturation are recorded, and any abnormalities acted upon. The early detection, timeliness, and competency responding to changes in clinical observations are important determinants of clinical outcomes in people with acute illness (Shropshire Community Health NHS Trust, 2022).

I have reflected upon a case in the journal GP online whereby a GP reviewed a patient with suspected exacerbation of COPD. The GP failed to take and/or document oxygen saturations and the patient was discharged with antibiotics and steroids. The patient later collapsed and died from a pulmonary embolus. The GP was criticised for this, and it is thought that if the oxygen saturation had been recorded then the GP would have recognised how serious the condition of the patient was. The GP had also not documented worsening advice. I have learned from this case study how patients can come to harm when observations are not recorded and documented, and safety netting

advice is not given/documented. I am aware that tests can be flawed or inaccurate, such as oxygen saturation readings being affected by suboptimal circulation (Gould & Bain, 2022), and therefore observations should be viewed seriously and reviewed in addition to the clinical state of the patient who presents to you.'

Training and strengthening practice on documenting clinical findings and clinical observations

'…I have considered the following points going forward to further strengthen my practice in this area. The Royal College of General Practitioners states that as a GP (relevant amongst nurses also) you must recognise the signs of illness and conditions that require urgent intervention. If basic observations are performed and documented, in situations where they could change the clinician's impression or diagnosis, it may be difficult to argue that you put yourself in a position to fully assess the patient. (RCGP 2018). This article has also helped me to realise that even if a patient has been seen recently, their clinical observations should be repeated and documented in the notes.'

Reflections on safety netting and red flags

'…On review of my documentation from the period in question, I acknowledge that I did not consistently document that I had informed patients what to do if their condition worsened. I accept this must not be the case going forward. My usual practice is to verbally inform patients of incidents when they would need to return, supplying them with resources such as a patient information leaflet on their condition where available. However, I admit that if I haven't documented this, in the eyes of my regulatory body "it wasn't done". I feel it is worth highlighting that through my reading on this subject as well as attendance at webinars, I have reflected upon the importance of providing patients with time frames. For example, "if no better in one week, then return for a review" or "if you worsen over the next 48 hours then seek medical attention" and document this. The RCGP (2018) states that we must "record the safety netting advice provided to patients. It can be identified that you provided the advice if it is documented in the notes rather than relying on the fact that it is your usual practice to do so, or that you "recall doing so".

I am aware that as part of the safety netting advice, red flags should be discussed. Discussing red flags should be integrated throughout the consultation, and not

rushed at the end, simple terms and avoidance of jargon and medical terms will help keep things clear for patients.'

Training and strengthening practice on safety netting and red flags

'…As part of my reflection on documentation and specifically identifying red flag symptoms, I have reviewed some literature. Red flag symptoms are warning signs that indicate a more serious underlying pathology. Red flag symptoms can range from weight loss and fatigue to more specific issues like rectal bleeding or vomiting blood. What I have learned from this is that during my consultations I should not only be looking for red flags during my questioning and examination of the patient but documenting these, and referring and escalating appropriately, including using the suspected cancer pathway. Nurses must feel confident to identify red flag symptoms and escalate and refer appropriately to reduce the risk of patient harm (Payton & Warren, 2014).'

Reflections, training and strengthening practice on prescribing safely

'…Issues were raised about the appropriateness of some medications that I prescribed. On one occasion a concern was raised about the quantity of medication I prescribed to be supplied. Prescribing decisions can be reached depending on several factors including personal experience, local formularies, NICE Guidance, and pain assessment tools. It is important only to prescribe the lowest effective dose of medication for the shortest amount of time in each case assessed. I have reviewed and reflected upon the relevant competency framework for all prescribers (Royal Pharmaceutical Society, 2022). This document represents the current standard that all prescribers should demonstrate and work to, forming the basis of non-medical prescribing education and competence assessment (RPS, 2022)

The framework is described by the society as follows: "This framework sets out what good prescribing looks like. It describes the demonstrable knowledge, skills, characteristics, qualities and behaviours for a safe and effective prescribing role. Its implementation and maintenance are important in informing and improving practice, development, standard of care, and safety (for both the prescriber and patient" (RPS, 2022).

I have reviewed the core competencies as part of this document, to help me strengthen my future prescribing practice. The parts that are linked to the areas of regulatory concern, and parts I feel that I can develop going forward are listed below. A structured approach and reflection on decision-making in the context of the RPS competency framework can support safe and effective consultations (Gould & Bain, 2022).

1.7Undertakes and documents an appropriate clinical assessment.

1.10 Requests and interprets relevant investigations necessary to inform treatment options.

1.14 refers to or seeks guidance from another member of the team, a specialist or appropriate information source where necessary.

It is important to consider when prescribing: genetics, age, renal impairment, and or pregnancy when making prescribing decisions.

3.5 Builds a relationship that encourages appropriate prescribing and not the expectation that a prescription will be supplied (I have heightened awareness that working in private practice there is often this assumption that a prescription will be supplied as the patient is paying for the consultation).

4.2 Understands the potential for adverse effects and takes steps to recognise, manage them whilst minimising risk.

4.6 Prescribes appropriate quantities and at appropriate intervals necessary to reduce the risk of unnecessary waste.

4.9 Electronically generates and or / writes legible, unambiguous, and complete prescriptions that meet legal requirements.

7.1 Prescribes within own scope of practice, and recognises the limits of own knowledge and skill

9.1 Improves by reflecting on own and others prescribing practice, and by acting upon feedback and discussion.

I have reflected upon the following articles which I hope reassure the panel that I have addressed areas in practice that were lacking in some of the areas below:

NICE guidance:

- *Management of gout including prescribing of colchicine*
- *Management of urinary tract infections*
- *Management of acute sore throat in primary care*

There was a concern raised about my prescription of Colchicine which is a medication used for the treatment of gout. The scenario involved a patient whom had attended the private GP practice with a history of Gout with a flare-up in one of his joints. The patient was not compliant taking his preventative medication for this condition. He also worked in England during the week, therefore it was difficult to see his General Practitioner (GP) for monitoring of this condition. The patient denied any history of kidney problems; however, I accept that I did not have any access to his past blood results to confirm what the patient reported. In hindsight, I felt pressured by the patient to prescribe a larger quantity of Colchicine so that he would have it to hand if he had a gout attack whilst away working in England. There is often an assumption in private practice that a prescription will be issued. I prescribed 100 tablets which in hindsight was excessive. On reflection, I am aware that it would have been more appropriate to have prescribed a one-off dose and referred the patient back to his own NHS GP for monitoring. I was working in a private GP care setting, and fully acknowledge that this prescription was not appropriate, or safe. I have since updated my knowledge on this drug, and also the management of gout by attending a GP update on rheumatology which includes the management of gout hosted by Dr Roger Stewart, Consultant Rheumatologist, I have reviewed Colchicine in the British National Formulary (Joint Formulary Committee, 2024) and read an article "Compliance of primary care providers with gout treatment recommendations – Lessons to Learn: Results of a nationwide survey (Sautner et al, 2020).

Further to this, the Uric acid blood test that I had requested came back within normal limits. [Ms 1] observed that I should have contacted the patient to advise him that this did not look like gout, and that there could be an alternative diagnosis. I have learnt through research that the serum uric acid isn't always raised in an acute attack. Serum uric acid concentrations may be supportive of a diagnosis of gout, but alone the presence of hyperuricemia or normal uric acid concentrations do not confirm or rule out the diagnosis of gout as frequently uric acid levels may be normal during an acute gout attack. (John Hopkins Centre for Arthritis, 2024).
nically documented.
[Ms 1] also raised concern regarding a patient who presented to me with chest pain in the urgent care clinic. [Ms 1] disagreed with my management of this patient, which I am aware can occur when clinicians have a difference of opinion in clinical management. Serious causes of chest pain include conditions such as Acute Coronary Syndrome (ACS), pulmonary embolism, aortic dissection and spontaneous pneumothorax (Thomsett & Cullen, 2018). The patient presented with a cardiorespiratory history, with pain relieved by and responding to GTN spray (this is a medication that opens the vessels around the heart). This response helped to support my differential diagnosis of ACS. GTN should be administered to patients whose chest pain is thought to be caused by ACS (Thomsett & Cullen, 2018). I called an ambulance for transfer to the emergency department. Patients with suspected ACS, including new onset angina, should be referred urgently to the nearest emergency department (Thomsett & Cullen, 2018).

In future I would deal with differences of professional opinion with colleagues by discussion and informed debate (NMC, 2018)

I agree with [Ms 1]'s observation that I should have conducted an electrocardiograph test. In hindsight, I recognise that I should have conducted the 12-lead electrocardiograph (ECG) to support the differential diagnosis. At the time, due to the urgency involved, it is clear I did not prioritise this. From experience, I believed the Paramedics would undertake their own ECG, and my priority at the time was to observe the patient and write a referral to the hospital. I now acknowledge after researching this scenario, that best practice would be to undertake an ECG. An ECG

should be performed within 10 minutes of assessing a patient with suspected ACS for identification of ST-elevation myocardial infarction (STEMI); ECG is a key immediate investigation primary care clinicians must obtain (Thomsett & Cullen, 2018).

I have further reflected on a patient who presented with a sore throat. This patient presented with a 10-day history of a sore throat, and had been seen by a different clinician, with a sub-optimal course of antibiotics prescribed which had not helped. The patient represented with ongoing throat pain and had visible pus on his tonsils. The presence of pus on the tonsils is not considered an immediate indication for antibiotics (Wilcox et al, 2022). At the time, and with the clinical picture I was presented with, I decided that a further course of antibiotics may be beneficial along with a prescription of the analgesic co-codamol (as the main issue was a pain). The patient's chief complaint in these cases, and reason for presentation is usually pain. Optimising analgesia and patient education regarding self-care will reassure patients and help them recover (Wilcox et al, 2022).

Reflecting on the case, I acknowledge that I failed to consider that the possibility there had been no improvement in the patient's condition could be owing to the infection being viral. I have since reflected on an article relating to acute sore throat (Wilcox et al, 2022) to update my knowledge in this common primary care presentation, for which antibiotics are commonly prescribed.

Antibiotics are not always required in sore throats, around two-thirds of cases are viral in origin (Wilcox et al, 2022). On reflection, I should have utilised a clinical prediction tool such as the FeverPain Score (NICE, 2018) These scores determine the likelihood of a streptococcal infection, their use is recommended by NICE, and if warranted issued a delayed prescription for antibiotics (NICE, 2018) NICE recommends delayed antibiotics unless symptoms are very severe, or the patient is vulnerable to complications (NICE, 2018).

NICE (2018)

I have looked at the CHESTESS mnemonic to aid my discussion of antibiotics with patients. This can help when explaining there is no need for an antibiotic if this is the conclusion the prescriber has met:

C ask specifically about the patient's CONCERNS, H, discuss HISTORY and examination, E, ask specifically about the patient's EXPECTATIONS, S, Provide a non-serious explanation of the SYMPTOMS, T, be specific about TIMELINE, usual course, S, explain the SHORTCOMINGS of antibiotics, S, advise patients how to SELF CARE, S, Provide SAFTEY-NETTING ADVICE (NICE, 2018).

The evidence demonstrates the majority of acute sore throats in general practice are viral, even if bacterial antibiotics are likely to reduce the symptoms by one day (Wilcox, 2022). I must consider this in the future when consulting patients presenting with this problem. My practice must incorporate risk stratification tools, such as the FeverPain score to aid my prescribing decisions.

As part of my commitment to self improvement and professional development, I have studied and reflected on the use of the RAPID CASE contemporary prescribing model which can assist me in undertaking a safe and effective consultation in keeping with the NMC's four themes of the code, that is prioritise people, practice effectively, preserve safety and promote professionalism and trust (NMC 2018). The use of such a guide can guide decision-making in prescribing, and assist the nurse in adhering to the professional dimensions of prescribing practice (Gould & Bain, 2022).

The RAPID CASE model of prescribing looks at RPPORT, ASSESSMENT, PSYCHOSOCIAL, INVESTIGATIONS, DIAGNOSIS, COST, EFFECTIVENESS, APPROPRIATENESS, SAFETY, AND EFFECTIVENESS.

I have also signed up for the Medicines, and Healthcare Products Regulatory Agency (MHRA) drug alerts to keep abreast of any safety alerts. To fulfil their duty of care, the prescribing nurse must keep up to date with MHRA alerts (Gould & Bain, 2022). I am a member of the Association of Prescribers which provides me with

access to peer support on prescribing practice, as well as regular home delivery of the Journal of Prescribing Practice and the Independent Nurse Journal, which helps me to keep abreast of evidence-based practices in non-medical prescribing. I have attended an Antibiotic Masterclass and prescribing update, evidence of which can be found in my CPD Log which the panel will have sight of.'

Reflections and strengthening practice on failure to consider test results

'…[Ms 1] identified specific areas of clinical practice where my standard of care fell below my usual standard of nursing practice. One of these areas was the interpretation of blood test results, with a concern raised in relation to the management of a patient with an abnormal BNP blood test. This patient's blood test was 1556. For context, NICE guidance says such patients with a pro BNP of between 400-2000 should be seen within 6 weeks by a specialist.

(NICE, 2018)

I accept that my knowledge of some blood tests, and the clinical management of abnormal results fell below the reasonable standard for a nurse working at an advanced level. I have since undertaken further study by sourcing and reading relevant academic articles including :

Milne, L. (2022). The diagnostic reasoning involved in interpreting blood results. British Journal of Nursing. 31(5), pp.1-17.

Watson, J, Sailsbury, C, Whiting F Whiting, Hamilton, T, Banks, J. (2022). "I guess I'll wait to hear" - communication of blood test results in primary care- a qualitavive study. British Journal of General Practice. 1(e747), pp.1-8.

Willis, J. (2024). Reviewing and Interpreting Blood Tests. [Online]. Geeky Medics. Last Updated: 17 Jan 24. Available at: https://geekymedics.com/reviewing-and-interpreting-blood-tests/ [Accessed 4 June 2024]

I have also attended a webinar run by GPNI where Dr Emma Murray, Specialist Registrar in Chemical Pathology, discussed practical approaches to interpreting common biochemistry results in primary care. This involved discussion on case studies, and

covered the causes and management of Hypo/Hypernatremia, Hypo/Hyperkalemia, Hypomagnesaemia, hypophosphatemia and hypo/hypercalcemia. In addition, I have attended a similar webinar through GPNI on common haematology laboratory results interpretation hosted by Dr Gary Benson, Consultant Haematologist, from the Belfast Trust. This consisted of reviewing of Haemoglobin (HB), White Cell Counts (WCC) and Platelet levels, Haematinics results, Coagulation screens and Thrombophilia screens. Evidence of reflection can be found in my CPD log.

I have undertaken independent studies through https://geekymedics.com/ to review articles on interpreting Liver Function Tests (LFT's), including when to order more advanced liver health screens. I have also reflected upon the interpretation of Thyroid Function Tests (TFT'S) when it is necessary to request Thyroid autoantibody tests and further management of abnormal results. Similarly, with bone profile results and haematinics.

[Ms 1] raised that I failed to undertake Ketone measurements in some patients attending the surgery with acute illness. However, evidence suggests it is not routine or common practice to undertake these readings in primary care. Point of care blood tests for ketones allow for rapid and accurate diagnosis and monitoring of diabetic ketoacidosis, A clear role of the ketone blood test in primary care is yet uncertain. However, it may be useful in the assessment of patients with known diabetes who are unwell or have very high glucose levels (Pluddemann et al, 2011). I accept that this is a useful test to consider in unwell patients presenting to general practice if there is a clinical suspicion of DKA. The limitations to these tests relate to training and availability in primary care.

Prior to this concern being raised, I had not had the opportunity to undertake any training around point-of-care ketone testing. I have since read and reflected upon the below articles and in my future practice will consider using this test as part of my assessment of confirmed diabetic patients, or those whom I have a clinical suspicion of undiagnosed type 1 DM presenting in an unwell state (if available in my practice setting). I have been able to learn the normal and abnormal ranges from my reading which is set out below in a table. I have reviewed the signs of DKA, which has refreshed my knowledge.'

Reflections, training and strengthening practice on prescribing of codeine

'…Part of my failings about prescribing was that I did not always justify my prescribing decisions by documenting pain scores and prescribing rationale. I have been able to reflect upon my practice after reading articles on prescribing and pain assessment and management. I also undertook a Level 2 Certificate in Principles of End of Life Care which was awarded May 2024, this took 60 hours of study remotely. As part of this qualification I studied pain assessment, pain scales, documentation and one module called "Understand how to provide support to manage pain and discomfort", this included pharmocological and non pharmocological methods. In Appendix 2 I have included some written feedback from the lecturer which will help demonstrate my learning. Going forward I now fully appreciate the importance of undertaking pain assessments and documenting prescribing decisions. I need to always document that I have discussed potential side effects and interactions with patients. Clinical records should include the relevant clinical findings that support the decision to prescribe opioids, the choice of drug, formation, dose and duration of treatment, I will also ensure to tell patients under which circumstances the opioid therapy should be stopped. This is in line with best practice. (Faculty of Pain Medicine. 2023).

I would like to acknowledge [Ms 1]'s observations about my prescribing of codeine and reassure the panel that going forward my documentation will be in line with current guidance and best practice. I agree that in her observation of potential side effects and addiction; this is something in which I will risk assess and document going forward. Abuse, misuse and addiction can occur, and patients should be appropriately counselled. (Peechakara, B.V, 2024.

To further evidence my understanding of the concerns raised I have undertaken several participatory training courses with ASCERT NI which is an addictions charity. These include 1. Understanding opioids (3 hours) Substance misuse (6 hours), 2. Understanding the misuse of prescription and over the counter (OTC) medicines (3 hours) and working with young people and substance misuse (6 hours). Also, to update my knowledge around treatment of opioid overdose I attended a 6-hour training session on the administration of naloxone (the reversal agent for opioids).'

Reflections on referral to specialists

'…In future I will always refer patients to or ask for help from another suitably qualified professional to carry out any action or procedure that is outside the limits of my competence. (NMC, 2018).'

Conclusions

'…In conclusion it is important to acknowledge the position of trust that the nursing profession holds within society, therefore. I must always work in ways that promote the public's confidence in the profession, I should always practice due diligence, and the ethical obligation of nonmaleficence (to do no harm). Even when things go wrong, I have a duty of candour to be open and honest about my failings, to learn from these through reflection and do better in the future. It is important to acknowledge the effect that my omissions and NMC case has had on my colleagues, patients, and members of the public including the cost associated with FTP hearings.

In addition, going forward, I need to be self-reflective of the circumstances that found me before the NMC, [PRIVATE]. This experience has highlighted to me how important it is to document to a high standard, prescribe safely including using assessment and diagnostic reasoning tools to evidence this. I must refer to others when a situation is outside of my scope of expertise. My plan for the future is to undertake a master's degree in advanced clinical practice, this will help consolidate and formalise my training and experience and is in keeping with my ethos of lifelong learning. I believe that I will be able to use my experience of my FTP journey to help students and other nurses be more aware of our professional, ethical and legal responsibilities as nurses.'

52. *The Parties consider taking into account the above reflections and training and evidence of strengthening practice that Mr Ward has demonstrated insight and remorse.*

Public protection impairment

53. *The Parties are conscious that consequent to the ICOPO imposed on 2 August 2019 and the subsequent ISO imposed on 5 September 2019, Mr Ward has not*

been able to act in his capacity as a registered nurse and an independent/supplementary prescriber. He has thus been unable to demonstrate, in practice, a strengthening of practice and therefore a risk of repetition remains. Additionally, whilst Mr Ward has carried out a vast amount of theory based training and learning and read up on academic studies, the NMC have not received evidence of practical training courses undertaken by Mr Ward in, for example, record keeping, patient assessment and management, medication management, prescribing safely and patient confidentiality in order to address the areas of deficiency. A finding of impairment is thus necessary on public protection grounds.

Public interest impairment

54. *In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:*

    "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."

55. *Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.*

56. *In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.*

57. *However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.*

58. *It is submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. The prioritisation of people, practising effectively, preservation of safety with references to prescribing and the upholding of the reputation of the profession are fundamental tenets of the profession. Nurses must ensure that their conduct at all times justifies the public's trust in the profession. It is submitted that a member of the public appraised of the facts, would be shocked to hear that a registered nurse was entitled to practice without restriction in the circumstances. As such, the need to protect the wider public interest calls for a finding of impairment to uphold standards of the profession, maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession, and the regulator, would be seriously undermined, particularly where there is a risk of repetition, as is present in this case.*

59. *Based on the above paragraphs, the Parties agree that Mr Ward's fitness to practise is impaired on public protection and public interest grounds.*

Sanction

60. *The appropriate sanction in this case is* ***an 18 month Conditions of Practice Order with review before expiry.***

61. *The following aggravating features of this care are agreed by the Parties to be:*

- *Mr Ward displayed a pattern of behaviour and with a large number of patients, some of whom were vulnerable young patients.*

62. *The following mitigating features of this case are agreed by the Parties to be:*

- *Mr Ward's behaviour appears to be over a short period of time.*

- *Mr Ward has demonstrated remorse and insight.*

63. *The Parties have considered the NMC's guidance to assist with the determination of the appropriate sanction. The Parties acknowledge that the panel will want to consider sanction in ascending order of seriousness.*

64. ***Taking no further action*** *or imposing a* ***caution order*** *would be wholly inappropriate as they would not sufficiently address the seriousness of the concerns in this case and would not meet the wider public interest. Poor medication management, incorrect prescribing practices, patient assessment and management, record keeping and patient confidentiality could potentially cause harm if not put right and is also sufficiently serious to undermine public confidence in the profession.*

65. *Imposing a* ***conditions of practice order*** *would be appropriate. The NMC's guidance (SAN-3c) provides that conditions will be appropriate where there are identifiable areas of the nurse's practice in need of assessment/retraining, there is potential and willingness to respond positively to retraining, patients will not be put in danger directly or indirectly as a result of the conditions, patients will be protected for the period they are in force, and the conditions can be monitored and assessed. The NMC consider that these factors are all present. There is no evidence of harmful deep-seated personality or attitudinal problems, nor evidence of general incompetence. Workable conditions could be put in place in relation to identifiable areas of Mr Ward's practice in need of assessment and retraining, for example, record keeping, patient confidentiality, patient assessment and management and medication management and prescribing practices.*

66. *In the circumstances, the Parties consider that a* ***suspension order*** *or a* ***striking order*** *would be wholly disproportionate.*

67. *The NMC considers that 18 months would provide Mr Ward sufficient time to strengthen his practise as the allegations are wide and varied and span several clinical areas which need addressing. A review before expiry would afford the*

NMC the opportunity to ensure that the misconduct has been sufficiently remediated.

68. *The NMC recommends the following conditions be included:*

1. *You must limit your nursing practice to one substantive employer. If this is an agency, you must only work in one setting for one organisation.*

2. *You must ensure you are directly observed by another registered health professional – either a doctor, or a nurse, (or a pharmacist, in relation to condition 2d only) anytime you are working when undertaking the following tasks until such a time you are signed off as competent by your line manager, mentor, or supervisor and confirmed in writing by your line manager, mentor or supervisor to your NMC case officer:*

    a. *Medication management;*

    b. *Patient management and assessment;*

    c. *Record keeping;*

    d. *Safe prescribing practices; and*

    e. *Patient confidentiality.*

3. *You must provide evidence of successfully completing the following competency assessments to your NMC case officer within 6 months of this order coming into effect:*

    a. *Medication management;*

    b. *Patient management and assessment;*

    c. *Record keeping;*

    d. *Safe prescribing practices; and*

    e. *Patient confidentiality.*

The courses referred to above must include theoretical and practical components.

4. *You must meet monthly with your line manager, mentor, or supervisor to discuss your general clinical performance and specifically:*
    a. *Medication management;*
    b. *Patient management and assessment;*
    c. *Record keeping;*
    d. *Safe prescribing practices; and*
    e. *Patient confidentiality.*
5. *You must work with your line manager, mentor, or supervisor to create a personal development plan (PDP). Your PDP must address the following concerns:*
    a. *Medication management;*
    b. *Patient management and assessment;*
    c. *Record keeping;*
    d. *Safe prescribing practices; and*
    e. *Patient confidentiality.*
6. *You must send your NMC case officer a copy of your PDP within the first six weeks of employment as a nurse and/or an independent/supplementary prescriber.*
7. *You must send your NMC case officer a report from your line manager, mentor, or supervisor, prior to any review hearing commenting on your progress towards achieving the aims set out in your PDP and also commenting on your general clinical performance and specifically:*
    a. *Medication management;*

b. *Patient management and assessment;*

c. *Record keeping;*

d. *Safe prescribing practices; and*

e. *Patient confidentiality.*

8. *You must keep the NMC informed about anywhere you are working by:*

   a. *Telling your case officer within seven days of accepting or leaving any employment.*

   b. *Giving your case officer your employer's contact details.*

9. *You must keep the NMC informed about anywhere you are studying by:*

   a. *Telling your case officer within seven days of accepting any course of study.*

   b. *Giving your case officer the name and contact details of the organisation offering the course of study.*

10. *You must immediately give a copy of these conditions to:*

    a. *Any organisation or person you work for.*

    b. *Any agency you apply to or are registered with for work.*

    c. *Any employers you apply to for work (at the time of application).*

    d. *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

11. *You must tell your case officer, within seven days of your becoming aware of:*

    a. *Any clinical incident you are involved in.*

    b. *Any investigation started against you.*

    c. *Any disciplinary proceedings taken against you.*

12. *You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*

    a. *Any current or future employer.*

    b. *Any educational establishment.*

    c. *Any other person(s) involved in your retraining and/or supervision required by these conditions.*

Maker of allegation comments

69. *The referrer organisation, Duality Health, has informed the NMC that they do not wish to receive any updates regarding this case. Therefore the NMC, in respecting their wishes, has not obtained comments from them on the CPD agreement.*

Interim order

70. *An interim order is required in this case.*

71. *The interim order is necessary for the protection of the public and otherwise in the public interest for the reasons given above.*

72. *The interim order should be for a period of 18 months in the event that Mr Ward seeks to appeal the panel's decision. The interim order should take the form of an interim conditions of practice order.*

73. *The interim conditions of practice should be as follows:*

74. *You must limit your nursing practice to one substantive employer. If this is an agency, you must only work in one setting for one organisation.*

    1. *You must limit your nursing practice to one substantive employer. If this is an agency, you must only work in one setting for one organisation.*

    2. *You must ensure you are directly observed by another registered health professional – either a doctor, or a nurse, (or a pharmacist, in relation to*

condition 2d only) anytime you are working when undertaking the following tasks until such a time you are signed off as competent by your line manager, mentor, or supervisor and confirmed in writing by your line manager, mentor or supervisor to your NMC case officer:

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c. *Record keeping;*

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e. *Patient confidentiality.*

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    a. *Medication management;*

    b. *Patient management and assessment;*

    c. *Record keeping;*

    d. *Safe prescribing practices; and*

    e. *Patient confidentiality.*

    The courses referred to above must include theoretical and practical components.

4. *You must meet monthly with your line manager, mentor, or supervisor to discuss your general clinical performance and specifically:*

    a. *Medication management;*

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7. *You must send your NMC case officer a report from your line manager, mentor, or supervisor, prior to any review hearing commenting on your progress towards achieving the aims set out in your PDP and also commenting on your general clinical performance and specifically:*

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9. *You must keep the NMC informed about anywhere you are studying by:*

a. Telling your case officer within seven days of accepting any course of study.

b. Giving your case officer the name and contact details of the organisation offering the course of study.

10. *You must immediately give a copy of these conditions to:*

a. *Any organisation or person you work for.*

b. *Any agency you apply to or are registered with for work.*

c. *Any employers you apply to for work (at the time of application).*

d. *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

11. *You must tell your case officer, within seven days of your becoming aware of:*

a. *Any clinical incident you are involved in.*

b. *Any investigation started against you.*

c. *Any disciplinary proceedings taken against you.*

12. *You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*

a. *Any current or future employer.*

b. *Any educational establishment.*

c. *Any other person(s) involved in your retraining and/or supervision required by these conditions.*

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.'

Here ends the provisional CPD agreement between you and the NMC. The provisional CPD agreement was signed by you on 12 August 2024 and by the NMC on 23 July 2024.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel noted that at paragraph 1 of the proposed CPD agreement it was stated that you did not intend to attend this hearing. However, as you have decided to attend and to be represented this paragraph was now factually incorrect. After hearing from the parties and receiving advice from the legal assessor, the panel decided that it would be sufficient to mention this matter in this (the panel's) decision, rather than amend the provisional CPD agreement. The panel was satisfied that this change in circumstances does not affect the substance of the provisional agreement.

Mr Gordon, on behalf of the NMC, referred the panel to the provisional CPD agreement. He referred the panel to the background as set out in the provisional CPD and outlined that the 22 charges arose in early 2019. Mr Gordon submitted that the suggested conditions of practice order would be sufficient to manage the risk that underlies the charges.

Mr Buxton, on your behalf, submitted that there was nothing further to add to what is contained in the provisional CPD.

The panel accepted the advice of the legal assessor.

The panel had regard to the NMC guidance on *'Consensual Panel Determinations'* and to the NMC *'Sanctions Guidance'* (SG). The panel noted it's powers, namely that it could accept, amend or outright reject the provisional CPD agreement reached between you and the NMC. Further, the panel was mindful that it should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

During the panel's deliberations, some questions about the basis of your admissions arose and it therefore invited the parties back into the hearing.

In respect of your admission to charge 2)a), the panel requested further clarification as it appears that your admission may be equivocal and in your reflection, you have stated that there was a difference in professional opinion and there was some debate over whether there was a *'clinical need'*.

In respect of your admission to charge 7)d), the panel also queried the basis of your admission as in your reflection, you provided the NICE guidelines and it appears that you do not fully admit the charge.

In response to the panel questions Mr Buxton, on your behalf, submitted that in respect of charge 2)a), you accepted Ms 1's opinion that this was an unnecessary use of resources given that the hospital is situated a short distance from the surgery.

In respect of charge 7)d), Mr Buxton submitted that you accept that you did not escalate matters as swifty as you could have. Mr Buxton submitted that following these matters, you have meticulously studied the guidance and your reflections were written with that gained insight, which he acknowledged may have caused ambiguities regarding your admissions. However, he submitted that you do accept that you failed to escalate appropriately and as quickly as you should have.

In conclusion, Mr Buxton submitted that you wish to maintain your full admissions to the charges.

The panel was satisfied with the further information provided and accepted your full admissions to the charges. The panel therefore found all of the charges proved by way of your admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on Fitness to Practise

The panel then went on to consider whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired. Whilst it acknowledged the agreement between you and the NMC and noted your acceptance of misconduct and current impairment, the panel has exercised its own independent judgement in reaching its decision.

In respect of misconduct, the panel determined that the charges are serious, wide ranging and related to a failure in patient assessments and management, poor record keeping, patient confidentiality and a failure to follow guidelines for advanced prescribing practice. The panel considered that whilst record keeping is important in all clinical practice, in the private sector where GP records are not readily available, it is even more important to keep an accurate record of patient care. The panel found that your actions and omissions placed patients, some of whom were particularly vulnerable, at a risk of suffering harm. Furthermore, the panel found that your actions and omissions related to fundamental nursing skills and were serious departures from the standards expected of a registered nurse and independent/supplementary prescriber. The panel endorsed paragraphs 32 to 37 of the provisional CPD agreement and found that the charges amounted to misconduct.

The panel went on to consider whether your fitness to practise is currently impaired by reason of your misconduct.

In coming to its decision, the panel had regard to the 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.'

The panel also had regard to the test set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)* by Cox J;

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 professions 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 professions; and/or

d. …

The panel found limbs a, b and c engaged in this case. The panel found that your failures in patient assessments, poor record keeping and a failure to follow guidelines for advanced prescribing practice placed 20 patients at unwarranted risk of harm.

The panel also found that your clinical failings and breach of confidentiality brought the profession into disrepute. The public expects high standards, and the panel was of the view that the seriousness of the misconduct is such that it calls into question the safety of any patient under your care. The panel considered that your actions had a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.

The panel noted that the provisions of the Code constitute fundamental tenets of the profession and your actions breached these in so far as they relate to prioritising

people, practising effectively, preserving safety and promoting professionalism and trust. They also relate to basic nursing knowledge. The panel found that your actions demonstrate a departure from the standards expected of a registered nurse and independent/supplementary nurse prescriber and constitute a breach of the fundamental tenets of the professions.

The panel considered that the misconduct in this case relates to your clinical skills and is therefore capable of remediation. In considering whether you have remediated your practice, the panel had regard to your reflective statement, the training you have undertaken since the charges arose and considered whether you have strengthened your practice.

In respect of current impairment, the panel endorse paragraphs 52 to 59 of the provisional CPD agreement.

The panel found that you have demonstrated remorse for your actions and omissions and insight into your misconduct. Whilst you have demonstrated remorse and insight, the panel noted that you have not practised as a registered nurse and an independent/supplementary prescriber since 2019. As a consequence, you have been unable to put your learning and training into practice, and unable to demonstrate strengthened practice. The panel therefore determined that there is a risk of repetition of the misconduct and a consequent risk of harm to patients. Accordingly, the panel found that your fitness to practise is currently impaired on public protection grounds.

The panel determined that a finding of impairment was required on public interest grounds. It considered that given the public protection issues identified and the wide ranging, repeated and fundamental nature of the misconduct a member of the public would be shocked to hear that a registered nurse was entitled to practise without restriction in the circumstances. The panel determined that public confidence in the profession and the regulator would be undermined if a finding of impairment was not made in these circumstances and proper standards of professional conduct would not be upheld.

The panel determined that your fitness to practise is currently impaired on both public protection and public interest grounds.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The misconduct was wide ranging, repeated and involved a high number of vulnerable patients.
- Your misconduct placed patients at a risk of harm.

The panel also took into account the following mitigating features:

- You have made full admissions to the charges.
- You have demonstrated remorse and have insight into your misconduct.
- Whilst the misconduct was repeated, this occurred during a short period of time.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the wide ranging failures and the risk of repetition and consequent public protection issues identified. The panel determined that not imposing an order would not protect the public and it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG

states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…;*
- *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 determined that there was no evidence of harmful deep-seated personality or attitudinal problems. The panel considered that there were identifiable areas of your practice in need of assessment and/or retraining, namely, patient assessment and management, record keeping, patient confidentiality and medication management and prescribing practices. The panel noted that you have made positive steps towards strengthening your practice, you have engaged with the NMC and indicated that you would comply with a conditions of practice order. Taking all of the above into consideration, the panel concluded that it would be possible to formulate appropriate

and practical conditions which would address the failings highlighted in this case and protect patients.

The panel had regard to the fact that whilst the errors were repeated and wide ranging, they occurred over a relatively short period of time. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case given that you have demonstrated remorse for your actions and omissions, you have demonstrated insight into your misconduct and taken positive steps in an attempt to strengthen your practice.

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

The panel agreed with the CPD that the following conditions are appropriate and proportionate in this case:

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

1. You must limit your nursing practice to one substantive employer. If this is an agency, you must only work in one setting for one organisation.

2. You must ensure you are directly observed by another registered health professional – either a doctor, or a nurse, (or a pharmacist, in relation to condition 2d only) anytime you are working when undertaking the following tasks until such a time you are signed off as competent by your line manager, mentor, or supervisor and confirmed in writing by your line manager, mentor or supervisor to your NMC case officer:

    a. Medication management;

    b. Patient management and assessment;

    c. Record keeping;

    d. Safe prescribing practices; and

    e. Patient confidentiality.

3. You must provide evidence of successfully completing the following competency assessments to your NMC case officer within 6 months of this order coming into effect:

    a. Medication management;

    b. Patient management and assessment;

    c. Record keeping;

    d. Safe prescribing practices; and

    e. Patient confidentiality.

    The courses referred to above must include theoretical and practical components.

4. You must meet monthly with your line manager, mentor, or supervisor to discuss your general clinical performance and specifically:

    a. Medication management;

    b. Patient management and assessment;

    c. Record keeping;

    d. Safe prescribing practices; and

    e. Patient confidentiality.

5. You must work with your line manager, mentor, or supervisor to create a personal development plan (PDP). Your PDP must address the following concerns:

    a. Medication management;

    b. Patient management and assessment;

    c. Record keeping;

    d. Safe prescribing practices; and

    e. Patient confidentiality.

6. You must send your NMC case officer a copy of your PDP within the first six weeks of employment as a nurse and/or an independent/supplementary prescriber.

7. You must send your NMC case officer a report from your line manager, mentor, or supervisor, prior to any review hearing commenting on your progress towards achieving the aims set out in your PDP and also commenting on your general clinical performance and specifically:

a. Medication management;

b. Patient management and assessment;

c. Record keeping;

d. Safe prescribing practices; and

e. Patient confidentiality.

8. You must keep the NMC informed about anywhere you are working by:

a. Telling your case officer within seven days of accepting or leaving any employment.

b. Giving your case officer your employer's contact details.

9. You must keep the NMC informed about anywhere you are studying by:

a. Telling your case officer within seven days of accepting any course of study.

b. Giving your case officer the name and contact details of the organisation offering the course of study.

10. You must immediately give a copy of these conditions to:

a. Any organisation or person you work for.

b. Any agency you apply to or are registered with for work.

c. Any employers you apply to for work (at the time of application).

d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your case officer, within seven days of your becoming aware of:

a. Any clinical incident you are involved in.

b. Any investigation started against you.

c. Any disciplinary proceedings taken against you.

12. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a. current or future employer.

    b. Any educational establishment.

    c. Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 18 months. The panel determined that 18 months would allow you sufficient time to secure employment, to put your learning and training into practice and to demonstrate strengthened practice.

Before the end of the period of the order, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Decision and reasons on interim order

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

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 agreed with the CPD that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be inconsistent with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

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

That concludes this determination.

This will be confirmed to you in writing.