Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 23 January 2024 – Thursday 25 January 2024

Virtual Hearing

Name of Registrant:	Helen Alexandra Firth
NMC PIN	90A1627E
Part(s) of the register:	Registered Nurse- Adult Nursing – RN1 – May 1993
Relevant Location:	Sheffield
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, lay member) Claire Matthews (Registrant member) Barry Greene (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Catherine Blake
Nursing and Midwifery Council:	Represented by Laura Holgate, Case Presenter
Miss Firth:	Not present and not represented at the hearing.
Facts proved:	Charges 1 and 2.
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Firth was not in attendance and that the Notice of Hearing letter had been sent to Miss Firth's registered address by recorded delivery and by first class post on 19 December 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Miss Firth's registered address on 19 December 2023. It was signed for by Miss Firth.

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

The panel accepted the advice of the legal assessor.

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

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision and reasons on proceeding in the absence of Miss Firth

The panel next considered whether it should proceed in the absence of Miss Firth. It had regard to Rule 21 and heard the submissions of Ms Holgate who invited the panel to continue in the absence of Miss Firth.

Ms Holgate summarised the extent of Miss Firth's engagement with the NMC in relation to this hearing. She noted that the matter was first scheduled for a substantive hearing in May 2023, but Miss Firth did not attend and the hearing was adjourned by the panel. In subsequent communication with the NMC, Miss Firth indicated her frustration that the initial hearing was adjourned. This hearing was notified to Miss Firth on 28 November 2023, and on 19 December 2023.

Ms Holgate submitted that Miss Firth has been made aware of the hearing and been provided with ample opportunity to attend but has chosen not to do so. Ms Holgate submitted that Miss Firth does not wish to take part in the proceedings, and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Firth. In reaching this decision, the panel has considered the submissions of Ms Holgate, the documentation in the bundle, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones* and *General Medical Council v Adeogba* [2016] EWCA

Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Good service has been effected by the NMC;
- No application for an adjournment has been made by Miss Firth;
- Miss Firth has previously communicated to the NMC her annoyance at an earlier adjournment;
- Miss Firth sent an email to the NMC on the morning of the hearing to say that she would not attend;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have attended today to give live evidence;
- The charges relate to events that occurred in 2020; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

Details of charge

That you, a registered nurse:

On a day shift 3 January 2020:

1. Were in attendance at work and unfit for duty.

2. Failed to administer morning medications to around 16 residents of the nursing unit.

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

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

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

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

The panel determined to rule on whether or not to go into private session in connection with [PRIVATE] as and when such issues are raised in order to protect her privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Holgate under Rule 31 to allow the written statement of Witness 3 into evidence. Ms Holgate informed the panel that Witness 3 has ceased communication with the NMC since their email of 17 January 2024 advising they

would not be attending the hearing. Ms Holgate submitted that whilst the NMC had made sufficient efforts to ensure that this witness was present, Witness 3 was not present at this hearing.

Ms Holgate referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted that despite their non-attendance, the evidence is highly relevant in this case. She further stated that there would be no injustice to Miss Firth by admitting the hearsay evidence of Witness 3 as it is not sole and decisive, and the panel would be able to test some of the evidence that concurs with other witness evidence who will be attending.

In the preparation of this hearing, the NMC had indicated to Miss Firth in the Case Management Form (CMF), dated 5 April 2023, that it was the NMC's intention for Witness 3 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 3, Miss Firth made the decision not to attend this hearing. On this basis Ms Holgate advanced the argument that there was no lack of fairness to Miss Firth in allowing Witness 3's written statement into evidence. Miss Firth was informed of this by the NMC on Friday 19 January 2024.

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

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by them. The panel considered the circumstances under which Witness 3's statement was made, and that the document exhibited to it was drafted contemporaneously with the incident. The panel also noted that Witness 3 did not know Miss Firth prior to the incident and determined there is no reason

to suspect that there was any animosity between them or that Witness 3's statement was in any way fabricated.

The panel also considered the content of Witness 3's statement, that it is not sole and decisive, and that there is no great conflict of evidence in their statement as compared with the statements of the other witnesses.

The panel acknowledged that reasonable efforts had been made to secure Witness 3's attendance at the hearing. It also noted that there was no medical evidence before it to justify their absence.

The panel considered whether Miss Firth would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of a written statement. The panel considered that as Miss Firth had been provided with a copy of Witness 3's statement and, as the panel had already determined that Miss Firth had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 3 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose while Miss Firth was employed as a registered nurse, on probation, by Alpine Lodge Care Home ('the Home').

On 3 January 2020 the Home was short staffed and it is alleged that Miss Firth was asked by the Home Manager to attend work to help cover a day shift. Upon her arrival between

9:30am and 10:00am, she was asked by the Home Manager to complete a medication round which had already been started. However, it is alleged that she instead went to sit in the residents' lounge where she had a drink and ate a sandwich. The Regional Manager witnessed this and informed the Home Manager, who asked Miss Firth to complete the medication round.

After having witnessed Miss Firth in the lounge for a period of time, the Regional Manager approached her and asked if she had completed the medication round to which she said she had not. The Regional Manager then asked Miss Firth if she was ok and fit to continue to administer medication, to which she replied that she was. [PRIVATE].

The care assistants spoke to the Regional Manager at around 11:15am as they were concerned for Miss Firth and the safety of the residents.

Miss Firth stated that she had only completed medication for about three or four residents. Some medication had been signed for but remained in their blister packs. The Regional Manager said that they then took the keys to the medication trolley and had to continue with the medication round as they felt Miss Firth was unsafe to continue. Around 10 minutes later, Miss Firth left her shift after being warned not to leave by the Regional Manager.

The Home Manager invited Miss Firth to meet with them twice in order to discuss the incident. However, Miss Firth did not attend either meeting. Therefore, her employment was terminated as she was still in her probationary period.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Holgate on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Firth.

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

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

- Witness 1: Regional Manager for the Home at the time of the incident.

- Witness 2: Home Manager at the time of the incident.

The panel saw written evidence from the following person on behalf of the NMC:

- Witness 3: Care Assistant at the Home at the time of the incident.

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

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

Charge 1

> "That you, a registered nurse, on a day shift 3 January 2020, were in attendance at work and unfit for duty"

This charge is found proved.

In reaching this decision, the panel took into account written and oral evidence of Witnesses 1 and 2, and the witness statement of Witness 3, as well as exhibits in the bundle.

For all the evidence received, the panel considered that the accounts are consistent and contemporaneous. [PRIVATE].

The panel also noted that the Regional Manager, Home Manager and two care assistants were so concerned about Miss Firth's ability to safely administer medication to the extent that the Regional Manager took the keys to the medication trolley off Miss Firth to complete the medication round herself. The panel considered this intervention goes beyond mere concern.

The panel also noted Miss Firth's recollection of the incident in her reflective account to being unfit to work stating *'on reflection, I should have refused the shift* [PRIVATE]. The evidence of those present on that day supports that she was unfit for duty. The panel accepted that evidence as correct.

In her CMF, signed on 1 April 2023, Miss Firth indicated an intention to admit to charge 1, however in a further CMF signed on 2 May 2023 she indicates that she does not accept the charge.

[PRIVATE]

The panel therefore concluded that, on the balance of probabilities, this charge is found proved.

Charge 2

> 'That you, a registered nurse, on a day shift 3 January 2020, failed to administer morning medications to around 16 residents of the nursing unit.'

This charge is found proved.

In reaching this decision, the panel took into account written and oral evidence of Witnesses 1 and 2, and the witness statement of Witness 3, as well as exhibits in the bundle.

The panel noted that in order for this charge to be found proved, Miss Firth must have had a clear duty to administer medication. Noting that Miss Firth had been called into work to cover for an agency nurse and that the agency nurse would have received a similar handover, the panel also considered the live evidence of Witness 2 that this handover might not have been as detailed as the full morning handover. However, even if this handover may not have been comprehensive, the panel considered that administering medication is a fundamental aspect of nursing practice in the care of elderly residents, particularly in the morning. The panel also noted that the medication round was half complete as the Home Manager had already started administering medication to the other unit, and that completing the medication round was clearly the priority. The panel also noted the live evidence of Witness 2 who informed the panel that Miss Firth had completed online training in medication administration and record keeping, and was a very experienced nurse.

The panel accepted the evidence that no harm was caused to any resident as a result of these events on 3 January 2020. The panel considered that there could have been harm if there was time sensitive medication such as painkillers or Parkinsons medication that had needed to be administered. There was no evidence that any resident was due any time sensitive medication. However, in her statement received 10 January 2021, Miss Firth stated that she did not know anything about the residents, so she could not have known that there were no time sensitive medications. The panel noted the written statement of Witness 1 and that concerns about Miss Firth's safety were raised by two care assistants who also reported a number of residents complained that they had not received their medication. The panel bore in mind that both Witnesses 1 and 3 suggested that there was

medication which had been signed for as being administered but had not in fact been given. However, the panel were cognisant that it did not see any Medicine Administration Record (MAR) charts or documentary evidence relating to this.

As a registered nurse on shift, the panel concluded that Miss Firth had a duty to administer the medication. The panel noted that failure implies there was something she should do but did not. It concluded that once the keys were taken away from her Miss Firth was unable to administer the medication, and at this point her duty was relinquished. However, for the period between arriving at the Home and having the keys taken away, the panel concluded that Miss Firth was under a duty to administer medication but failed to do so.

The panel concluded, on the balance of probabilities, that Miss Firth prioritised herself over the needs of the residents receiving their morning medication. The panel therefore determined that this charge is found proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Miss Firth's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Holgate invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) in making its decision.

Ms Holgate identified the specific, relevant standards where she submitted Miss Firth's actions amounted to misconduct, and that paragraphs 4, 19, 20, 20.1 and 20.8 of the Code are engaged.

Submissions on impairment

Ms Holgate moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Ms Holgate addressed the panel regarding the test in *Grant*. She submitted that the first three limbs are engaged in this case. Regarding the first limb she submitted that, although there was no allegation of actual patient harm, Miss Firth's conduct had the potential to place those in her care under unwarranted risk of harm. She submitted that administering

medication correctly is an essential skill in nursing and not doing so puts residents at risk. Further, that when providing care nurses should be in a fit state to do so, and that Miss Firth was not.

Ms Holgate drew the panel's attention to the second limb of *Grant* and submitted that both charges had the potential to bring the nursing profession into disrepute. Applying the test of a reasonable and properly informed member of the public, Ms Holgate submitted that Miss Firth's actions fell short of the standard expected of a nurse and undermined public trust and confidence in the profession.

Addressing the panel on the third limb of *Grant*, Ms Holgate submitted that the fundamental tenets of nursing practice can be ascertained by looking at the main themes of the Code, namely prioritising people, practising effectively, preserving safety and promoting professionalism. She submitted that, on the basis of the charges found proved Miss Firth had breached fundamental tenets of the Code.

Ms Holgate then addressed the panel on the questions in *Cohen,* and whether the misconduct is remediable. She submitted that the misconduct can be remediated with adequate insight and understanding. In respect of charge 1, Ms Holgate submitted that Miss Firth has demonstrated limited insight. She noted Miss Firth's reflective statement, in which she said '*I should have refused the shift [PRIVATE]'* and that she has learned to be more considerate before accepting shifts, [PRIVATE].

In respect of charge 2, Ms Holgate submitted that the issues are capable of being remediated with suitable training. However, she submitted that there is no evidence that Miss Firth has undertaken additional training. Ms Holgate noted that Miss Firth is currently working as a healthcare assistant in a role with no medication administration responsibilities, and submitted that there is no evidence that Miss Firth has been able to strengthen her practice.

Ms Holgate submitted that while this was an isolated incident, Miss Firth has demonstrated a lack of sufficient insight to remediate the concerns in this case. She submitted that Miss Firth's reflective statement is mostly personal and there is a theme of apportioning blame to other people and factors such as there being a difficult computer system at the Home. Ms Holgate submitted that this is despite evidence of Witness 2 who said that medication administration was paper based at the time.

[PRIVATE]

Ms Holgate submitted that there is therefore a risk of repetition of the same type of behaviour if Miss Firth were allowed to practice unrestricted. She submitted that it is not implausible to assume that Miss Firth may be placed in a similar situation in future in terms of being asked to cover a shift last minute. Ms Holgate submitted that there is limited information as to how Miss Firth would act differently. She referred to Miss Firth's reflective account in which she stated, *'I have become more adept at recognising my own abilities and am able to say no, even when put under pressure by the management team,'* but submitted that there is no further explanation as to what she would actually do if this situation was repeated. Ms Holgate submitted that the panel should find on the grounds of public protection that Miss Firth's practice was currently impaired. of public protection.

Ms Holgate submitted that a reasonable and properly informed member of the public would be concerned if Miss Firth were permitted to practise without some form of restriction. Ms Holgate invited the panel to make a finding of impairment on the ground of public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

The panel had regard to the terms of the Code in making its decision.

The panel was of the view that Miss Firth's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the Code to the extent that they were misconduct. Specifically:

'1 Treat people as individuals and uphold their dignity

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.

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

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.

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

20 Uphold the reputation of your profession at all times.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Charge 1

The panel considered that Miss Firth's conduct in relation to charge 1 constituted a significant breach of paragraphs 1.2, 13.4, 16.3, and 20. The panel noted that taking accountability for personal safety goes to a nurse's fitness for duty and ability to effectively deliver the fundamentals of care. The panel also noted that Miss Firth had ample

opportunity to notify the Regional or Home Manager that she was unfit for work, for example when they approached her in the dining room, but that she did not. The panel therefore determined that Miss Firth's actions at charge 1 were serious and fell short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 2

The panel considered that Miss Firth's conduct in relation to charge 1 constituted a significant breach of paragraphs 1.2, 1.4, 16.3, 19 and 20. Despite there being no evidence that actual harm was caused, the panel was of the view that administering medication is a fundamental requirement for the profession, and that delaying administration of medication can create a risk of harm, especially for vulnerable service users who are reliant on nurses. The panel therefore determined that Miss Firth's actions at charge 2 were serious and fell short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.
In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the*

public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel found limbs a, b, and c of *Grant* are engaged in this case.

The panel finds that residents were put at risk of harm as a result of Miss Firth's misconduct. It considered that Miss Firth's misconduct had breached the four elements of the Code (namely prioritising people, practising effectively, preserving safety and promoting professionalism) and brought the nursing profession's reputation into disrepute.

The panel was satisfied Miss Firth's misconduct in this case is capable of being remediated, however, having regard to the evidence before it, the panel was not satisfied that she has done so. The panel saw no evidence of additional training or education undertaken by Miss Firth. With regard to her current role, the panel bore in mind that she has not had any opportunity to strengthen her practice in regard to medication administration in her current role. The panel also noted that the only reflective piece they have received from Miss Firth is over three years old and is not comprehensive, and that it has no information relating to Miss Firth's future intentions. It would have been helpful to have had evidence about Miss Firth's current employment, particularly from her employer. [PRIVATE]. The panel could assess matters only on the basis of the evidence from four years ago, and Miss Firth's reflective piece from some three years ago. In light of this, and lack of evidence, the panel is ultimately of the view that there is currently a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Firth's fitness to practise impaired on the grounds of public interest.
Having regard to all of the above, the panel was satisfied that Miss Firth's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that Miss Firth's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

Ms Holgate informed the panel that in the Notice of Hearing, dated 19 December 2023, the NMC had advised Miss Firth that it would seek the imposition of a conditions of practice order for 12 months if it found Miss Firth's fitness to practise currently impaired. Ms Holgate submitted the following aggravating features of this case:

- That Miss Firth's misconduct was directly linked to clinical practice and there is no evidence of further training in medications administration or management.
- That Miss Firth was previously referred to NMC in 2019, which was dealt with by way of warning, and that this demonstrates a pattern of misconduct over time.

Ms Holgate submitted that, as a mitigating factor, Miss Firth has shown some reflection and limited evidence of insight. She submitted that it is up to the panel to attribute appropriate weight to this.

Ms Holgate submitted that taking no action would not be appropriate given the seriousness of this case. She submitted that no action would not adequately protect the public nor satisfy the public interest concerns identified in this case.

Ms Holgate submitted that for the panel to be satisfied that a caution order is the appropriate sanction it will need to be satisfied that Miss Firth has demonstrated sufficient

insight. Ms Holgate submitted that there is no evidence of developed insight in this case, nor is there any evidence that Miss Firth has strengthened her practice. Ms Holgate submitted that the misconduct found proved in this case is too serious to be dealt with by a caution.

Ms Holgate submitted that a conditions of practice order is the appropriate sanction in this case. She submitted that in Miss Firth's case there is no evidence of deep-seated attitudinal issues. Ms Holgate submitted that Miss Firth's misconduct goes to identifiable areas of practice that could be strengthened and addressed through retraining, namely medication administration and management. She submitted that there are workable and practical conditions that could be formulated to address the risks identified. Ms Holgate further submitted that while such conditions would protect the public and uphold professional standards, they would also support Miss Firth in her return to practice as a nurse. Ms Holgate submitted that a period of safe and effective practice is required in order to satisfy future panels that Miss Firth has fully remediated and has sufficient insight so as not to pose a risk of repeating this behaviour in the future. She therefore invited the panel to impose a conditions of practice order for 12 months.

Ms Holgate submitted that a suspension or a striking off order would be disproportionate in this case.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The misconduct is directly linked to clinical practice.

- Multiple patients were delayed receiving their medication and that this posed a potential risk of harm.
- No evidence of further training in medications administration or management.
- That Miss Firth was previously referred to the NMC in 2019 (over a matter in her private life).

The panel also took into account the following mitigating features:

- That this was an isolated incident occurring over one shift.
- That Miss Firth has provided reflection and insight, albeit limited.

[PRIVATE].

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

The panel 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 Miss Firth's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that a caution order would be inappropriate in view of the risks identified. The panel noted that there is no evidence that Miss Firth has developed insight. 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 Miss Firth's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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, as the misconduct was in relation to one shift and there is no other clinical concern in Miss Firth's lengthy career, it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that these incidents happened a long time ago. The panel was of the view that it was in the public interest that, with appropriate safeguards, Miss Firth should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that 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 Miss Firth's case because her misconduct is remediable. The panel considered there were elements of attitudinal issues in that Miss Firth walked out of shift after being asked not to, did not appear for interviews with the Home Manager twice, and has not fully engaged with NMC proceedings except for brief correspondence. However, the panel felt that it did not have sufficient evidence to suggest that these issues are deep-seated.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will address the risks identified, 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 determined 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 work to one substantive employer, which may be an agency, provided that you work at only one place of employment.
>
> 2. You must undertake assessed courses in medication administration and management. You must send your NMC case officer evidence of successful completion and indicative content of the courses upon completion.
>
> 3. You must be directly supervised by a registered nurse when administering medication until signed off as competent by a more senior nurse.
>
> 4. Once employed as a registered nurse, you must work with your manager, mentor or supervisor to create a Personal Development Plan (PDP) about medication administration and management. You must send your case officer a copy of your PDP prior to any review of this order.

5. You must meet once a month with your line manager or supervisor to discuss your progress towards achieving the aims set out in your PDP.

6. Seven days prior to any review of this order, you must send your case officer:

   a) A report from your line manager or supervisor showing your progress towards achieving the aims set out in your PDP, and your performance at work.
   b) A reflective piece outlining your insight in relation to the charges.
   c) [PRIVATE].

7. 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.

8. 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 that course of study.

9. 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.

10. 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.

11. 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 panel decided to make this order for a period of 18 months.

The panel considered that it might take some time for Miss Firth to meet the conditions it decided upon and so made the order for 18 months. The panel acknowledged that Miss Firth may be required to complete, and had said she was in the process of researching, a return to practice course and that this may need to be completed before she can return to practice. Miss Firth can, if she has reason to do so, apply for an early review of this order.

Before the order expires, a panel will hold a review hearing to see how well Miss Firth has 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.

Any future panel reviewing this case would be assisted by the following:

- Miss Firth’s full engagement and attendance at any future review hearings.
- If not employed as a nurse, but employed in the healthcare sector, a report from Miss Firth’s line manager as to her performance at work.

This will be confirmed to Miss Firth in writing.

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 Miss Firth’s own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Holgate who invited the panel to impose an interim conditions of practice order mirroring the sanction for a period of 18 months.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the risks identified in making the substantive order when reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible 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 Miss Firth is sent the decision of this hearing in writing.

That concludes this determination.