**Nursing and Midwifery Council**

**Fitness to Practise Committee**

**Substantive Hearing**

**Monday, 1 July 2024 – Wednesday, 10 July 2024**

Virtual Hearing

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| **Name of Registrant:** | Kevin John Brewer |
| **NMC PIN:** | 97I7687E |
| **Part(s) of the register:** | Registered Nurse Adult – Sub part 1<br>Level 1 – 25 September 2000 |
| **Relevant Location:** | Taunton |
| **Type of case:** | Misconduct |
| **Panel members:** | John Penhale (Chair, Lay member)<br>Timothy Kemp (Registrant member)<br>Michael Glickman (Lay member) |
| **Legal Assessor:** | Christopher McKay |
| **Hearings Coordinator:** | Eyram Anka |
| **Nursing and Midwifery Council:** | Represented by Ben Edwards, Case Presenter |
| **Mr Brewer:** | Present and represented by John Mackell, Counsel (instructed by the Royal College of Nursing (RCN)) |
| **Facts proved by way of admission:** | Charges 1(a), 5, 6(a), 6(b), 6(c)(iii) |
| **No case to answer:** | Charge 6(c)(ii) |
| **Facts proved:** | Charges 1(c), 2, 3(b)(iii), 3(c), 3(d), 4(a), 4(b) |
| **Facts not proved:** | Charges 1(b), 1(d), 3(a), 3(b)(i), 3(b)(ii), 6(c)(i) |

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| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 months)** |
| **Interim order:** | **Interim conditions of practice order (18 months)** |

**Details of charge**

That you, a registered nurse:

1) Between 8 August 2022 and 16 August 2022:

    a) Did not review and / or sign Resident A's daily records.

    b) Did not monitor Resident A's decline in fluids and increased drowsiness.

    c) Did not put in place the New Early Warning Score system for Resident A when it would have been clinically appropriate to do so.

    d) Did not escalate Resident A's decline in fluids and increased drowsiness when it would have been clinically appropriate to do so.

2) On 12 August 2022, gave Resident A's GP inaccurate information about Resident A's physical health in that you omitted to tell Resident A's GP that Resident A had begun declining food and fluids and sleeping for extended periods of time.

3) On 9 September 2022, when Resident B had been found on the floor with a skin tear:

    a) Did not conduct a body check despite the possibility of Resident B having suffered an unwitnessed fall.

    b) Did not:

        i) clean Resident B's wound with an antiseptic wipe or otherwise.
        ii) put Resident B's skin back into place.
        iii) take a photograph of Resident B's wound when dressing it.

c) Left Resident B on the floor for c.30 minutes.

d) Advised Colleague A to ‘leave her on the floor to calm down whilst I go and do patches for other resident’s’ or words to that effect.

4) On an unknown date, did not document and/ or investigate concerns from Colleague A regarding:

a) A senior member of staff documenting resident’s fluids when the resident was not receiving these fluids.

b) Mouthcare being documented for Resident B that had not taken place.

5) On 8 August 2022 after re-dressing Resident C’s pressure ulcer did not take a photograph of the wound when it would have been clinically appropriate to do so.

6) On 12 August 2022:

a) Categorised Resident C’s pressure ulcer as a category 1 when it was a category 3 or 4.

b) Recorded that Resident C’s pressure ulcer had improved when it had deteriorated.

c) Did not, when clinically appropriate to do so:

i) monitor Resident C more closely and / or
ii) change Resident C’s dressings more regularly and / or
iii) make a referral to the tissue viability nurse for Resident C.

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

**Background**

You were referred to the NMC on 21 October 2022 by the manager of Oake Meadows Care Home (the Home). You were employed as a registered nurse at the Home for three years until 23 September 2022, when you resigned.

The concerns raised were in relation to three incidents which occurred at the Home between August 2022 and September 2022.

Incident one relates to Resident A on 16 August 2022. Resident A was admitted to hospital where it was identified that she was severely dehydrated, and it appeared that she had not received any mouth care for some time. The deputy manager of the Home was made aware of this and began an internal investigation into the matters. The investigation included a review of Resident A's fluid charts from 8 August 2022 to 16 August 2022, care records and Medication Administration Record (MAR) charts. It was identified that you were the registered nurse on duty for the four consecutive days prior to Resident A's hospitalisation. It is alleged that you took no action when Resident A began declining food and fluids and sleeping for extended periods of time, between 9 August 2022 and 11 August 2022. It is alleged that you failed to give accurate information to the GP who reviewed Resident A on 12 August 2022 and as a result the GP did not ensure appropriate escalation.

Incident two relates to Resident B, who, on 9 August 2022 was found on the floor by a care assistant (Colleague A), after apparently having fallen out of bed. Resident B had a skin tear on her right elbow. It is alleged that you, as the nurse in charge on that shift, did not do a body check, use an antiseptic wipe, put the skin back into place or take a picture of the wound when you attended to Resident B. Colleague A alleges that you left Resident B on the floor whilst you attended to other residents. On 23 September 2022, the care assistant who found Resident B retrospectively raised a concern to the Home manager. It is alleged that you did not follow the Home's policy in regard to management of falls.

Incident three relates to Resident C, an individual who resided in the rehabilitation unit of the Home (Willow Unit). On 15 July 2022, Resident C had a pressure ulcer which was assessed as category 2. The ulcer improved and was assessed as category 1 on 28 July 2022 and during this time, photographs were taken of the ulcer. When the dressing was changed on 4 August 2022, a photograph was taken to evidence that there was a slight deterioration in the ulcer, however, it was not a significant change.

On 8 August 2022 you redressed the ulcer but did not take a photograph of the wound. In the evaluation record you stated there had been improvement and graded the ulcer as category 1. On 12 August 2022, you redressed the wound and took photographs which showed that the wound had deteriorated significantly and had become black and necrotic. You graded the ulcer as category 1 and recorded that the wound had improved. On 17 August 2022, the unit manager determined that the wound care had not been followed as per the Home's policy and that your documentation in this regard was inadequate.

On 23 September 2022, you resigned from the Home.

**Submissions on application of no case to answer**

At the close of the NMC's case, Mr Mackell made an application for no case to answer in respect of charges 2, 3(c), 3(d), 4(a), 4(b) and 6(c)(ii). This application was made under Rule 24(7).

Mr Mackell provided both oral and written submissions.

In his written submissions Mr Mackell asked the panel to consider each component part of the individual charges, the wording that has been settled and the decisions taken by the NMC. He reminded the panel that the burden and standard of proof lies with the NMC.

4. *'The test to consider whether there is a case to answer at the conclusion of the*

*NMC's evidence is best encapsulated in the case of R v Galbraith [1981] 1WLR 1039. The application of the test requires, in my submission, the panel to consider two key questions:*

- *Whether there is any evidence of the complaints raised; if not, the facts should be deemed not to have been proven.*
- *Whether the evidence taken at its' highest is such that a panel properly directed could not properly convict upon it; It is the Panel's duty in such circumstances to deem the facts not to have been proved.*

5. *The Panel is invited to review the charges set out above. The particulars of those charges require careful consideration when determining whether the evidence taken at its' height could lead the panel to find the facts proven. This application is primarily grounded in the second limb of Galbraith.*

*Charge 2:*

6. *At the outset of any consideration of Charge 2 the Panel is respectfully reminded that there is no direct evidence from any witness as to what was discussed between the Registrant and GP. The NMC has not advanced a statement from the GP indicating what they were or were not informed of. That is a significant break in the continuity of evidence.*

Mr Mackell submitted that you accept that you did not sign the notes, but you do not accept that you did not review the notes.

7. *Separately, the evidence in documentary form indicates that on the morning of 12th August Resident A consumed all their breakfast and thereafter consumed fluids. This is recorded at page 119 of the Exhibits Bundle. The previous template charts*

*for the dates leading up to the 12th August 2022 were all completed as the Resident was independently taking fluids. Concerns were not highlighted to this nurse that there was persistent failure to take food and fluids. There is no documented history from any of the notes that concerns were raised by the Nursing staff in handover or at any time regarding the intake of fluids or food. As such, the information provided to the GP could not have been inaccurate. In any event, the GP examined the Resident and did not raise concerns or implement changes to the care/treatment of this Resident.*

8. *Simply put, taken at its' height none of the witnesses can give evidence as to the content of the discussion between the GP and the Registrant.*

*Charges 3 (c) and 3(d):*

9. *The particular charges start from a premise that Resident B was left on the floor. In oral evidence from [Witness 4] it was confirmed that the Resident was on a 'crash mat' and not on the floor.*

10. *The witness confirmed that the floor and mat are two different things. In addition [Witness 1] confirmed in her witness evidence, her recollection, that the Resident had a separate mattress beside her bed. This is a position at odds with [Witness 4] in keeping with the evidence that will be provided by Mr. Brewer.*

11. *There is now no evidence that this Resident was left on 'the floor' by Mr. Brewer. At worst the Resident remained with [Witness 4] on a crash mat. The Panel are encouraged to view the wording of the settled charges. In the absence of evidence that the Resident was on the floor Charge 3 (c) ought to fall. The time that the Resident may have been on the floor is also seriously in doubt. The length of time referred to by [Witness 4] as around 30 minutes was clarified in evidence as perhaps feeling longer than it actually was. The Registrant records the accident*

*occurring at 18.40 with Next of Kin informed at 19.00. (pages 55-57 of the Exhibit bundle). No credible evidence has been advanced to contradict this chronology. Evidently, the Resident could not have been sitting for 30 minutes or anytime around that period given the available documentary forms. It must also be recognised that the Registrant completed the forms before a concern had been raised by [Witness 4] and would therefore not have known the significance of the timings of the incident i.e. 30 minutes on the floor etc. In any event it is not accepted that evidence has been provided from the only direct witness to the initial fall that the Resident was left on the floor.*

12. *In so far as Charge 3(d) is concerned there is insufficient evidence to support a contention that the Registrant referred to leaving the Resident 'on the floor' when all the evidence now suggests that the Resident was positioned on a mat, on the evidence of [Witness 4], or alternatively on a mattress such as the one confirmed by [Witness 1] as being present in the room. It is inconceivable that the Registrant said such words in the circumstances where the Resident was not located on the floor. This was not contradicted by [Witness 4] during her evidence.*

Mr Mackell submitted that it is important to note that in the Fall Reporting form dated 9 September 2022, there is no reference to Resident B being left on the floor and at the time the form was completed you would not have been aware of the significance of being on the mat or on the floor. You just set out what your recollection was, what you experienced and what you recorded in your notes.

*Charges 4a and 4b:*

13. *There is an absence of detail so far as these two charges are concerned. [Witness 4] agreed that she may not have been aware of the actions taken to investigate the concerns raised. As such, there is no witness available who can say that the Registrant did not investigate the concerns raised. It was put to the witness as to the separate actions taken by the Registrant when the concerns were raised.*

14. *The concern at 4b relating to mouthcare was relayed to the Night Nurse as it involved staff on the night shift. The witness agreed that such an action was appropriate. The action did not require to be documented. The charge asserts that the Registrant did not document and/or investigate. As such, there is an absence of evidence that the Registrant did not investigate the concerns and act upon them. As the Panel will be aware it is not for the Registrant to prove anything - the burden rests with the NMC. At the height of the evidence it has not been shown that the Registrant failed to investigate.*

15. *The concern at 4(a) appears to relate to fluid recording. Whilst the concern is not referred to in the NMC witness statement of [Witness 4] it is referred to in the in-house statement. It is unclear why this allegation, which forms a charge before the Panel, was not included in the statement. However, the actions taken by the Registrant were outlined to the witness and no contrary evidence was provided by her. As such, there is no evidence to contradict the position of the Registrant that such a concern raised was investigated. The Panel has not heard such evidence. The witness also referred to this concern as a general concern that did not only relate to the Registrant. In any event, it was denied by the Registrant and the investigation he undertook was explained to the witness and no contrary view outlined in evidence thereafter.*

16. *It has not been defined as to what an 'investigation' ought to look like. The information received from [Witness 4] was considered, followed up and actioned. The steps taken were appropriate in all the circumstances. No evidence is available to diminish or contradict that position.*

*Charges 6(c)(ii):*

17. *This charge indicates that when clinically appropriate the Registrant did not change the dressings 'more regularly'. It is fair to say that 'more regularly' is not defined. However, if one considers the available documentary evidence at page 195 the*

*Registrant is recorded as changing the dressing on 8th and 12th August 2022. This is in keeping with the care plan outlined at page 197 of the Exhibit bundle whereby the dressing is to be changed every 4 days. A photograph was taken on 12th August 2022.*

18. *The dressing was changed by another member of staff on 15th August 2022, at page 198 of the Bundle, a period of 3 days after the last dressing change. Photographs were also taken at that time. [Witness 3] records on 17th August 2022, at page 199, that a new wound assessment has been completed and the dressing is to be changed every 3 days. Before the 17th August 2022 the plan was for a change every 4 days. This was also the case on and after the 15th August 2022 when an entirely different member of nursing staff changed the dressing. That person has not provided a statement to the NMC however the records maintained by that Nurse do not reflect a requirement for the regularity of the dressing change to be amended. On what basis therefore is the NMC suggesting that this Registrant ought to have changed the dressing more regularly?*

19. *There is no evidential basis to support that position. The records do not support that position. The oral evidence of [Witness 3] seemed to suggest that on occasion daily changing may be required but this position is at odds with her onsite assessment on 17th August 2022. The glaring fact here is that another member of nursing staff changed the dressing and assessed the wound on 15th August 2022. When is it suggested that the regularity of dressing change ought to have been amended? There is no evidence advanced of that position.*

*Conclusion:*

20. *The Panel is referred to the case of Dutta v General Medical Council [2020] EWHC 1974 (Admin) paras 38-40 when assessing the available witness evidence:*

*In summary, we believe memories to be more faithful than they are. Two common*

*errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.*

*Memories are fluid and malleable, being constantly rewritten whenever they are retrieved.*

*21. I ask the Panel to review the wording and content of each charge settled upon by the NMC. The panel is asked to review each component part of the existing charges.*

*22. In light of the foregoing submissions and the absence of sufficient evidence demonstrated, I invite the Panel to declare that there is no case to answer and to determine that the facts have not been proven for each of the charges above.'*

Mr Edwards submitted that the NMC opposes the no case to answer application in respect of charges 2, 3(c), 3(d), 4(a), 4(b) and 6(c)(ii).

In assessing this application, the NMC invite the panel to not just consider the documentary evidence that has been highlighted by Mr Mackell but all the evidence within the exhibit bundle that is relevant to those particular charges. He asked that careful consideration be given to what was written in the care notes at the time of each incident and the appropriate steps that were taken or where appropriate steps were not taken. Further, he told the panel to take into account the policies of the Home that were relevant and in place at the time of the incidents. Mr Edwards asked the panel to also consider that you were the registered nurse on duty and the nurse in charge, more 'medically trained' than those that you were working with in the Home at that time. Therefore, there is a higher level of accountability and an expectation to make appropriate assessments of situations.

**Charge 2**

Mr Edwards submitted that the panel should first consider that you accepted charge 1(a). He submitted that he appreciates that Mr Mackell submitted in respect of charge 1(a), that you did not sign the daily record notes, but you did review them.

Mr Edwards referred the panel to the 12 August 2022 GP & Multidisciplinary Team Visit & Communication Record entry. He drew the panel's attention to the fact that there is no mention of any decline in Resident A's health or Resident A declining food and fluids and sleeping for extended periods of time. He asked the panel to consider why that information was missing from the record. Further, he referred to Resident A's daily care records dated 8 August 2022 to 12 August 2022 and submitted that the notes show that Resident A was declining more food and fluids each day. It was Mr Edwards' submission that if what Mr Mackell says is correct, that you reviewed Resident A's daily records but did not sign them, then you should have raised a concern about Resident A's continuous refusal of food and fluids, as the nurse in charge at the time.

Further, Mr Edwards submitted that if you had indeed reviewed Resident A's notes then you would have highlighted the concerns to the GP on 12 August 2022. Mr Edwards accepted that the panel has not had any information from the GP but submitted that the evidence is clear from carers who observed Resident A during the time relevant to the charge. Mr Edwards therefore submitted that there is sufficient evidence for the panel to conclude that there is indeed a case to answer, in respect of charge 2.

**Charges 3(c) and 3(d)**

Mr Edwards reminded the panel that Resident B was a particularly vulnerable resident, who was 101 years old.

Mr Edwards accepted what Mr Mackell submitted in relation to the meaning of '*[circa].30'* in charge 3(c). He invited the panel to consider that it means approximately 30 minutes.

He told the panel that the reason it is written as a *circa* is because Witness 4 said in her evidence that she thought it was around 30 minutes. He said that from the documentation the panel can conclude that it was at least 20 minutes and that is a lengthy period of time to leave a 101-year-old resident out of their bed, whether it be on the floor or on a mat.

Mr Edwards addressed Mr Mackell submission about the difference between Resident B being left on the floor and on a mat. He submitted that either option does not matter because Resident B should have been in her bed. He reminded the panel that Witness 4 said that Resident B was upset and distressed and could not be moved without the help of another person. Mr Edwards submitted that this adds credibility to charge 3(d) because it is alleged that you advised Witness 4 to '*leave her on the floor to calm down…*'. He told the panel that this suggests that this is what you said. He also submitted that from the evidence, the panel can conclude that you left the room for an extended period of time.

Mr Edwards asked the panel to consider the second limb of *Galbraith* to determine whether the evidence is tenuous. He submitted that the evidence is clear. Therefore, there is a case to answer in respect of charges 3(c) and 3(d).

**Charge 4(a) and 4(b)**

Mr Edwards referred the panel to relevant sections of Witness 4's witness statement where she expresses that her concerns about the care of other residents were not taken seriously by you. As a result, she escalated her concerns to Witness 1. Mr Edwards asked the panel to also consider Witness 4's internal statement, written at the request of Witness 1 on 23 September 2022.

Mr Edwards referred to Mr Mackell's submission that there is insufficient evidence before the panel to suggest that the concerns raised to you were not investigated. He told the panel that the only suggestion that you had addressed Witness 4's concerns came from Mr Mackell, on your behalf. He said that there was no mention of any investigation into the concerns in Witness 1's evidence. He referred to the relevant paragraph in Witness 1's

witness statement and told the panel that if you carried out an investigation into Witness 4's concerns about Resident B then as the Home manager, Witness 1 should have been aware of this and would have made some reference to it in her evidence but there is no mention of any investigation or documentation of those concerns.

When assessing charge 4(a), Mr Edwards submitted that the evidence suggests that you missed important points in relation to the health and wellbeing of residents. Mr Edwards accepted that charge 4(a) is not mentioned in Witness 4's statement, however, it was his submission that it does not cause difficulty because it was mentioned in her local statement and she was able to give oral evidence to that point. He also asked the panel to consider Witness 1's statement which confirms that Witness 4 indeed raised the concerns to her.

In the light of the above, Mr Edwards submitted that there is sufficient evidence to find a case to answer in respect of charges 4(a) and 4(b).

**Charge 6(c)(ii)**

Mr Edwards asked the panel to firstly consider your admissions made to charges 6(a), 6(b) and 6(c)(iii). He referred to Witness 3's witness statement as it relates to these charges. Mr Edwards submitted that you failed to assess the severe deterioration in Resident C's ulcer on 12 August 2022. He reminded the panel that when he asked about the expectation in terms of monitoring and perhaps changing the dressing for an ulcer at the stage Resident C's was at on 12 August 2022, Witness 3's suggested that it could be daily. Mr Edwards invited the panel to consider the policy that was in place at the time and the expectation that the ulcer should be checked more regularly which would involve, if clinically appropriate to do so, changing residents' dressings more regularly. Given that this was a category 3 or 4 ulcer and not a category 1 as wrongly categorised by you, it was Mr Edwards' submission that it would have been clinically appropriate to change Resident C's dressing more regularly.

Mr Edwards submitted that there is sufficient evidence to find a case to answer in respect of charge 6(c)(ii).

In response to Mr Edwards submissions, Mr Mackell submitted that the wording of the charges is determined by the NMC. It was  not disputed by either party at the beginning of this hearing.

Mr Mackell referred the panel to the wording of charge 2, *'On 12 August 2022, gave Resident A's GP inaccurate information…'*. He submitted that the evidence therefore requires the panel to know what information was given and no one has given any evidence as to the nature of the information and its accuracy. He told the panel that no one that was party to that discussion has given any evidence and the panel are not going to hear from the GP. Therefore, Mr Mackell asked the panel to consider how it could reach a threshold where inaccurate information is given. He submitted that it is a quantum leap to say that because something is recorded in a resident's notes, that it ought to have been shared with the GP and it affects the accuracy of the information that was shared.

Further, Mr Mackell addressed Mr Edwards' submissions on charge 3(c) and 3(d). He told the panel that based on the evidence, the incident happened at 18:40 and the next of kin was informed at 19:00, therefore the time was considerably less than 30 minutes. He submitted that the crux of the charge 3(d) is that Resident B was left on the floor. Mr Mackell told the panel that the mat is not the same as the floor. He said that the wording of the charge could have been amended but the NMC chose not to. He submitted that the panel did not hear any evidence from Witness 4 to say that Resident B was left on the floor. Further, he told the panel that it is inconceivable that one would say '*leave her on the floor*' when at no point was she sitting on the floor.

In relation to charge 4(a) and 4(b), Mr Mackell told the panel that no one required you to carry out a formal resolution or escalation of the concerns raised by Witness 4. He reminded the panel that the burden of proof lies with the NMC to prove that you did not investigate the concerns.

In respect of charge 6(c)(ii), Mr Mackell submitted that at no point has it been evidenced that you should have changed Resident C's dressings more regularly. Mr Mackell stated that Witness 3 made a comment in her oral evidence that on occasion this could be done daily but that was the only mention of it. He submitted what Witness 3 said in her oral evidence is at odds with the professional exercise of judgement and assessment and contemporaneous written record.

Mr Mackell asked the panel to consider the component parts of each charge and the wording when making its decision on whether there is a case to answer in respect of the proposed charges.

**Decision and reasons on application of no case to answer**

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in respect of charges 2, 3(c), 3(d), 4(a), 4(b) and 6(c)(ii).

**Charge 2**

The panel considered all the documentary and oral evidence, particularly the notes of internal investigation interview carried out by Witness 2 on 18 August 2022. The panel considered that you made an apparent admission during that interview and this evidence has not been questioned or challenged by Mr Mackell, on your behalf.

The panel determined that there is sufficient and credible evidence that could potentially support the charge at this stage. Therefore, it was not prepared, based on the evidence before it, to accede to the application of no case to answer.

**Charge 3(c) and 3(d)**

The panel considered all the documentary and oral evidence, particularly the notes internal investigation meeting carried out by Witness 1 on 23 September 2022, when you referred to Resident B being '*on the floor face down on the alert mat'*. The panel took the view that the argument about the difference between Resident B being left on the floor or the mat could not in itself be the reason why there is no case to answer in respect of charges 3(c) and 3(d). The intent of the charge was clearly that Resident B was left on the level to which she had fallen rather than being returned to bed.

The panel was satisfied based on the oral and documentary evidence that there is sufficient evidence to potentially find these charges proved. Therefore, it was not prepared, based on the evidence before it, to accede to the application of no case to answer.

**Charge 4(a) and 4(b)**

The panel considered all the documentary and oral evidence, particularly the notes of the internal investigation meeting carried out by Witness 1 on 23 September 2022, during which you appear to admit the allegations. Based on this evidence, the panel determined that there is sufficient evidence of a case to answer. Therefore, it did not to accede to the application of no case to answer.

**Charge 6(c)(ii)**

The panel carefully considered all the documentary and oral evidence and took the view that the evidence does not support a requirement for you to have changed Resident C's dressing more regularly on 12 August 2022. The panel determined that there was not a realistic prospect that it would find the facts of charge 6(c)(ii) proved. Therefore, the panel finds that in respect of charge 6(c)(ii), there is no case to answer.

**Decision and reasons on facts**

At the outset of the hearing, the panel heard from Mr Mackell, who informed the panel that you made full admissions to charges 1(a), 5, 6(a), 6(b), 6(c)(iii).

The panel therefore finds charges 1(a), 5, 6(a), 6(b), 6(c)(iii) proved in their entirety, by way of your admissions.

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

- Witness 1: Home Manager
- Witness 2: Deputy Home Manager
- Witness 3: Willows Unit Manager
- Witness 4: Care Assistant (Colleague A)

The panel heard evidence from you under affirmation.

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 Mr Edwards on behalf of the NMC and by Mr Mackell, on your behalf.

The panel noted that the internal investigation interviews carried out by the Home do not appear to have been conducted in accordance with best practice, in that you were not given formal notice, were not given the opportunity to be accompanied by a supporter or union representative and were returned to your shift immediately afterwards. The panel noted that you have given evidence that you felt 'overwhelmed'. However, as you have not disputed the accuracy of the interview notes, it determined that they could be taken as an accurate record of the discussions that took place.

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.

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 Mr Mackell.

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

**Charge 1b)**

"That you, a registered nurse, between 8 August 2022 and 16 August 2022:

b) Did not monitor Resident A's decline in fluids and increased drowsiness."

**This charge is found NOT proved.**

The panel took into account the documentary and oral evidence before it, particularly the care notes dated 12 August 2022. It also had regard to your admission in respect of

charge 1(a) in regard to not signing the notes. The panel also determined that you had not reviewed the notes.

In reaching its decision, the panel was of the view that reviewing a resident and monitoring them are two different things. It determined that 'to review' implies a formal documentation of a resident's condition after examining said resident, whereas the panel interpreted monitoring as informally checking on a resident's condition, which does not necessarily involve a formal record.

The panel took into account Resident A's care notes on 12 August 2022 which shows that Resident A's food and fluid intake was monitored and as you were the nurse in charge on that shift, the panel was satisfied that on the balance of probabilities, it is more than likely that you were the one that initiated it.

For these reasons, the panel decided that charge 1(b) is not proved.

**Charge 1c)**

"That you, a registered nurse, between 8 August 2022 and 16 August 2022:

c) Did not put in place the New Early Warning Score system for Resident A when it would have been clinically appropriate to do so."

**This charge is found proved.**

The panel took into account the Home's policy, Resident A's monthly observations/ New Early Warning System (NEWS) score and the internal investigation notes dated 18 August 2022.

The panel had regard to the Home policy on using the NEWS which states,

*'Clinical observations will also be commenced when a service user is diagnosed with an infection, becomes clinically unwell or their physical condition has changed and is of concern. This will be recorded on Care-FR-63 Clinical Observation Record (NEWS 2) and a score obtained which will indicate actions to be taken, and the urgency with which actions need to be taken'.*

The panel determined that as you initiated the recording of Resident A's fluid and food intake on the 12 August 2022 because you noted a deterioration in their condition and it was noted that Resident A appeared '*very hot*', you should also have initiated the NEWS score in accordance with the policy.

Accordingly, the panel found charge 1(c) proved.

**Charge 1d)**

"That you, a registered nurse, between 8 August 2022 and 16 August 2022:

d) Did not escalate Resident A's decline in fluids and increased drowsiness when it would have been clinically appropriate to do so."

**This charge is found NOT proved.**

The panel took into account Resident A's GP & Multidisciplinary Team Visit & Communication Record.
When considering this charge, the panel understood the word '*escalate*' to mean to refer or speak to someone more senior than yourself. It determined that there is evidence that you escalated the concern when you called the GP who came to check on Resident A on 12 August 2022. The panel did not have any evidence of what was said to the GP or the GP's notes, therefore could not determine the specifics of the escalation. However, it bore

in mind that this charge relates specifically to you escalating the concerns and it found that you did that by speaking to someone more senior than yourself.

The panel noted that in the internal interview conducted by Witness 2 on 18 August 2022, you confirm that you escalated Resident A's decline in fluids and increased drowsiness. However, the panel considered that you accept that you may not have told the GP about certain aspects of Resident A's condition because you were not aware of them.

For the reasons set out above, the panel concluded that it did not have sufficient evidence before it to find this charge proved.

**Charge 2)**

> "That you, a registered nurse, on 12 August 2022, gave Resident A's GP inaccurate information about Resident A's physical health in that you omitted to tell Resident A's GP that Resident A had begun declining food and fluids and sleeping for extended periods of time.

**This charge is found proved.**

In reaching this decision, the panel considered all the documentary and oral evidence and determined that the only evidence relevant to this charge is the note about the GP's visit on 12 August 2022 in Resident A's GP & Multidisciplinary Team Visit & Communication Record and your admissions in the internal investigation interview conducted by Witness 2 on 18 August 2022. The panel noted that the only information the Communication Record provided was that the GP made no changes to Resident A's treatment at the time. The panel does not have the GP's notes and therefore cannot determine what was said to the GP.

Further, the panel also had regard to the internal interview notes in which you made admissions to Witness 2 in respect of this charge. The panel noted that you said that you

did not hand over the concerns regarding Resident A's fluid and food intake and her extended periods of sleep as you were not aware of these concerns because you did not review Resident A's daily care records.

On the balance of probabilities, the panel is satisfied based on the evidence set out above, that you did not accurately inform the GP about Resident A's health. Accordingly, the panel found charge 2 proved.

**Charge 3**

Before considering this charge, the panel addressed the use of the word '*floor'* in the stem of this charge because it was a point of contention in Mr Mackell and Mr Edwards' submissions. The panel noted that the word *'floor'* was used in the internal investigation interview and that witnesses have used it interchangeably with *'mat'* and *'mattress'* throughout this hearing. The panel interpreted '*floor*' to mean at a level lower than the bed in accordance with its determination on the no case to answer application. The panel accepts that Resident B fell onto some type of mat or mattress and was not left in direct contact with the floor.

**Charge 3a)**

> "That you, a registered nurse, on 9 September 2022, when Resident B had been found on the floor with a skin tear:
>
> a) Did not conduct a body check despite the possibility of Resident B having suffered an unwitnessed fall."

**This charge is found NOT proved.**

In reaching this decision, the panel considered your documentary and oral evidence as well as the documentary and oral evidence of Witness 4.

The panel found it significant that Witness 4 does not mention a failure to carry out a body check in her witness statement or her statement of concerns about you to Witness 1. In fact, her statement of concerns does imply that you carried out a body check. It states,

> *'Kevin was the nurse in charge on my unit (Redwood) that day so once [Resident B] had been checked over he told everybody who was in the room that he could take it from here…'*

In addition to this inconsistency, Witness 4 was relatively inexperienced at the time and two weeks elapsed before she reported this incident.

The panel determined that there is insufficient evidence supporting this charge therefore the NMC failed to prove that you did not conduct a body check on Resident B after she had suffered an unwitnessed fall. Consequently, the panel find this charge not proved.

**Charge 3(b)(i) and 3(b)(ii)**

> "That you, a registered nurse, on 9 September 2022, when Resident B had been found on the floor with a skin tear:
>
> b) Did not:
>
> i) clean Resident B's wound with an antiseptic wipe or otherwise.
> ii) put Resident B's skin back into place"

**These charges are found NOT proved.**

In reaching this decision, the panel considered your documentary and oral evidence as well as the documentary and oral evidence of Witness 4.

The panel preferred your evidence over Witness 4's on the basis that Witness 4 was relatively inexperienced at the time and that she took two weeks to report these concerns. The panel noted that in relation to charge 3(a), it had found that Witness 4 had been inconsistent in her recollection of events. This also impacted on the panel's view of her evidence in relation to this charge.

The panel accepted your oral evidence when you stated that you went to the office to get a dressing, sterile saline and swabs to clean the wound. It considered that this account was plausible. However, it noted that your account contradicts Witness 4's oral evidence that you failed to properly clean the wound, although she confirmed that you went to the office and brought back a dressing.

The panel noted that Witness 4 said in her oral evidence that she was sitting with Resident B as you were dressing her wound and could see that you were not cleaning the wound correctly. However, you gave evidence that Resident B was holding her arm in a bent position so that it was difficult to access and the panel considered that this may have prevented Witness 4 from seeing what you were doing.

The panel had no information regarding the severity of the wound or the size of the skin flap, so it was unable to determine whether you could have cleaned the wound and replaced the skin flap without Witness 4 noticing. Although Witness 3 gave evidence that she cleaned and redressed the wound after you had applied your dressing, the panel considered that she could not have been certain what treatment had already been carried out.

In the light of the above, the panel determined that there is insufficient evidence for it to be able to conclude that on the balance of probabilities you did not *'clean Resident B's wound with an antiseptic wipe or otherwise'* and '*put Resident B's skin back in place'*. Therefore, the panel found charge 3(b)(i) and 3(b)(ii) not proved.

**Charge 3(b)(iii)**

"That you, a registered nurse, on 9 September 2022, when Resident B had been found on the floor with a skin tear:

b) Did not:

iii) take a photograph of Resident B's wound when dressing it."

**This charge is found proved.**

The panel found this charge proved on the basis that you made admissions to the charge in the course of your oral evidence.

**Charge 3c)**

"That you, a registered nurse, on 9 September 2022, when Resident B had been found on the floor with a skin tear:

c) Left Resident B on the floor for 30 minutes."

**This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence, Resident B's accident form dated 9 September 2022, and the documentary and oral evidence of Witness 3 and Witness 4.

The panel accepted Witness 4's evidence that Witness 3 had come to help her with Resident B after around 30 minutes. The panel carefully considered that the accident form states that the incident occurred at 18:40 and you informed Resident B's next of kin at 19:00, which implies that you had finished attending to Resident B by that time.

The panel noted that Mr Mackell suggested in his submissions that the accident form supports your account. However, the panel heard from Witness 3 and Witness 4 that Witness 3 redressed Resident B's wound and told you to complete the accident form and body map. Therefore, you were completing the paperwork according to their account. The panel took the view that the paperwork was therefore not necessarily contemporaneous as it was not completed by the clinician who carried out the treatment.

The panel heard in your oral evidence that you left Resident B for some time to finish your medication round for other residents. This account was corroborated by Witness 4's oral evidence. However, the dispute is regarding the amount of time that you left Resident B with Witness 4.

During your oral evidence, when the panel asked about how you were able to attend to Resident B, complete your medication round and call the next of kin in 20 minutes, you could not give the panel a clear explanation and repeatedly contradicted yourself regarding timings, claiming at one point that you had spent at least 25 minutes with Resident B before leaving to complete the medication round.

For these reasons, the panel did not accept your account in relation to the timings and determined that there is sufficient evidence to prove that you '*left Resident B on the floor for c.30 minutes*'. Accordingly, the panel found this charge proved.

**Charge 3d)**

> "That you, a registered nurse, on 9 September 2022, when Resident B had been found on the floor with a skin tear:
>
> d) Advised Colleague A to 'leave her on the floor to calm down whilst I go and do patches for other residents' or words to that effect."

**This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence and Witness 4's oral and documentary evidence.

The panel noted that you said repeatedly in oral evidence that Resident B was safe sitting on the mattress and often sat there to eat meals. You seemed to accept that she was left sitting on the mattress with Witness 4 for some time because you wanted to give her enough time to "*calm down*" and your only objection was to the word '*floor*'. The panel took into account that you accepted in your oral evidence that you could have given Witness 4 clearer instructions when leaving her with Resident B.

Therefore, the panel decided that on the balance of probabilities, it is more likely that not that you said something along the lines of '*leave her on the floor to calm down whilst I go and do patches for other residents' or words to that effect'*. Therefore, the panel found this charge proved.

**Charge 4**

> "That you, a registered nurse, on an unknown date, did not document and/or investigate concerns from Colleague A regarding:
>
> a) A senior member of staff documenting resident's fluids when the resident was not receiving these fluids.
>
> b) Mouthcare being documented for Resident B that had not taken place."

**This charge is found proved.**

In reaching this decision, the panel took into account the internal interview notes dated 23 September 2022. It also considered your documentary and oral evidence of the documentary and oral evidence of Witness 1 and Witness 2.

The panel considered that the only direct evidence related to this charge is in the internal interview that was conducted by Witness 1 on 23 September 2022. The panel noted that in the interview Witness 1 asked,

> *'Have you had a concern raised recently within the last day or two that a carer was concerned that mouthcare was being documented but again suspicions that that the oral care did not take place?... what have you done with that information?'*

The panel noted that you replied,

> *'Yes, it was [Witness 4]. Sorry I should have done something'*.

The panel noted that you gave evidence that you felt 'overwhelmed' during the interview. However, it was of the opinion that if you had investigated the concerns, you would have denied the allegation rather than admitting it and apologising.

The panel had no documentary evidence showing that you followed up on those concerns. Further, the panel noted that the only evidence you provided of an escalation was during your oral evidence when you stated that you spoke to the night manager about Resident B's mouthcare and determined that there were no concerns.

On the basis that you did not report the concerns to anybody, your admission in the internal interview that you had not investigated the concerns and the fact that the panel does not have any documentary evidence to support your account, the panel concluded that there is sufficient evidence to find this charge proved.

**Charge 6c)**

"That you, a registered nurse, on 12 August 2022:

c) Did not, when clinically appropriate to do so:

i) monitor Resident C more closely and/or..."

**This charge is found NOT proved.**

The panel could not determine what '*monitor*' and '*more closely*' means because it has not been given any evidence of how often Resident C's pressure ulcer should have been checked and what '*more closely*' would have involved. The panel therefore took the view that this particular charge is extremely vague and difficult to determine.

Further, the panel was not taken to a specific part of the Home policy which sets out what monitoring means and how often it should be done. Therefore, the panel could not find this charge 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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, your fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

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

Mr Edwards 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.

Mr Edwards submitted that on the basis of the charges found proved you have breached the following sections of the Code: 1.1, 1.2, 1.4, 3.1, 11.2, 11.3, 16.1, 16.4, 20.1.

Mr Edwards submitted that the misconduct is so serious that it falls below the standards expected of a registered nurse. It was his submission that the public would expect a nurse to provide competent care to their patients and take seriously any concerns raised to them. Mr Edwards took the panel through the specific charges found proved which are relevant to a finding of misconduct. He invited the panel to find that the charges found proved both individually and cumulatively amount to misconduct.

Mr Mackell provided both oral and written submissions. The following is a summary of his submissions.

1. *'Misconduct is a matter for the panel's professional judgment. The leading case is Roylance v GMC [2000] 1 AC 311 which says:*

   *"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 proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."*

2. *In Calhaem v GMC [2007] EWHC 2006 (Admin) Mr Justice Jackson commented on the definition of misconduct, and he stated:*

   *'it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'*

3. *Mr Justice Collins in Nandi v GMC [2004] EWHC 2317 (Admin) stated that:*

   *"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 practitioners."*

4. *As the case of Mallon v GMC [2007] ScotCS CSIH17 at [18] relays it is a matter for the panel in the exercise of their own skilled judgement on the facts and circumstances to determine whether there is misconduct.*

5. *The Registrant admitted Charges 1(a), 5, 6(a), 6(b) and 6(c)(iii) from the very outset of the proceedings. The Registrant has not sought to diminish the nature of those charges and accepts responsibility for his actions.*

6. *Separately, the Panel has found the following Charges proven: 1(c), 2, 3(b)(iii), 3 (c), 3(d), 4(a) and 4(b). The Registrant accepts the considered determination of the Panel.*

7. *The Registrant acknowledges that Misconduct is a matter for the panel to determine on the basis of the evidence presented and available.*

8. *The Panel is asked to consider the context within which these complaints have arisen. Complaints in relation to Residents A and C arose during a week when the Registrant was covering for annual leave, felt under pressure and unfamiliar with the working environment at that time.*

9. *These respective charges are consistent with a nurse under pressure to fully review notes and records, to carry out tasks on an unfamiliar Unit and undertake tasks which were not familiar to him. The Registrant accepts his professional errors and misjudgements on this occasion. The Registrant completed a reflection addressing these failings which is contained in the bundle.*

10. *The complaints in relation to Resident B arise from an unseen fall whereby the Registrant attended to assist whilst he was in the process of completing another clinical task. The complaints in essence for Resident B relate to a failure to take a photograph of the wound and leaving the Resident whilst he completed another clinical task. There is no suggestion that the Resident was left in harm's*

*way or was at risk of harm. The Panel has spent significant time considering the 'floor' element of the two index charges. This was at the corner stone of the position adopted by the Registrant in contesting those charges. The Registrant accepts that he ought to have assisted the Resident to bed before leaving to complete his other tasks.*

11. *The Panel refer to the in-house investigatory meetings. It is worth considering the approach of the Registrant in these meetings. The Registrant is not defensive or ostrich like. The Registrant was described by [Witness 2] in evidence as someone who admitted failings. The nature of the investigatory meetings is candid and frank. The complaints resonated with the Registrant when he spoke with management.*

12. *An ability to reflect, at the very first opportunity is a telltale sign of indicative insight. This is highlighted within the reflective piece but also within the choice of training courses completed. The Registrant identified courses that would suitably address his professional omissions and failings on this occasion.*

13. *Ancillary charges arising at charges 4a and 4b were not denied at investigatory meetings. The Registrant accepts his responsibility as a nurse to action concerns, to document such and to report such back to the original source of the concerns. This is good governance that the Registrant is committed to.*

14. *The Panel may wish to consider the case of Khan v Bar Standards Board [2018] EWHC 2184 where the person was not guilty of prof misconduct where they engaged in behaviour that is trivial, or inconsequential, or a mere temporary lapse, or otherwise excusable, or 'forgivable'. The behaviour in totality here is, I submit, forgivable. The insight is clear. The reflection submitted by the Registrant demonstrates insight, candour and offers genuine remorse. Harm or annoyance caused to a colleague was temporary. There is no evidence of*

*dishonesty or attitudinal concerns, and this is in keeping with a 20 year regulatory history of known good conduct.'*

**Submissions on impairment**

Mr Edwards 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).

Mr Edwards referred the panel to the 4 limbs of *Grant* (as referred to later in this determination) and submitted that limbs *a, b* and *c* are engaged in this case. He told the panel that limb *'d'* is not relevant to its considerations as there has been no suggestion or findings of dishonesty.

In relation to the limb '*a'*, Mr Edwards submitted that your conduct caused harm to Residents A, B and C. He reminded the panel that Resident A was admitted to hospital due to severe dehydration and acute kidney injury as a result of your actions and Resident B was left on the floor to calm down for around 30 minutes, which was inappropriate in those circumstances. Further, Mr Edwards said that Resident C could have suffered severe harm due to your inadequate management of the pressure ulcer, particularly in incorrectly assessing it.

In relation to limb *'b'*, Mr Edwards submitted that you have brought the nursing profession into disrepute through your repeated failings in relation to this case.

In respect of limb *'c'*, Mr Edwards submitted that you have breached multiple standards of the code as set out above.

Mr Edwards said that the panel may wish to consider the approach taken in the case of *Cohen v General Medical Council* [2007] EWCH 581 (Admin) when considering impairment. Based on *Cohen*, the panel would need to consider whether the concerns are remediable and the likelihood of the conduct being repeated.

Mr Edwards acknowledged that you have displayed some insight into your failings through your reflective statement dated 28 June 2024 and through the admissions your made at the outset of this hearing. He told the panel that you demonstrated some level of understanding into your failings and what led to your referral to the NMC. However, it was his submission that your reflective statement only relates to Residents A and C and is not enough for the panel to determine whether you have remediated the concerns and gained full insight so as to negate the need for a finding of impairment.

Further, he reminded the panel that during your oral evidence you repeatedly attempted to apportion blame to others for what happened to the residents, rather than looking at your own actions or inactions, particularly in relation to Resident A. It was Mr Edwards' submission that the tendency to blame others rather than take full accountability for those failings shows a significant lack of insight. He said that the panel may also consider whether you may have attitudinal issues based on you seeking to blame others rather than take responsibility for your failings. In addition, Mr Edwards submitted that your limited insight and understanding into the failings suggests that there remains a risk that the incidents found proved could be repeated in the future.

Mr Edwards acknowledged the training certificates and the positive reference you provided. However, he told the panel that they do not detract from the seriousness of your failings. Therefore, Mr Edwards invited the panel to find your fitness to practise impaired on public protection grounds.

Given the nature and seriousness of the charges found proved, Mr Edwards submitted that a finding of impairment on public interest grounds should also be made in this case, to declare and uphold proper standards of conduct and behaviour. It was his submission that

to not make a finding of impairment on public interest grounds would undermine public confidence in the nursing profession and the NMC as regulator.

Mr Mackell provided both oral and written submissions. His submissions on impairment were:

15. *Current impairment is not defined in the Nursing and Midwifery Order or the Rules. The NMC have defined fitness to practise as the suitability to remain on the register without restriction.*

16. *The panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin):*

    *"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:*

    *Has in the past, and/or is liable in the future to act as so as to put a patient or patients at unwarranted risk of harm;*

    *Has in the past, and/or is she liable in the future to bring the profession into disrepute;*

    *Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the profession;*

    *Has in the past, and/or is she liable in the future to act dishonestly."*

17. *As further stated at paragraph 74 of Grant, the Panel should:*

> *"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."*

18. *The Panel may also wish to consider Cohen v GMC [2008] case of Cohen v General Medical Council [2008] EWHC 581 (Admin) in which it was stated that:*

> *"... It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

19. *It is respectfully submitted that the conduct here is all remediable, has been remedied and is highly unlikely to be repeated.*

20. *As the Panel are aware an assessment of impairment has one eye on the future albeit made in the context of the past conduct of this case. These complaints arose from events leading up to conduct in August and September 2022. We are now 22 months post the events which led to the Registrant leaving his employment. The evidence of current impairment is naturally diminished by the passage of time. Whilst past conduct is relevant the assessment of impairment must be 'current'.*

21. *A finding of misconduct does not lead inexorably to a finding that the Registrant's fitness to practise is impaired.*

22. *The Panel is asked to consider the following when reaching a determination as to impairment, in line with the case of Grant -*

23. *There is no evidence that the Registrant has engaged in any acts of dishonesty. The Registrant's own actions did not ultimately place a patient at unwarranted risk of harm. The Registrant does not diminish his role in any way, his omissions and professional errors of judgment. The Registrant recognises, in particular with Resident A, he could have acted in a more expeditious manner with the NEWS score activation and that he has a responsibility to review written records fully and to provide a clear and sufficient handover to a GP prior to their rounds.*

24. *When considering other limbs of Grant there is a clear emphasis on whether conduct would be liable to be repeated. To answer that question in a fulsome manner it is helpful to look at the context of when these complaints arose, the actions taken by the Nurse since and the ordinarily positive regulatory career of the Registrant.*

25. *The panel are asked to give weight to the fact the Registrant was covering for a week period of annual leave, his unfamiliarity with the working environment, the task of managing the work tasks usually as the sole Nurse on duty and the clinically demanding environment. This is all the more evident when one considers the 20 year career of the nurse where he has not come to adverse regulatory nature of the NMC. Evidently, this is a competent and diligent Nurse operating as required, in so far as can be identified, by the regulator.*

26. *The Registrant resigned from his employment. The Registrant took up a post with a new employer 18 months ago. That employment has proved very productive. The Registrant has been promoted to the position of Deputy Manager and a positive testimonial is available from the employer. This demonstrates his competency, albeit in a non-nursing role. This role requires a good knowledge and understanding of policies and governance.*

27. *The Registrant has completed many training courses which seek to focus on professional development whilst also addressing concerns arising from these complaints. Courses are outlined in the Bundle and include; Wound and Pressure Sore care, Communication, Stress Management, Safeguarding, Fluids and Nutrition, Recording and Reporting. The Registrant is also upskilling and undertaking Management Qualifications. The Registrant enjoys the leadership role he currently undertakes and wishes to continue in this area of work. This has given him a better understanding of working with and communicating with team members more effectively.*

28. *The Registrant's reflective piece refers candidly to his approach. He states the following:*

    *"I take responsibility for my actions and recognise how I may have been able to do things differently. I sincerely apologise for my failures which emerged from feeling out of my depth and overwhelmed. I wish to give an assurance that I have learnt from these experiences and wish to take measures to ensure this never occurs again. I have worked in nursing since registration in 2000, I am proud to be a nurse and put my patients first. It is my deep and heartfelt regret that such incidents occurred over a very short period in an environment where I constantly felt overwhelmed and out of my depth and I intend to take whatever measures are necessary to ensure this never happens again. I am passionate about the welfare of patients in my care and deeply regret the effect my actions have had."*

29. *The available Testimonial from the current employer confirms the following:*

    *"I have had the pleasure of working closely with Kevin Brewer as the role of his Manager at Elm Tree House Residential Home since 23.2.2023 and ongoing*

*and can attest to their unwavering commitment to providing the highest standard of care to patients."*

30. *Separately, his current manager states:*

> *"He collaborate(s) effectively with other healthcare professionals and contribute(s) positively to the workplace environment. He has a willingness to assist colleagues whenever needed exemplify his dedication. He consistently displays honesty, reliability, and respect for all individuals, making him a role model for others in the healthcare field."*

31. *In these charges there in an absence of dishonesty nor there is any evident attitudinal issues or concerns. Evidently, the Registrant has shown insight and reflected on his conduct. The Registrant has a clear and unblemished regulatory record over 20 years. This conduct all relates to a short period of time in somewhat unusual circumstances. Additional training has been undertaken to remedy concerns, upskill and improve knowledge in the interim since August/September 2022. The Testimonial demonstrates a competent, hardworking and diligent member of staff. This is the current view of the Registrant's work manager.*

32. *As such the Panel is respectfully invited to find that the Registrant is not currently impaired.*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Rylance v General Medical Council* [1999] Lloyds Rep Med 139, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Cohen v General Medical Council* [2007] EWCH 581 (Admin).

**Decision and reasons on misconduct**

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically: 1.1, 1.2, 1.4, 3.1, 8.2, 8.5, 8.6, 10.1, 11.2, 11.3, 13.1, 13.2, 13.3, 16.1, 16.4, 20.1.

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

*To achieve this, you must:*

*1.1 treat people with kindness, respect and compassion*

*1.2 make sure you deliver the fundamentals of care effectively*

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

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

*To achieve this, you must:*

*3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.'*

*'**8 Work co-operatively***

*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 the event, recording if the notes are written some time after the event.'*

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

*To achieve this, you must:*

*11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*

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

*'**13 Recognise and work within the limits of your competence***

*To achieve this, you must:*

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

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

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

*'**16 Act without delay if you believe that there is a risk to patient safety or public protection***

*To achieve this, you must:*

*16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels*

*available to you in line with our guidance and your local working practices*

*16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.'*

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

*To achieve this, you must:*

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

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

**Charge 1(a) and 1(c)**

In deciding whether these charges amounted to misconduct, the panel considered that your failure to properly review the daily care records and put in place the NEWS system at an earlier stage was a significant contributing factor to Resident A being hospitalised. The panel determined that your actions led to the actual harm of Resident A. The panel found that you have breached the following sections of the Code: 1.2, 1.4, 3.1, 8.2, 8.4. Therefore, it determined that your actions were so serious that they amounted to misconduct.

**Charge 2**

The panel had regard to your admission to not handing over the concerns regarding Resident A's fluid and food intake and becoming *'very sleepy'* to the GP because you had not reviewed the daily care records. The panel took the view that you put Resident A at risk of deterioration. The panel found that you have breached the following sections of the Code: 1.4, 2.1, 3.1, 8.2, 8.3, 10.1, 13.1. Therefore, it determined that your actions in respect of charge 2 were so serious that they amounted to misconduct.

**Charge 3(b)(iii), 3(c) and 3(d)**

3(b)(iii)

The panel took the view that failure to take photographs of a wound that was otherwise documented was a relatively minor failure and does not amount to misconduct.

3(c)

The panel considered that it was not best practice to leave Resident B *'on the floor for c.30 minutes*.' However, on the evidence, the panel took the view that you used your clinical judgement based on Resident B's prior habits of often sitting and sometimes having meals on the mattress. It determined that leaving Resident B on the mattress in the care of Witness 4 was not a serious failure on your part and does not amount to misconduct.

3(d)

The panel took the view, based on your oral evidence, that you were acting in the best interests of Resident B, although it may not have been best practice. It considered the words of the charge, particularly, the phrase '*words to that affect'* and determined that you probably said something that conveyed the same meaning. The panel was of the view that that communication was in keeping with acting in the best interests of Resident B. It noted in assessing this charge contextually, there could be valid professional reasons for acting in this way. For these reasons, the panel found that your actions in respect of charge 3(d) were not a serious failure on your part and do not amount to misconduct.

The panel found that your actions breached the following sections of the Code: 1.1, 8.2, 10.1, 11.1, 11.2, 11.3. However, the panel decided that the actions in charge 3(b)(iii), 3(c) and 3(d) were not sufficiently serious as to amount to misconduct.

**Charge 4**

The panel determined that by not escalating, investigating or taking other appropriate action with information which could have directly impacted on resident wellbeing you put the residents at risk of harm. It took the view that failing to act in those circumstances, is such a serious failure that it amounts to misconduct. The panel found that your actions breached the following sections of the Code: 8.6, 8.5, 16.1, 16.4.

**Charge 5**

The panel took the view that not taking a photograph of the pressure ulcer when it was clinically appropriate to do so was a failing and an omission but on its own, it is not such a serious failure to amount to misconduct.

**Charge 6(a), 6(b) and 6(c)(iii)**

The panel determined that your actions in charges 6(a), 6(b) and 6(c)(iii) constituted a serious error which could have led to patient harm. Although recording the wrong category for the pressure ulcer could have been a simple clerical error, stating that it was *'improving'* was a significant failure. Therefore, the panel decided that your actions in regard to these charges amount to misconduct. The panel found that your actions breached the following sections of the Code: 13.1, 13.2, 13.3, 16.2.

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

**Decision and reasons on impairment**

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

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.'*

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

d) *...'*

The panel determined that limbs *a, b* and *c* of Grant are engaged when considering the past. The panel had regard to the actual harm that was caused to the residents, namely Resident A and Resident C. The panel found that your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. particularly when taking into consideration a nurse not escalating concerns, not adequately reviewing care records and not correctly assessing a pressure ulcer. The panel found that your conduct fell significantly below the standards expected of a registered nurse.

The panel acknowledged that you made some admissions at the outset of this hearing. It determined that you demonstrated developing insight and understanding of your misconduct.

The panel was satisfied that the misconduct in this case is capable of being remedied. The panel carefully considered the evidence before it in determining whether you have taken steps to strengthen your practice. The panel took into account your reflective statement dated 28 June 2024, the positive testimonial from your current manager and the certificates relating to relevant training that you have undertaken. It considered that you are not currently working in a clinical nursing role. It took the view that because you have not worked in a highly pressurised clinical setting since the incidents occurred, you have not had the opportunity to adequately address the concerns identified.

The panel noted that the concerns arising from the charges are not a failure of clinical knowledge or attitudinal issues. They are a result of a lack of assertiveness, and confidence in speaking up when you feel *'overwhelmed'* and asked to undertake clinical tasks that you do not feel competent in practising. This has been a consistent theme through all these charges and only too evident during this hearing. The panel is of the view that these concerns are challenging to overcome and whilst you have taken some steps on that journey they are not remediated at this time. Therefore, the panel was not convinced that matters of the kind found proved would not be repeated in the future. It therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because of your misconduct and the risk of repetition. 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 finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

**Sanction**

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your 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**

Mr Edwards submitted that a conditions of practice order is appropriate in light of the panel's findings.

Mr Edwards invited the panel to consider the following aggravating factors in this case:

- You caused harm to Resident A which resulted in her hospitalisation.
- Your actions put other residents at risk of harm.

Mr Edwards invited the panel to consider the following mitigating factors in this case:

- You demonstrated developing insight.
- There have been no other concerns were raised in relation to your practice since this referral.
- The positive testimonial from your manager.
- You have shown that you have taken steps to strengthen your practice by undertaking relevant training.

Mr Edwards submitted that a conditions of practice order is the most appropriate and proportionate order to protect the public and serve the wider public interest. Mr Edwards

referred to the panel's decisions and reasons on impairment and submitted that steps need to be taken to ensure that the concerns identified are sufficiently addressed. He asked the panel to consider the following conditions:

- A personal development plan (PDP) should be put in place
- Regular meetings with a line manager to assess your progress in relation to the PDP and a report should be sent to the NMC for a future reviewing panel.

Mr Edwards invited the panel to impose a conditions of practice order for 12 months with a review at the end of that period.

Mr Mackell provided both oral and written submissions. His submissions on sanction were:

3. *'The Registrant accepts that, as per the case of Fatnani v GMC [2007] EWCA Civ 46,*

   *'a principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice'.*

4. *The panel is respectfully referred to the oft quoted case of Giele v GMC [2005] EWHC 2143 (Admin). The presiding Judge opined that the maintenance of public confidence in the profession must outweigh the interests of the individual doctor. If I can paraphrase 'but that confidence will surely be maintained by imposing such sanction as in all the circumstances appropriate. Thus, in considering the maintenance of confidence,* ***the existence of a public interest in not ending the career of a competent Nurse, will play a part.'***

*History:*

8. *The Registrant was first registered as a Nurse in 2000 and has spent over 20 years working as a nurse. The Registrant continues to work in the health and social care sector. The Registrant enjoys a clear regulatory record with the*

*NMC. There have been no findings of a regulatory nature previously. As we sit today the Registrant has a clear regulatory record in so far as findings, save for these index matters. It is submitted that the Registrant's employment and professional history demonstrates that this nurse is one who is competent, hardworking and dedicated to his patients.*

9. *The Panel has access to a testimonial from the Registrant's current employer. The Reference were freely given with the provider aware of the ongoing proceedings.*

10. *The reference refers as follows: I have had the pleasure of working closely with Kevin Brewer as the role of his Manager at Elm Tree House Residential Home since 23.2.2023 and ongoing and can attest to their unwavering commitment to providing the highest standard of care to patients.*

11. *The Registrant is further described as someone who "collaborate(s) effectively with other healthcare professionals and contribute(s) positively to the workplace environment. He has a willingness to assist colleagues whenever needed exemplify his dedication. He consistently displays honesty, reliability, and respect for all individuals, making him a role model for others in the healthcare field."*

12. *In keeping with Giele is there any public interest in ending the career of such a Nurse?*

*Approach of the Registrant:*

13. *The Registrant from the very outset accepted a number of charges faced. The approach of the Registrant was not ostrich like. The Registrant further accepted wrongdoing and took responsibility for his actions at a very early opportunity during in-house investigatory meetings.*

14. *Often, the Panel will be all too aware, a Registrant may seek to minimise their role in potential regulatory misconduct. It is not uncommon for blanket denials to be issued to allegations and for less than complete co-operation to be demonstrated. The complete opposite was evident in this case during the in-house investigations. A free acceptance of many of the concerns was evident from the very earliest engagement.*

15. *This approach supports the contention that the Registrant took the matter seriously, recognised the significance of the complaints raised and has demonstrated both insight and remorse.*

*Dishonesty and Attitudinal Concerns:*

16. *There is an absence of dishonesty or deep seated attitudinal concerns from the charges on this occasion.*

17. *The misconduct and Impairment identified relate to, in the submission of the Registrant, matters which can be remedied and where the risk can be suitably managed.*

*Insight:*

18. *The Registrant has set out how he has learned from this episode in his reflection. The Nurse has learned from this experience, completed training modules to address the concerns identified from these complaints. The Nurse has had the best part of 2 years to reflect on his actions.*

19. *The Reflection from the Registrant provide further information demonstrating insight as follows:*

*"I take responsibility for my actions and recognise how I may have been able to do things differently. I sincerely apologise for my failures which emerged from feeling out of my depth and overwhelmed. I wish to give an assurance that I have learnt from these experiences and wish to take measures to ensure this never occurs again.... It is my deep and heartfelt regret that such incidents occurred over a very short period ...I intend to take whatever measures are necessary to ensure this never happens again. I am passionate about the welfare of patients in my care and deeply regret the effect my actions have had..."*

*Impact on Registrant:*

20. *The Registrant has paid a toll to date because of the complaints raised against him. The Registrant resigned his employment and was unable to secure employment for a period of months. The Registrant has also ruminated on the complaints and has found the proceedings to be stressful. The Panel will understand the impact that proceedings will naturally have on a nurse. The Registrant is keen to move on with his career in a manner that is suitable and acceptable to the panel.*

21. *Evidently, the Registrant has faced significant challenges and endured damage to his reputation and career as a result of these proceedings. Such submissions don't seek to diminish the misconduct and impairment found however it is simply a way of assisting the Panel when determining what may be a proportionate outcome to the matter when considering all relevant factors engaged in this case.*

*Outcome:*

22. *As the Panel is all too aware there is a familiar and well-trodden path to consider a step-wise approach to sanctions. In that regard the Panel is encouraged to consider lesser sanctions before imposing a greater sanction.*

23. *On this occasion, the Panel will no doubt wish to reflect the misconduct found and the circumstances surrounding the complaints arising. The public no doubt expect nurses to adhere to appropriate standards of conduct.*

24. *The Registrant has worked for 18 months in a non Nursing role. This step was taken by the Registrant as he was unable to secure employment with the Interim Order in place.*

25. *The Panel found in their determination on Impairment: "The panel was satisfied that the misconduct in this case is capable of being remedied."*

26. *Separately, the Panel set out that the concerns in this instance: "are a result of a lack of assertiveness, and confidence in speaking up when you feel 'overwhelmed' and asked to undertake clinical tasks that you do not feel competent in practising. This has been a consistent theme through all these charges and only too evident during this hearing."*

27. *The concerns in this case can all be remedied. There is a clear indication from the facts of this case that additional support and supervision may be needed for the Registrant to effectively practice as a nurse, for a period of time. There may be issues around resilience, exerting oneself and effective communication. Suitable training may address such concerns along with conditions of practice. It may be that the panel considers it appropriate for the Registrant to be subject to indirect supervision where the presence of a mentor or manager will assist the Registrant when performing clinical tasks. Overall, these concerns ought to be viewed through a prism of 20 years of sound clinical service delivery.*

28. *A period of suspension will make it more difficult for the Registrant to return to nursing practice shortly and gain the required additional experience to demonstrate to the public and indeed the Regulator that confidence can be maintained. The Registrant accepts without challenge that it is entirely a matter for the Panel to determine a proportionate sanction in this matter.*

29. *There is no evidence of deep seated attitudinal or personality problems in this case. Separately, the Registrant has shown good and developing insight to the reasons which led to the poor judgment exhibited. The Registrant is agreeable to work with any conditions. In the absence of any general clinical competency issues raised by the facts of this case it is submitted that a Conditions of Practice Order is a proportionate outcome to the case.*

30. *Conditions could be put in place that are workable, relevant and measurable in this instance to address concerns identified.'*

The panel accepted the advice of the legal assessor.

**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:

- Your conduct caused actual harm to residents.
- The residents were vulnerable.

The panel also took into account the following mitigating features:

- You made some early admissions in the internal investigation and at this hearing.
- You have had an otherwise unblemished 20-year career.
- You have displayed evidence of developing insight.
- You have taken steps to strengthen your practice by way of relevant training.
- Your current line manager has provided a positive testimonial.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the public protection issues identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action, nor would it protect patients and the public.

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 you're 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, nor would it protect patients and the public.

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;*
- *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 it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents happened over a short space of time when the panel accepts you were under pressure and in an unfamiliar clinical setting and that, other than these incidents, you have had an unblemished 20-year career as a registered nurse. 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 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 your case. The panel determined that it could manage patient safety with a conditions of practice order. It considered that the identified areas of professional development cannot be addressed if you were not permitted to practice. The panel took the view that imposing a suspension order or a striking off order would be inconsistent with its findings.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order 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 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. This must not be through an agency.

2. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of working at all times on the same shift and in the same building as, but not always directly observed by another registered nurse.

3. You must work with your line manager/mentor/supervisor [who must be a registered nurse] to create personal development plan which must address the concerns raised about:

    - Escalating concerns about a deteriorating patient
    - Pressure ulcer and wound management and recording.
    - Record keeping.
    - Your ability to work under pressure.

    You must send your case officer a copy of your PDP within 2 weeks of commencing employment.

4. You must meet with your line manager/mentor/supervisor [who must be a registered nurse] at least every 2 weeks to discuss your progress towards achieving the aims set out in your PDP and your general clinical performance.

5. You must send your case officer a report from your line manager/mentor/supervisor [who must be a registered nurse] quarterly and prior to any NMC hearings which details your progress toward achieving the aims set out in your PDP and your general clinical performance.

6. You must not undertake wound care (including those that have resulted from pressure areas) unless supervised by another registered nurse (except in life threatening emergencies) until you are assessed as competent by your line manager to practise independently. Your supervision must consist of:

    - One to one support
    - Observation
    - Written reflection and log of the care you have provided. This must be signed by another registered nurse each time and contain feedback on how you gave the care and identify areas for further development.

    You must send your NMC case officer a copy of this report quarterly and prior to any review.

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 employers you apply to for work (at the time of application).
   c) 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 period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to assess your compliance with the order and gauge progress. 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.

**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.

**Submissions on interim order**

Mr Edwards invited the panel to impose an interim conditions of practice order for a period of 18 months. Given the sanction the panel decided to impose, it was Mr Edwards' submission that it is both necessary and proportionate to impose an interim conditions of practice order (with the same conditions as the substantive conditions of practice order) to cover any potential appeal period.

Mr Mackell submitted that imposing an interim conditions of practice order with the same conditions as the substantive sanction would not prejudice you. He left the decision up to the panel.

**Decision and reasons on interim order**

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

The panel concluded that 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 to allow for the appeal period as not to do so would be inconsistent with its previous findings. In making this order, the panel took account of the impact the order will have on you and is satisfied that this order, for this period, is appropriate and proportionate.

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.