**Nursing and Midwifery Council**

**Fitness to Practise Committee**

**Substantive Hearing**
**Wednesday, 24 July 2024**

Virtual Hearing

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| **Name of Registrant:** | **Member Iorhom** |
| **NMC PIN:** | 21C1179O |
| **Part(s) of the register:** | Registered Nurse - Sub part 1<br>Adult nurse, level 1 (23 March 2021) |
| **Relevant Location:** | Edinburgh |
| **Type of case:** | Misconduct & Lack of competence |
| **Panel members:** | Elliott Kenton (Chair, Lay member)<br>Purushotham Kamath (Registrant member)<br>Caroline Taylor (Lay member) |
| **Legal Assessor:** | Michael Hosford-Tanner |
| **Hearings Coordinator:** | Eyram Anka |
| **Nursing and Midwifery Council:** | Represented by Mary Kyriacou, Case Presenter |
| **Mr Iorhom:** | Present and represented by Simon Holborn, Humans Ltd |
| **Consensual Panel Determination:** | Accepted as Amended |
| **Facts proved by way of admission:** | The whole of charges 1 and 2 |
| **Fitness to practise:** | Impaired |

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|---|---|
| **Sanction:** | **Conditions of practice order (18 months)** |
| **Interim order:** | **Interim conditions of practice order (18 months)** |

**Details of charge (as amended)**

That you, a registered nurse:

1. Between October 2021 and 25 March 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a band 5 nurse in that you:

    a) On 14 October 2021:
        i) Failed to take action upon being informed a patient's human albumen was available for collection.
        ii) Were unable to identify how to take blood for blood gas analysis.

    b) On 19 October 2021 failed to check a patient's ventilator alarms in a timely manner.

    c) On 28 October 2021:
        i) Failed to escalate a patient's high blood pressure alarm.
        ii) Failed to act promptly when instructed to apply a 'Bair hugger' to a patient.

    d) On 1 November 2021 failed to administer anti-epileptic medication to a patient.

    e) On 4 November 2021:
        i) Failed to administer a patient's 10am dose of Pancrex.
        ii) Failed to use a second checker before connecting a new bottle of Propofol to a patient's infusion machine.
        iii) On more than one occasion failed to respond to alarms.

    f) On 18 November 2021:

i) Failed to carry out the specific suctioning procedure on a patient as instructed.
ii) Incorrectly recorded that a patient was not in pain.

g) On 22 November 2021 failed to deal appropriately with a patient's oxygen alarm.

h) On 23 November 2021 failed to deal appropriately with a patient whose oxygen saturation was dropping.

i) On 25 November 2021:
i) Failed to compare patient breaths with ventilator breaths.
ii) Were unable to distinguish PICC lines from PICCO lines.
iii) Had to be prompted to add observations to patient notes.
iv) Failed to respond to alarms.
v) Had to be prompted to hand over all relevant aspects of care during handover.

j) On 29 November 2021 failed to identify that a patient was extremely ill.

k) On 9 December 2021:
i) Removed the oxygen connector from an adjacent bed space without replacing it.
ii) Failed to respond to alarms.
iii) Were unable to explain a patient's status to the surgeon doing rounds.

l) On an unknown date in 2022:
i) Failed to escalate a patient's early warning score of 5.
ii) Incorrectly place 2g of Vancomycin in a patient's IV bag when the correct dose was 1.5g.

m) Inappropriately slept whilst on duty on the following dates:

i) 15 January 2022.

ii) 16 January 2022.

iii) 31 January 2022.

n) On 5 to 6 February 2022, inappropriately slept overnight on the ward.

o) On 10 February 2022:

i) Failed to escalate a patient's early warning score of 6.

ii) Failed to take full observations on a new patient.

2. Having accepted undertakings on 2 March 2023, failed to comply with said undertakings in that you failed to notify the NMC of an internal investigation commenced by your employer on 25 April 2023 in breach of undertaking 4.

AND in light of charge 1 above, your fitness to practise is impaired by reason of your lack of competence.

AND in light of charge 2 above, your fitness to practise is impaired by reason of your misconduct.

**Consensual Panel Determination**

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

Ms Kyriacou made a preliminary application to amend the charges as set out in the CPD. Mr Holborn accepted the amendments on your behalf.

The panel accepted the advice of the legal assessor.

The panel approved the application to amend the charges.

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

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

That provisional CPD agreement reads as follows:

> *'The Nursing & Midwifery Council ("the NMC") and Member Iorhom ('Mrs Iorhom'), PIN 21C1179O ("the Parties") agree as follows:*
>
> …

***Preliminary issues***

2. *In accordance with Rule 28 of the Rules, the parties apply to amend charges 1(c) [stem], 1(c)(ii), 1(e)(ii), 1(e)(iii), and 1(i)(ii).*

   *<u>Charge 1(c) [stem] and 1(c)(ii).</u>*

3. *Charge 1(c) [stem] and 1(c)(ii) included in the notice of hearing is as follows:*

   *c) Between 27 and 28 October 2021:*
      *i) Failed to act promptly when instructed to apply a 'bear hugger' to a patient.*

4. *The parties apply to amend these charges as follows:*

   c) ~~*Between 27 and*~~ ***On*** *28 October 2021:*

      i) *Failed to act promptly when instructed to apply a '~~bear~~* ***Bair*** *hugger' to a patient.*

5. *The amendment correctly states the date on which the alleged incident took place, and the correct proprietary name of the equipment involved.*

*Charges 1(e)(ii) and (e)(iii).*

6. *Charge 1(e)(ii) and (e)(iii) included in the notice of hearing are as follows:*

   ii) *Failed to use a second checker when checking the correct medication was being administered to a patient.*

   iii) *On more than one occasion failed to respond to ventilator alarms.*

7. *The NMC applies to amend these charges as follows:*

   ii) *Failed to use a second checker ~~when checking the correct medication was being administered to a patient~~* ***before connecting a new bottle of Propofol to a patient's infusion machine.***

   iii) *On more than one occasion failed to respond to ventilator alarms.*

*Charge 1(i)(ii)*

8. *Charge 1(i)(ii) included in the notice of hearing is as follows:*

   ii) *Were unable identify PICC and PICCO lines for medication infusion.*

9. *The Parties apply to amend this charge as follows:*

   ii) *Were unable ~~identify~~* ***to distinguish*** *PICC* ***lines from*** *~~and~~ PICCO lines ~~for medication infusion~~.*

10. *The amendments for charges 1(e)(ii), (e)(iii), and (i)(iii) particularise the misconduct more clearly.*

11. *The Parties agree that the amendments do not materially change the nature of the charges and thus do not cause any prejudice to Mrs Iorhom.*

***The charge***

12. *Mrs Iorhom admits the following charges (as amended):*

*That you, a registered nurse:*

1. *Between October 2021 and 25 March 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a band 5 nurse in that you:*

a) *On 14 October 2021:*
   i) *Failed to take action upon being informed a patient's human albumen was available for collection.*
   ii) *Were unable to identify how to take blood for blood gas analysis.*

b) *On 19 October 2021 failed to check a patient's ventilator alarms in a timely manner.*

c) *On 28 October 2021:*
   i) *Failed to escalate a patient's high blood pressure alarm.*
   ii) *Failed to act promptly when instructed to apply a '*[Bair] *hugger' to a patient.*

d) *On 1 November 2021 failed to administer anti-epileptic medication to a patient.*

e) *On 4 November 2021:*
   i) *Failed to administer a patient's 10am dose of Pancrex.*
   ii) *Failed to use a second checker before connecting a new bottle of Propofol to a patient's infusion machine.*
   iii) *On more than one occasion failed to respond to alarms.*

f) *On 18 November 2021:*
   i) *Failed to carry out the specific suctioning procedure on a patient as instructed.*
   ii) *Incorrectly recorded that a patient was not in pain.*

g) *On 22 November 2021 failed to deal appropriately with a patient's oxygen alarm.*

h) *On 23 November 2021 failed to deal appropriately with a patient whose oxygen saturation was dropping.*

i) *On 25 November 2021:*
   i) *Failed to compare patient breaths with ventilator breaths.*
   ii) *Were unable to distinguish PICC lines from PICCO lines.*
   iii) *Had to be prompted to add observations to patient notes.*
   iv) *Failed to respond to alarms.*
   v) *Had to be prompted to hand over all relevant aspects of care during handover.*

j) *On 29 November 2021 failed to identify that a patient was extremely ill.*

k) *On 9 December 2021:*

i) *Removed the oxygen connector from an adjacent bed space without replacing it.*
ii) *Failed to respond to alarms.*
iii) *Were unable to explain a patient's status to the surgeon doing rounds.*

l) *On an unknown date in 2022:*
i) *Failed to escalate a patient's early warning score of 5.*
ii) *Incorrectly place 2g of Vancomycin in a patient's IV bag when the correct dose was 1.5g.*

m) *Inappropriately slept whilst on duty on the following dates:*
i) *15 January 2022.*
ii) *16 January 2022.*
iii) *31 January 2022.*

n) *On 5 to 6 February 2022, inappropriately slept overnight on the ward.*

o) *On 10 February 2022:*
i) *Failed to escalate a patient's early warning score of 6.*
ii) *Failed to take full observations on a new patient.*

2. *Having accepted undertakings on 2 March 2023, failed to comply with said undertakings in that you failed to notify the NMC of an internal investigation commenced by your employer on 25 April 2023 in breach of undertaking 4.*

*AND in light of charge 1 above, your fitness to practise is impaired by reason of your lack of competence.*

*AND in light of charge 2 above, your fitness to practise is impaired by reason of your misconduct.*

***The Facts***

13. *Mrs Iorhom appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse – Adult and has been on the NMC register since 23 March 2021.*

14. *On 17 March 2022, the NMC received a referral from the Deputy Head of Nursing at East Kent Hospitals University NHS Foundation Trust ('the Trust') with concerns about Mrs Iorhom's competence. Mrs Iorhom had worked at three of the Trust hospitals.*

15. *Mrs Iorhom qualified as a nurse overseas in 2000. In December 2020, following an international recruitment campaign by the Trust, she successfully gained employment on Clark Ward at Kent and Canterbury Hospital as a Band 5 nurse. She received her NMC PIN on 23 March 2021 and completed her probationary period on Clark Ward on 17 August 2021.*

16. *During her probationary period, Mrs Iorhom applied for and was successful in gaining a post in the Intensive Care Unit/Critical Care Unit ('ICU/CCU') at William Harvey Hospital. This was despite references from Clark Ward expressing concern about her competence and clinical practice. She started on ICU/CCU on 06 September 2021.*

17. *When new nurses join ICU/CCU, they are given two to three mentors for support and monitored by way of competencies until they are signed off as able to look after ICU patients independently. Local nurses would be supernumerary for 4-8 weeks, while international nurses would be supernumerary for around 10 weeks.*

18. *In September 2021, Mrs Iorhom started being supported by Clinical Skills Facilitator, [Colleague 1] and Band 7 Clinical Educator, [Colleague 2]. Towards the*

*end of September 2021, Clinical Nurse Educator, [Colleague 3], received several concerns from staff about Mrs Iorhom's practice. [Colleague 3] began the process of devising an action plan to support her. On 27 October 2021 [Colleague 3] placed Mrs Iorhom on a 6-week action plan, which began on 28 October 2021.*

19. *Concerns continued to be raised about Mrs Iorhom's practice. On 01 November 2021 she failed a stage 2 Performance Improvement Plan ('PIP') assessment and on 01 December 2021 she failed a stage 3 PIP assessment.*

20. *In mid-December 2021 Mrs Iorhom successfully applied for a role as a staff nurse at in the Surgical Assessment Unit ('SEAU') at the Queen Elizabeth, The Queen Mother Hospital. She started in early January 2022 in a supernumerary capacity. Concerns were again raised about Mrs Iorhom's competence and practice, and she was placed on an action plan in mid-January 2022. On 28 January 2022 she resigned and left the Trust's employ on 25 March 2022.*

*<u>Charge 1(a)</u>*

21. *On 14 October 2021 Mrs Iorhom was working with Senior Band 5 Nurse, [Colleague 4]. The Ward clerk delivered a message to Mrs Iorhom that the human albumen ordered for a patient was available. Human albumen is a time sensitive treatment for removing fluid that has built up in the wrong part of a patient's body. When notification is received from the lab that it is ready, nurses instruct the porters to collect the albumen, which is then administered intravenously. [Colleague 4] overheard the message but waited to see if Mrs Iorhom would take the initiative to inform her to collect it from the lab. Mrs Iorhom did not speak to [Colleague 4] about the message. After a while with no action from Mrs Iorhom, [Colleague 4] asked her if she would collect the albumen. Mrs Iorhom told [Colleague 4] that she did not know what albumen it was, and she had not sought clarification or guidance from [Colleague 4].*

22. *During the same shift, [Colleague 4] asked Mrs Iorhom to perform the blood gasses for a patient. This is one of the first tasks learned when a nurse is supernumerary in ICU/CCU because most of the patients are on ventilators and need to be monitored regularly.*

23. *Blood gasses are taken from an arterial line, which looks like a cannula but has a tap on it. To take the gasses, 3ml of liquid are first removed as the line is flushed with 3ml of saline every hour to prevent blockage. Once the saline has been removed, a sample is removed and the vial is placed into the arterial blood gas machine, which provides a printout of the blood gases. Mrs Iorhom was unable to grasp which way to turn the tap and how to stop the blood from flowing.*

*Charge 1(b)*

24. *On 19 October 2021 Mrs Iorhom was again working with [Colleague 4]. [Colleague 4] tasked Mrs Iorhom to check the alarms on a patient's ventilator. There were six alarms to check, which should have taken only around three to five minutes. Mrs Iorhom took 15 minutes to complete this basic task.*

*Charge 1(c)*

25. *On 28 October 2021 Mrs Iorhom was working with [Colleague 1]. [Colleague 1] noted that a patient's temperature was significantly low i.e., 34.8°C. Mrs Iorhom asked [Colleague 1] if she should place a blanket on the patient. [Colleague 1] instructed Mrs Iorhom to place a Bair hugger blanket on the patient, which is a type of warming blanket. After nearly an hour, the patient's temperature had dropped to 34.2°C and Mrs Iorhom had still not placed the Bair hugger blanket. [Colleague 1] told Mrs Iorhom to ask a healthcare assistant to retrieve the blanket if she was too busy, which Mrs Iorhom agreed to do but did not act on. Ultimately, [Colleague 1] retrieved the blanket from the equipment room and showed Mrs Iorhom how to put it on the patient.*

26. *During the same shift there was another patient who was on Noradrenaline, which is used to maintain a good blood pressure. If a patient's blood pressure is too high, the amount of Noradrenaline needs to be lowered. The patient's high blood pressure alarm sounded, indicating the blood pressure was too high. Mrs Iorhom silenced the alarm without escalating the issue or attempting to lower the Noradrenaline.*

*Charge 1(d)*

27. *On 01 November 2021 Mrs Iorhom was working with [Colleague 2]. There was a patient on an Intellivent ventilator. It has two types of SATS probes attached to the patient that feedback information to the ventilator, allowing the ventilator to adjust the Oxygen levels to the patient accordingly. At 11.00 hours Mrs Iorhom informed [Colleague 2] that the patient's vital anti-epilepsy medications were due at 12.00 hours. Mrs Iorhom however failed to administer the medications at 12.00 hours. At 12.20 hours the patient was extubated. The patient's condition then began to deteriorate i.e., they had difficulty breathing, and they were reintubated.*

*Charge 1(e)*

28. *On 04 November 2021 Mrs Iorhom was working with Nurse Team Manager, [Colleague 5].*

29. *One of the patients had pancreatitis. They were due to receive a dose of Pancrex at 10.00 hours, but Mrs Iorhom failed to administer it until 11.45 hours on prompting from [Colleague 5] i.e., 15 minutes before the next dose.*

30. *At around 11.02 hours a patient's Propofol infusion alarm began to sound, indicating it was 'near end of infusion'. Mrs Iorhom retrieved a bottle of Propofol from the medication cupboard and replaced the bottle connected to the infusion*

*machine with it without obtaining a second checker to review the prescription or bottle. Propofol is an intravenous drug and since she was supernumerary, Mrs Iorhom should have had a second checker. There was a risk that she had retrieved the incorrect medication and/or set up the infusion incorrectly, which would have resulted in patient harm.*

31. *That morning Mrs Iorhom did not respond to multiple patient alarms until directed to by [Colleague 5]. At approximately 08.50 hours she failed to respond to a patient's ventilator alarm, which indicated that the patient's breath size was not as expected. At around 09.38 hours she failed to respond to a patient's SATS alarm, which indicated that the SATS probe had been repositioned and/or the patient was not breathing properly. At 10.00 hours she failed to respond to a patient's ventilator alarm after the ventilation mode was changed by a consultant. At around 10.35 hours she failed to respond to a Phosphate infusion alarm. At around 11.30 hours she failed to respond to an infusion alarm, which indicated that there was a blockage between the Propofol pump and the patient. Not responding to alarms is dangerous and places patients at risk of harm. Certain alarms alert staff to changes in patients' health and that medication potentially needs to be adjusted.*

*<u>Charge (1)(f)</u>*

32. *On 18 November 2021 Mrs Iorhom was again working with [Colleague 5]. They were caring for a patient who was being weaned off their ventilator after 32 days by reducing the size of trach tube to a mini trach.*

33. *The patient on occasion required deep suction of his trach tube, as he was unable to cough deeply enough to expectorate sputum. This needed to be done with an open suction catheter. [Colleague 5] showed Mrs Iorhom how to perform this procedure, which was new to Mrs Iorhom. [Colleague 5] then asked her to suction the front of the patient's trach using a yankauer sucker, a simpler procedure and one for which she had been signed off as competent in using on 18 September*

*2021. Whilst [Colleague 5] was in another bedspace Mrs Iorhom instead attempted to perform a deep suction with the open suction catheter, rather than the simple suction with the yankauer sucker. She had not been signed off in open suction catheterisation and thus it was beyond the limits of her competence.*

34. *When completing the assessment section of the patient's care plan, Mrs Iorhom wrote that he was not in any pain. She knew this was not the case due to the patient's condition; he had a very painful scrotum. This presented the risk that the patient would not have received extra pain relief medication from colleagues who had read Mrs Iorhom's notes.*

*Charge 1(g)*

35. *On 22 November 2021 Mrs Iorhom was working with [Colleague 1]. Whilst she was detangling a patient's ECG leads the patient started desaturating, and the ventilator alarm began to sound. Mrs Iorhom did not look up from the leads. [Colleague 1] highlighted the desaturation to Mrs Iorhom, who looked at the ventilator machine but continued to detangle the leads. On further prompting from [Colleague 1], she then administered an Oxygen bolus.*

*Charge 1(h)*

36. *On 23 November 2021 Mrs Iorhom was again working with [Colleague 1]. They were caring for a patient on 2L of Oxygen via nasal cannula. The patient's target saturation was ≥94% but it kept dropping to 90%. Instead of increasing the patient's Oxygen, Mrs Iorhom moved the SATS probe. She did not seek to administer the patient's due medications or promptly complete an A-E (airway, breathing, circulation, neurological (disability) and exposure) assessment but was instead focused on getting the patient a cup of tea, retrieving his bag from the ward, and helping him ring his wife.*

*Charge (1)(i)*

37. *On 25 November 2021 Mrs Iorhom was working with [Colleague 5].*

38. *When carrying out A-E checks, Mrs Iorhom could not identify how many breaths a patient was taking versus how many breaths the ventilator was carrying out for the patient. If a ventilator is not set correctly, the patient would be vulnerable to deterioration.*

39. *When carrying out the 'E' section of the A-E assessment, Mrs Iorhom incorrectly identified the PICC line instead of the PICCO line. She had been signed off on 18 September 2021 as being able to do distinguish between the two. Failure to distinguish between the two is dangerous. A PICCO line is an arterial line that cannot be used to infuse medications due to potential damage to the artery.*

40. *Although she had been signed off as competent in taking patient observations, Mrs Iorhom did not add observations such as suction, heart rate, and additional medications for (a) patient(s).*

41. *Mrs Iorhom also again failed to respond to patient alarms and required several prompts from [Colleague 5] to hand over all the relevant aspects of care during handover.*

*Charge 1(j)*

42. *On 29 November 2021 Mrs Iorhom was working with [Colleague 1]. They were caring for a post-emergency laparotomy level 3 patient, who had a midline dressing and stoma. The patient was extremely ill; he was on lots of support and his condition was deteriorating. However, when asked by the surgeon how the patient was doing, Mrs Iorhom told them that the patient was 'thriving'. She did not appreciate the seriousness of the patient's condition.*

*Charge 1(k)*

43. *On 09 December 2021 Mrs Iorhom was working with [Colleague 5]. She was tasked with checking the water circuits on a patient and knew that the circuit needed to be plugged into an Oxygen source. The patient's bedspace did not have the correct connector. Mrs Iorhom removed a connector from an adjacent bedspace but did not return it for 45 minutes, nor did she replace it. This compromised the adjacent patient; that patient was consequently vulnerable to delays in treatment if they were struggling to breathe.*

44. *Mrs Iorhom cancelled the 'near end of infusion' alarm on a patient's IV Amiodarone and did not prepare the replacement infusion within the 15-minute limit. She did not respond to some other alarms e.g., SATS alarms, either.*

45. *During the surgeons' ward round Mrs Iorhom was unable to explain the patients' status to the surgeon e.g., why a patient's nasal specifications were not Optiflow like the day before. Without a full picture, surgeons cannot make decisions about continued patient treatment, meaning a patient could be left without the treatment they need.*

*Charge 1(l)*

46. *On an unknown date Mrs Iorhom was working on SEAU and being monitored by Ward Sister, [Colleague 6]. Mrs Iorhom took a patient's observations, and the patient had an Early Warning Scale Score of 5. If a patient scores 5 or above, the patient must be escalated for sepsis screening. Mrs Iorhom did not escalate the patient. Sepsis patients are commonly encountered on ICU and therefore Early Warning Scores and their escalation are common knowledge amongst ICU staff. Mrs Iorhom thus should have known to escalate the patient based on her ICU experience.*

47. *On a separate unknown date, Mrs Iorhom was again being monitored by [Colleague 6]. Mrs Iorhom placed 2g of the antibiotic Vancomycin into a bag for a patient, despite being instructed to place 1.5g in the bag. There would have been a risk to the patient if too much Vancomycin had been given. [Colleague 6] was acting as second checker and noticed the error before it was administered.*

*Charge 1(m)*

48. *On 15, 16, and 31 January 2022 Mrs Iorhom worked with Senior Staff Nurse, [Colleague 7], on SEAU. On all three days Mrs Iorhom fell asleep at one of the computer tables and was woken by [Colleague 7]. Sleeping on duty compromises the safety of patients and undermines the public's confidence of professionalism of registrants.*

*Charge 1(n)*

49. *On 05 February 2022, Mrs Iorhom slept on a bed in the treatment room on SEAU after her shift. She was found in the morning of 06 February 2022 by [Colleague 6]. Mrs Iorhom first told [Colleague 6] that she had done this because she had missed her bus. She then said it was because there were no buses running on Sunday mornings and she would have been late for her shift. Mrs Iorhom had not raised her transport issues with [Colleague 6] to explore the possibility of her shifts being adjusted to accommodate this. SEAU is a closed ward and if, for example, there had been a fire, no one would have known of her presence. It was therefore a fire safety risk. It also presented an infection/hygiene control issue as Mrs Iorhom did not have any clean clothes to change into for her shift and could not shower on the ward.*

*Charge 1(o)*

*50. On 10 February 2022 Mrs Iorhom was working with [Colleague 7]. Mrs Iorhom took a patient's observations, and the patient had an Early Warning Scale Score of 6. Mrs Iorhom did not escalate the patient for sepsis screening. Mrs Iorhom should have known to escalate the patient based on her ICU experience.*

*51. During the same shift Mrs Iorhom failed to take full observations for a new patient who arrived on SEAU. It is standard protocol to take observations, bloods, and a lateral flow test for new patients. Mrs Iorhom took the bloods and lateral flow test but did not take the observations. This was not realised until an hour later by [Colleague 6].*

*<u>Charge 2</u>*

*52. The NMC completed its investigation into the concerns contained within the referral. On 13 January 2023 the matter was considered by the Case Examiners, and they found that Mrs Iorhom had a case to answer with respect to all the regulatory concerns. The Case Examiners recommended undertakings, which Mrs Iorhom accepted, and they came into effect on 02 March 2023.*

*53. On 30 May 2023 the NMC received notification from [Colleague 8], Home Manager of Castlegreen Care Home ('the Home'), where Mrs Iorhom had worked as a Staff Nurse from 23 March 2022. [Colleague 8] advised that an internal investigation had commenced on 25 April 2023 due to concerns raised about Mrs Iorhom's conduct and practice. The Home's investigation concluded on 07 June 2023.*

*54. One of the undertakings Mrs Iorhom agreed to was:*

*4) You will tell your case officer, within seven days of your becoming aware of:*

- *Any clinical incident you are involved in.*
- *Any investigation started against you.*
- *Any disciplinary proceedings taken against you.*

55. *Although she was aware of the Home's investigation Mrs Iorhom did not inform the NMC of it at any point, despite contacting the NMC in between April and September 2023 with updates on her compliance with the undertakings.*

56. *On 12 September 2023, the Case Examiners revoked the undertakings and referred the matter to a panel of the Fitness to Practise Committee for adjudication.*

57. *On 15 April 2024 Mrs Iorhom, through her representatives the RCN, admitted the charges in full and impairment.*

***Lack of competence***

58. *The NMC's guidance on 'Lack of competence (FTP-2b)' provides:*

> *"Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice."*

59. *This guidance is in line with the test set out in the case of R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin), where at paragraph 39 Jackson J summarised that deficient professional performance "connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the [registrant's] work." Further guidance in defining lack of competence can be found at paragraph 75 of Holton v GMC [2006] EWHC 2960 (Admin), in which Burnton J stated that lack of competence can be judged as performance of a practitioner that falls below what is "expected of a competent practitioner in the circumstances."*

60. *The Parties agree that the conduct of Mrs Iorhom outlined in charges 1(a) to 1(o)*

*represents a fair sample of her work. The charges cover a period of nearly six months across two separate units. It is agreed that the evidence provided by the witnesses gives a holistic view of Mrs Iorhom's work during a defined period relating to consistent areas of concern and includes continued summaries of Mrs Iorhom's overall progress and competencies through e.g., action plans, and notes from direct observation carried out.*

61. *The Parties agree that Mrs Iorhom's level of work, as captured by charges 1(a) to 1(o), falls below the standards expected of a band 5 nurse, and not only placed patients at risk of harm but undermined the public's confidence in the profession.*

62. *Medication administration, patient escalation, the ability to identify deteriorating patients, and proactive patient management (effective practice), are fundamental competencies expected of a nurse for them to be able to provide safe and effective care to patients. It is agreed that consistent failings in the areas highlighted therefore represent an unacceptably low standard of work.*

63. *At all relevant times, Mrs Iorhom was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. On the basis of the charges alleged, it is agreed the following provisions of the Code have been breached in this case:*

***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 psychological 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*

***4 Act in the best interests of people at all times***

***6 Always practise in line with the best available evidence***

*To achieve this, you must:*

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

***8 Work cooperatively***

*To achieve this, you must:*

*8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

*8.2 maintain effective communication with colleagues*

*8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

*8.5 work with colleagues to preserve the safety of those receiving care 8.6 share information to identify and reduce risk*

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

*To achieve this, you must, as appropriate:*

*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 your competence*

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

*To achieve this, you must:*

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

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

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

*To achieve this, you must:*

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

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

*To achieve this, you must:*

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

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

***22 Fulfil all registration requirements***

*To achieve this, you must:*

*22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance*

64. *The Parties agree that Mrs Iorhom's acts and omissions, as set out in charges 1(a)*

*to 1(o), amount to a lack of competence which impairs her fitness to practise. Mrs Iorhom was provided with dedicated support over a several months, yet the concerns continued, and she failed to successfully pass PIP assessments or work independently for a consistent period. The concerns relate to basic nursing knowledge. By failing to demonstrate the standards of knowledge expected of a registered nurse, Mrs Iorhom placed patients at risk of harm and consequently undermined the public's confidence in the profession.*

***Misconduct***

65. *It is agreed that the facts amount to misconduct in relation to charge 2.*

66. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct: '[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*

67. *Further assistance may be found in the comments of Jackson J in R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin) respectively: '[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'. And 'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*

68. *Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct ('the Code').*

69. *At all relevant times, Mrs Iorhom was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. On the basis of the charges alleged, the Parties agree the following provisions of the Code have been breached in this case:*

***Promote professionalism and trust***

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

*To achieve this, you must:*

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

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

*23. Cooperate with all investigations and audits*

*This includes investigations or audits either against you or relating to others, whether individuals or organisations…*

*To achieve this, you must:*

*23.1. cooperate with any…other relevant audits that we may want to carry out to make sure you are still fit to practise*

70. *It is agreed that Mrs Iorhom's conduct as detailed in charge 2 is a breach of the fundamental tenets of professionalism, trust, and integrity, and falls far short of the standards expected of a registered nurse. Registered professionals occupy a position of privilege and trust in society and are expected at all times to be professional. Mrs Iorhom's significant departure from the principle of promoting professionalism and trust by failing to comply with undertakings agreed with her regulator, designed to protect the public, would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession.*

***Impairment***

71. *The Parties agree that Mrs Iorhom's fitness to practise is currently impaired by reason of her misconduct and lack of competence.*

72. *The NMC's guidance at DMA-1 explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. 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?"*

73. *Guidance can also be found in case law. The following considerations were suggested by Dame Janet Smith in the 5th Shipman Report and approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;*

    a) *Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
    b) *Has in the past brought and/or is liable in the future to bring the professions into disrepute; and/or*
    c) *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the professions; and/or*
    d) *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

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

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

*75. In this case, the Parties suggest that limbs (a), (b), and (c) are engaged. Taking the limbs in turn:*

*Limb (a)*

*76. By failing to demonstrate a level of competence over significant period in medication administration, patient escalation, the ability to identify deteriorating patients, and proactive patient management, despite receiving additional support, Mrs Iorhom placed patients at risk of harm. She also placed patients at risk of harm by failing to adhere to the undertakings agreed to with the NMC, which were designed to protect patients. It is agreed that a member of the public would be extremely concerned to hear that an incompetent nurse was allowed to practise without restriction. They consequently may be deterred from seeking medical assistance when required, thus placing them at further risk of harm.*

*Limb (b)*

*77. Nurses occupy a position of privilege and trust in society. They are thus expected at all times to maintain an adequate standard of competence and promote professionalism. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must always ensure that their standard of competence and professionalism justifies both their patients' and the public's trust in the profession. As such the Parties agree that Mrs Iorhom's lack of clinical competence and misconduct is liable to bring the nursing profession into disrepute.*

*Limb (c)*

*78. Prioritising people, preserving safety, practicing effectively, and promoting professionalism and trust are fundamental tenets of the profession. The Parties*

*agree that in failing to demonstrate clinical competence and adhere to the undertakings, Mrs Iorhom has breached those fundamental tenets.*

79. *Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions:*

    *i) whether the concern is easily remediable;*

    *ii) whether it has in fact been remedied; and*

    *iii) whether it is highly unlikely to be repeated.*

80. *The Parties have considered the NMC's guidance entitled: Can the concern be addressed? (Reference: FTP-14a) which states: '…Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*

    - *medication administration errors*
    - *poor record keeping*
    - *failings in a discrete and easily identifiable area of clinical practice'*

81. *It is agreed that Mrs Iorhom's lack of competence could be remediated through training and supervision. The concerns are of the nature described in its guidance and relate to discrete and easily identifiable areas of clinical practice.*

82. *The Parties agree that a failure to uphold and promote public confidence in the profession is not easily remediable. Remorse, reflection, insight, training and strengthening practice*

83. *It is agreed that by virtue of agreement to this CPD, Mrs Iorhom has displayed some insight into her misconduct and lack of competence.*

84. *Mrs Iorhom has not provided a substantive response to the charges and thus not*

*expressed remorse. She has not provided evidence that she e.g., understands the seriousness of the concerns or has reflected to identify factors that may have contributed to her failing to demonstrate competence so that they may be overcome or the implications of failing to adhere to undertakings designed to protect the public agreed with her regulator. The Parties therefore agree that Mrs Iorhom has demonstrated some extremely limited insight, which needs to be developed further.*

85. *Mrs Iorhom has provided training certificates to confirm some relevant training undertaken since the concerns were raised e.g., completion of Adult Arterial Line Management Competency assessment, Tracheostomy Management Competency assessment, Drug Calculation assessment, Intravenous Pump and NG Drug Administration assessment in August 2021. The Parties however agree that single courses completed over two years ago are insufficient to demonstrate current competence. Mrs Iorhom is yet to complete a personal improvement development plan, which was a condition of her undertakings, thus she has not demonstrated strengthened practice. She has not completed any relevant training with reference to professionalism and ethics. The Parties therefore agree that the lack of competence and misconduct have not been remediated and consequently a risk of repetition remains.*

*Public protection impairment*

86. *The Parties agree that a finding of impairment is necessary on public protection grounds based on Mrs Iorhom's failure to demonstrate remorse, reflection, or strengthened practice (remediation) and the consequent risk of repetition.*

*Public interest impairment*

87. *It is agreed that a finding of impairment is necessary on public interest grounds.*

88. *In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery*

*Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:*

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

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

90. *Although the extract outlined above dealt with consideration for impairment by reason of misconduct, the Parties agree that the principles are equally applicable to impairment by reason of lack of competence.*

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

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

93. *The Parties agree that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. It is agreed that a member of the public would be extremely concerned to hear that an incompetent nurse who failed to comply with restrictions imposed by a regulator to protect the public was allowed to practise without restriction. As such, the need to protect the wider public interest calls for a finding of impairment to uphold standards of the profession, maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession, and the regulator, would be seriously undermined, particularly where there is a risk of repetition, as is present in this case.*

***Sanction***

94. *The Parties submit that the appropriate sanction in this case is an **18-months conditions of practice order with review**.*

95. *The public interest must be at the forefront of any decision on sanction. The public interest includes protection of members of the public, including patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour within the profession. The public interest in this case lies with maintaining public confidence in the profession and upholding proper professional standards by declaring that Mrs Iorhom's failure to demonstrate competence and comply with restrictions agreed with her regulator was unacceptable.*

96. *Any sanction imposed must do no more than is necessary to meet the public interest and must be balanced against Mrs Iorhom's right to practice in her chosen career. To achieve this the panel is invited to consider each sanction in ascending order.*

97. *In their contemplation the Parties have considered the following aggravating and*

*mitigating factors:*

*<u>Aggravating factors:</u>*

- *Clinical failure in fundamental areas of nursing across two separate placements, despite support and supervision.*
- *A failure to comply with undertakings.*
- *A lack of full insight, remorse and remediation.*
- *Placed vulnerable patients at a significant risk of harm.*

*<u>Mitigating factors:</u>*

- *Acceptance of the concerns.*
- *Initial engagement with the regulator.*

98. *With regard to the NMC's sanctions guidance, the following aspects have led the Parties to this conclusion:*

*98.1 Taking no action: The allegations are too serious to take no further action. To achieve the NMC's overarching objective of public protection, action needs to be taken to secure public trust in nurses and to promote and maintain proper professional standards and conduct.*

*98.2. A caution order is only appropriate for cases at the lower end of the spectrum. This case is not at the lower end of the spectrum because it involves significant concerns relating to basic nursing knowledge.*

*98.3. A conditions of practice order is the appropriate sanction in this case. The NMC's guidance on conditions of practice orders (SAN-3c) states that a conditions of practice order may be appropriate when factors are present including:*

*98.3.1. No evidence of harmful deep-seated personality or attitudinal problems; 98.3.2. Identifiable areas of Mrs Iorhom's practice in need of assessment and/or retraining; 98.3.3. Willingness to engage positively with retraining;*

*98.3.4. Patients will not be put in danger either directly or indirectly as a result of the conditions;*
*98.3.5. The conditions will protect patients during the period they are in force; and*
*98.3.6. Conditions can be created that can be monitored and assessed.*

*98.4. In this instance the Parties agree that the facts do not indicate harmful deep-seated personality or attitudinal problems, despite Mrs Iorhom's failure to comply with condition 4 of the previously agreed undertakings. There are clear and identifiable areas of Mrs Iorhom's practice which can be addressed by assessment and retraining. Given her acceptance of the undertakings and this CPD, there is a willingness to engage positively to retraining. If conditions are appropriately drafted any public protection concerns can be addressed, and the conditions can be appropriately monitored and assessed.*

*98.5. The Parties propose the following conditions:*

1. *You will keep us 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.*

2. *You will keep us 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.*

3. *You will immediately give a copy of these conditions to:*
    a. *Any organisation or person you work for.*
    b. *Any agency you apply to or are registered with for work.*
    c. *Any employers you apply to for work (at the time of application).*

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

4. *You will 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.*

5. *You will allow your case officer to share, as necessary, details of your performance, your compliance with and progress towards completing 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.*

6. *You will limit your nursing practice to a single substantive employer, which will not be a nursing agency.*

7. *You will ensure that you are supervised by another registered nurse any time you are working. Your supervision will consist of:*
    - *Working at all times on the same shift as, but not always directly observed by a more senior nurse*

8. *You will not dispense or administer medications (except in life threatening emergencies) unless supervised by a workplace supervisor or mentor who is a registered nurse. This supervision will consist of:*
    - *Being observed administering medication until you have been assessed and deemed competent to administer medication unsupervised by your workplace supervisor or mentor. This*

*supervision must include two further competency assessments, which must be completed within six months from the date that these conditions take effect.*

9. *You will send your case officer, within six months of these conditions taking effect, evidence that you have been assessed as competent in the following areas:*
    a. *the prompt escalation of patient concerns*
    b. *record keeping and documentation*
    c. *communication*

10. *You will work with your workplace supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns set out at conditions 8 and 9. You will:*
    a. *send your case officer a copy of your PDP within four weeks of these conditions taking effect*
    b. *meet with your supervisor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP.*
    c. *send your case officer a report from your supervisor every month. This report will show your progress towards achieving the aims set out in your PDP.*
    d. *contain feedback from your supervisor on how you gave the care The monthly report required at 10(c) must confirm whether there have been any investigations started and/or disciplinary proceedings instigated against you.*

11. *You will keep a reflective practice profile. The profile will:*
    - *detail examples of the four concerns about your practice as set out in conditions 8 and 9.*
    - *set out the nature of the care given.*
    - *provide a detailed reflection of what you have learned from each of*

*the examples*

- *be signed each time by your workplace supervisor or mentor.*

*You will send your case officer a copy of the profile every three months, with the first being due three months from the date these conditions take effect. The expectation is that, by the time of our reviewing these conditions after six months from the date they take effect, we will be in possession of two reports. We expect these conditions to have been completed within six months of the date that they become effective.*

*98.6. A **suspension order** would be inappropriate. According to the Guidance (SAN-3d), in cases where the only issue relates to the registrant's lack of competence, a suspension order should be imposed where there is a risk to patient safety if they were allowed to continue to practise even with conditions. It is agreed that there is no evidence to suggest that if Mrs Iorhom were to practise with conditions a risk to patient safety would remain. There is no evidence of harmful deep-seated personality or attitudinal problems, and the concerns are not so serious so as to warrant temporary removal from the register. Furthermore, whilst Mrs Iorhom's breach of the undertakings was serious, temporary removal from the register would not allow Mrs Iorhom to engage with supervision and therefore demonstrate safe practice.*

*98.7. A striking-off order would be inappropriate and is unavailable to the panel. The NMC guidance at SAN-3e provides that striking-off orders cannot be Page 30 of 31 used if a registrant's fitness to practise is impaired due to a lack of competence. Furthermore, Article 29(6) of the Nursing and Midwifery Order 2001 provides that a striking-off order may not be made where a registrant has been found impaired by reason of a lack of competence "unless the person concerned has been continuously suspended or subject to a conditions of practice order, for a*

*period of no less than two years immediately preceding the date of the decision of the Committee to make such and order." Mrs Iorhom has not been subject to a substantive suspension or conditions of practice order for two years.*

***Maker of allegation comments***

99. *On 24 June 2024 the NMC wrote to the Deputy Head of Nursing at the Trust for their comments on the CPD agreement and requested a response by 08 July 2024. To date a response is yet to be received. If comments are received ahead of the CPD hearing, the panel will be notified.*

***Interim order***

100. *An interim order is required in this case. The interim order is necessary for the protection of the public and/or otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that Mrs Iorhom seeks to appeal the panel's decision. The interim order should take the form of an interim conditions of practice order.*

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

Here ends the provisional CPD agreement between the you and the NMC. The provisional CPD agreement was signed by you on 15 July 2024.

**Decision and reasons on the CPD**

The panel decided to accept the CPD following agreed amendments.

Ms Kyriacou referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. She reminded the panel that they could accept, suggest amendments or outright reject the provisional CPD agreement reached between you and the NMC. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel heard and accepted the legal assessor's advice.

The panel noted that you admitted the facts in the charges. Accordingly, the panel was satisfied that the charges are found proved by way of your admissions, as set out in the signed provisional CPD agreement.

**Decision and reasons on impairment**

The panel then went on to consider whether your fitness to practise is currently impaired. Whilst acknowledging the agreement between the you and NMC, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of lack of competence, the panel took the view that the evidence before it indicates that your clinical skills fell below the standards expected of a band 5 nurse and put patients at risk of harm. The panel determined that a finding of impairment is necessary in respect of lack of competence to uphold the proper professional standards, maintain public confidence in the nursing profession and the NMC as regulator.

In this respect, the panel endorsed paragraphs 58 to 64 of the provisional CPD agreement in respect of lack of competence.

In respect of misconduct, the panel agreed your actions in respect of the charges fell seriously short of the standard set out in The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). It considered that the areas of the Code that had been identified by the NMC were appropriate. Therefore, the determined that your actions were so serious that they amounted to misconduct.

In this respect, the panel endorsed paragraphs 65 to 70 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether your fitness to practise is currently impaired by reasons of misconduct and lack of competence.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

The panel determined that your fitness to practise is currently impaired as your actions breached fundamental tenets of the profession, pose an ongoing risk to patient safety and would be deemed concerning by the public. Based on the information before the panel and what has been agreed, the panel was not satisfied that you can practise kindly, safely and professionally at this time, without restriction.

The panel determined that your fitness to practise is currently impaired.

In this respect, the panel endorsed paragraph 71 to paragraph 93 of the provisional CPD agreement.

**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:

- Clinical failure in fundamental areas of nursing across two separate placements, despite support and supervision.
- A failure to comply with undertakings.
- A lack of full insight, remorse and remediation.
- Placed vulnerable patients at a significant risk of harm.

The panel also took into account the following mitigating features:

- Acceptance of the concerns.
- Engagement with the regulator.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because the charges could be addressed by a more proportionate sanction such as conditions of practice order. The panel carefully considered whether a suspension order may be more appropriate but determined that the risk to patient safety would be addressed by conditions of practice and therefore determined that a suspension order is not appropriate.

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 had some observations as to the conditions of practice and sent those observations to the parties for consideration. The parties confirmed that they agreed with the observations and accordingly prepared an amended CPD which was agreed.

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

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

1. You will keep us 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.

2. You will keep us 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.

3. You will immediately give a copy of these conditions to:
    a. Any organisation or person you work for.
    b. Any agency you apply to or are registered with for work.
    c. Any employers you apply to for work (at the time of application).
    d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

4. You will 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.

5. You will allow your case officer to share, as necessary, details of your performance, your compliance with and progress towards completing 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.

6. You will limit your nursing practice to a single substantive employer, which will not be a nursing agency.

7. You will ensure that you are supervised by another registered nurse any time you are working. Your supervision will consist of:
    - Working at all times on the same shift as, but not always directly observed by a more senior nurse

8. You will not dispense or administer medications (except in life threatening emergencies) unless supervised by a workplace supervisor or mentor who is a registered nurse. This supervision will consist of:

    - Being observed administering medication until you have been assessed and deemed competent to administer medication unsupervised by your workplace supervisor or mentor.

    - Once deemed competent, two further competency assessments, which must be completed.

    These assessments must be recorded, signed off by a supervisor and sent to your case officer within six months of starting your position as a registered nurse.

9. You will send your case officer, within six months of starting your position as a registered nurse, evidence that you have been assessed as competent in the following areas:
    a. the prompt identification and escalation of clinical concerns
    b. record keeping and documentation
    c. communication

10. You will work with your workplace supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns set out at conditions 8 and 9. You will:

    a. send your case officer a copy of your PDP within four weeks of starting your position as a registered nurse.
    b. meet with your supervisor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP.
    c. send your case officer a report from your supervisor every month. This report will show your progress towards achieving the aims set out in your PDP.
    d. contain feedback from your supervisor on how you gave the care
    The monthly report required at 10(c) must confirm whether there have been any investigations started and/or disciplinary proceedings instigated against you.

11. You will keep a reflective practice profile. The profile will:

    - detail examples of the four concerns about your practice as set out in conditions 8 and 9.
    - set out the nature of the care given.
    - provide a detailed reflection of what you have learned from each of the examples
    - be signed each time by your workplace supervisor or mentor.

    You will send your case officer a copy of the profile every three months, with the first being due three months from the date these conditions take effect. The expectation is that, by the time of our reviewing these conditions after six months from the date they take effect, we will be in possession of two reports. We expect these conditions to have been completed within six months of starting your position as a registered nurse.

The period of this order is for 18 months.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece on how your insight has developed into the charges 1 and 2.
- Your continued engagement throughout this process.
- Evidence of training and any activities you have completed in order to strengthen your clinical practice.

This will be confirmed to you in writing.

**Decision and reasons on interim order**

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

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

The panel agreed with the CPD that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be 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 to lapse.

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.