Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 17 June 2024 – Friday, 19 July 2024

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Karen Josephine Morgan**
NMC PIN:	75J3658E
Part(s) of the register:	Registered Nurse – Sub Part 2 Adult Nursing (Level 2) – 4 January 1977
Relevant Location:	Birmingham and Derbyshire
Type of case:	Misconduct and Lack of competence
Panel members:	Philip John Sayce (Chair, Registrant member) Bryan Hume (Lay member) Karen Naya (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Taymika Brandy (17-21 June 2024) Charis Benefo (24 -28 June 2024) Max Buadi (2 - 19 July 2024)
Nursing and Midwifery Council:	Represented by Amy Taylor, Case Presenter
Ms Morgan:	Not present and unrepresented
Facts proved:	1k, 1l, 1n(i), 1n(ii), 1o, 1p, 1q, 2c, 2e(i), 2e(ii), 2p, 2q, 3l, 3m, 3n 3o, 3q(i), 3q(ii), 3q(iii), 3q(iv), 3q(v), 3q(vi), 3q(vii), 3s, 3t, 3u, 3v, 3w, 3x(i), 3x(ii), 4g, 4h, 5c, 6 , 7a, 7b, 7c, 7d, 8, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k, 13l, 14, 15a, 15b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d, 17e, 18, 19, 20, 21a, 21b, 22a, 22b, 23, 24, 25, 26, 27, 29, 30, 31, 32, 33a, 33b and 34.

Facts not proved:	1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 2a, 2b, 2d, 2f, 2g, 2m, 2n, 2o, 3a, 3b, 3c, 3d,3e, 3f, 3g, 3h, 3i, 3j, 3k, 3p, 3r, 4a, 4b, 4c, 4d, 4e, 4f, 5a, 5b,13b, 13g, 13j(i), 13j(ii), 13j(iii) and 28
Fitness to practise:	**Impaired**
Sanction:	**Strike-off order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Morgan was not in attendance and that the Notice of Hearing letter had been sent to Ms Morgan's registered email address by secure email on 8 May 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Ms Morgan

The panel next considered whether it should proceed in the absence of Ms Morgan. It had regard to Rule 21 and heard the submissions of Ms Taylor who invited the panel to continue in the absence of Ms Morgan. She submitted that Ms Morgan has voluntarily absented herself.

Ms Taylor referred the panel to an email dated 4 February 2024, from Ms Morgan to her NMC Case officer, as follows:

> *'[…] just to let you know I will not be attending any of the meetings. This is because I cannot afford to have time off work .*

[…]

Please can you put this letter in the bundle with all the other letter'

Ms Taylor submitted that Ms Morgan had not made any application for an adjournment and there is no reason to suppose that adjourning would secure her attendance at some future date. In addition, she submitted that that there is a strong public interest in the expeditious disposal of the case.

Ms Taylor acknowledged that there is some disadvantage to Ms Morgan in proceeding in her absence. However, she submitted that any injustice can be mitigated by the panel exploring any inconsistencies in the evidence which it may identify. Further, by it taking into account Ms Morgan's documentation before it, in which she expresses her view on this case.

Ms Taylor invited the panel to proceed in the absence of Ms Morgan for the reasons set out above.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones.*

The panel has decided to proceed in the absence of Ms Morgan. In reaching this decision, the panel has considered the submissions of Ms Taylor. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Morgan;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- 20 witnesses are due to attend to give live evidence; and not proceeding may inconvenience the witnesses and their employer(s);
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- The allegations in the case are serious; and
- There is a strong public interest in the expeditious disposal of the case.

In addition to the above, the panel had regard Ms Morgan's email dated 4 February 2024 to her NMC Case officer. The panel noted that whilst Ms Morgan had confirmed that she would not be attending this hearing, she had reported that this was because she could not afford to have time off work. The panel was mindful that the Notice of Hearing sent to Ms Morgan included information about how the NMC can provide financial support with travel and overnight accommodation. Taking all of the above into consideration, the panel concluded that Ms Morgan has voluntarily absented herself.

There is some disadvantage to Ms Morgan in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

The panel was also informed at the outset of this hearing that the NMC had received documentation from Ms Morgan which included her responses to the allegations. The panel are yet to determine the admissibility of this documentation. If the panel finds that this documentation is both fair and relevant to its consideration, it will attach the appropriate weight to the material at a later stage in the hearing.

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

Decision and reasons on application to amend the charge

Ms Taylor made an application amend the wording of the following charges:

- 1k),1e), 1o, 1p, 1q, 2q (previously labelled charge 2s in error), 2a), 3q)v, 3t, 3u, 3x, 7b,16a) and b).

Charge 1k)

Proposed amendment

> (k) On one or more occasions on or before 28 June 2019 left **medication** keys un**attended and not secure,**

In respect of charge 1k), Ms Taylor submitted that the proposed amendment would properly reflect the evidence before the panel, namely the witness statement of Witness 2 in which she outlines this allegation.

Charge 1e)

Proposed amendment

(e) On 15 July 2019 failed a medication competency assessment by:

> i. Incorrectly identifying patient allergies.
> ii. On one or more occasions did not assess the patient prior to administering paracetamol

In relation to charge 1e), Ms Taylor submitted that the proposed amendment would provide clarity, by creating sub-charges i.-iii. For charge 1e), which were not initially reflected in the current schedule of charges. She explained that this would affect the numbering of the charges thereafter and thus, this would also need to be reflected in the amended schedule of charges.

Charges 1o),1p) and 1q)

<u>Proposed amendment</u>

1. Medication management and/or medication administration but not limited to the following:
    1. On **or before** 3 December 2021 did not administer the following medication to Resident B at 09.00am: ...
    2. On **or before** 3 December 2021 **administered or** attempted to administer insulin to Resident A prior to checking their blood sugar levels beforehand.
    3. On one or more occasions on or before 3 December 2021 left the door to the **medication room** ~~drugs trolley~~ open and/or unlocked.

It was submitted by Ms Taylor that the proposed amendments would more accurately reflect the evidence given by the witnesses, correct typographical errors, and clarify the charges.

Charges 2a) and 2b)

- *On or before 9 April 2019 thrown a patient's admission documentation, green Waterloo book away.*
- *On or before 9 April 2019 incorrectly replaced the green Waterloo book with the pressure ulcer book.*

<u>Proposed amendment</u>

(a) On or before 9 April 2019 thrown a patient's admission documentation, green Waterlow book away.
(b) On or before 9 April 2019 incorrectly replaced the green Waterlow book with the pressure ulcer book.

In relation to charges 2a) and 2b), Ms Taylor submitted that the proposed amendments are to correct typographical errors and to properly reflect the evidence in this case which refers to a 'waterlow book'.

Charges 2q (previously labelled charge 2s in error), 3q)v, 3t, 3u, 3x

Proposed amendment

(v) Safe patient care and/or patient observations but not limited to the following:

16. **(q)** On **or before** 3 December 2021 did not check Resident A's blood sugar levels prior to **administering or** attempting to administer insulin to them.

(vi) Record Keeping and/or documentation but not limited to the following:

1. On 15 July 2019 failed a medication assessment by:
   (o) On one or more **occasions** pre-signed medication that had yet to be administered.
   ~~(s)~~ On 26 May 2020 ~~incorrectly~~ faxed a tissue Viability for the wrong patient.
   ~~(t)~~ On 26 May 2020 ~~incorrectly~~ sent a wound swab that was labelled with another patient's details.
   (q) On **or before** 3 December **2021** ~~2020~~ incorrectly signed the MAR chart indicating that the following medication had been administered Resident B at 09.00:...

It was submitted by Ms Taylor that the proposed amendments would more accurately reflect the evidence given by the witnesses, correct typographical errors, and clarify the charges.

Charge 7b)

Proposed amendment

(t) On 6 January 2020, prior to administering Clopidogrel to the Patient, failed to:

(x) Ensure that the drug chart was **clear** ~~not unambiguous and/or unclear~~.

In relation to charge 7b) Ms Taylor submitted that the proposed amendment would more accurately reflect the evidence given by the witnesses, correct typographical errors, and clarify the charge.

Charge 16a)

- *On or before 28 March 2022 breached your interim conditions of practice order that was imposed on your registration on 2 July 2021 by;*
    - *Failing to in the NMC that you had accepted employment as a nurse with Leonard Cheshire Disability within 7-days of accepting that employment.*

Proposed amendment

16. On or before 28 March 2022 breached your interim conditions of practice order that was imposed on your registration on 2 July 2021 by;

a. Failing **to inform or notify** the NMC that you had accepted employment as a nurse with Leonard Cheshire Disability within 7-days of accepting that employment.

In relation to charge 16a) Ms Taylor submitted that the proposed amendment would correct a typographical error and to properly reflect the evidence in this case.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was noted that the proposed amendments did not alter the mischief or nature the allegations. It considered that the proposed amendments would provide clarity to the charges by correcting typographical errors and by properly reflecting the evidence in this case. The panel was satisfied that there would be no prejudice to Mrs Morgan and no injustice would be caused to either party by allowing the proposed amendment. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit further evidence

Ms Taylor made an application to admit further evidence, namely, the Case Management Form (CMF) sent to Ms Morgan in anticipation of this hearing. She explained that this form asked Ms Morgan to confirm whether she made any admission to the charges and whether she wished to provide any further information to be put before the panel. Ms Taylor explained that the NMC received part of form back from Mrs Morgan (47 of 59 pages) via post and this was scanned by the NMC on 4 October 2022. Further, she explained that the missing pages would have included space for Mrs Morgan to sign and date this document and confirm the following declaration:

> '*By signing this form, you're declaring the following statement: I understand the panel will use any admissions I've made in this form when they're making the final decision about the charges against me*'.

Ms Taylor invited the panel admit this document as the CMF includes reflections for Mrs Morgan which provide her response to the alleged incidents and further

contextual evidence. She submitted that if the panel were to admit this material, it can test this evidence with Mrs Morgan's responses contained in the registrants bundle. She submitted that it is fair and relevant to admit this document.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel took into account the submissions made by Ms Taylor and the CMF form.

The panel noted that the CMF was not signed and whilst the NMC could confirm that it had received the document via post, it was unable to verify whether this had been sent by Mrs Morgan. The panel considered that as this document contained reflections on some of the alleged incidents, it could assist the panel in determining the factual charges of the case as it provides contextual information. The panel was mindful that although there was indication within the CMF of charges that are admitted or denied, these could not stand as Mrs Morgan's admissions, as the form was not signed. The panel acknowledged that Mrs Morgan is not in attendance. However, the panel considered that it had other evidence before it, namely Mrs Morgan's email correspondence with the NMC which could be used to cross reference the information provided with the CMF and mitigate any unfairness to Mrs Morgan.

The panel determined that in these circumstances, it is fair and relevant to admit the CMF into evidence. The panel will give that evidence what weight it deems appropriate once it has heard and evaluated all the evidence before it.

Decision and reasons on application for Witness 10 to give evidence with her manager supporting her

Prior to the start of Witness 10's oral evidence, Ms Taylor informed the panel that Witness 10 had asked whether her manager could sit with her in the same room during her live evidence. Witness 10 was due to attend the hearing via video-link. Ms Taylor submitted that Witness 10's manager is the Deputy Chief Nurse at the George

Eliot Hospital NHS Trust. Ms Taylor submitted that Witness 10's manager wanted to support her during her evidence, and had no intention of advising Witness 10 or saying anything during the course of her evidence. She submitted that Witness 10's manager was happy to be visible on screen if she were allowed to support Witness 10.

Ms Taylor submitted that Witness 10 was not a vulnerable witness for the purpose of an application for special measures. She submitted that it would be a matter for the panel to decide whether to allow Witness 10's manager to sit with her during the course of her live evidence.

The chair, having noted that Witness 10's manager works at the Trust where the alleged incidents took place, invited Ms Taylor to ask Witness 10 whether her manager was ever involved with the concerns at a local level in any capacity. He also invited her to ensure that Witness 10 understood that any evidence given in the presence of her manager would have to be truthful.

Having spoken to Witness 10, Ms Taylor informed the panel that Witness 10 was aware that she would have to give truthful evidence and the manager was not intimately involved in the charge.

The panel accepted the advice of the legal assessor.

The panel considered Ms Taylor's request for Witness 10 to give oral evidence in the presence of her manager for support and decided to accede to the application. It was mindful that Witness 10's manager works at the same Trust where the concerns took place.

The panel was satisfied that Witness 10 would give her evidence truthfully and that her manager would not advise Witness 10 on what to say, or speak during her evidence. It decided that Witness 10's manager would need to be visible on screen during the course of Witness 10's evidence.

Decision and reasons on application to admit documentary evidence

The panel heard an application made by Ms Taylor under Rule 31 to admit documentary evidence, which had already been included in the exhibit bundle, into evidence. She informed the panel that these documents had not been attributed to any of the NMC's live witnesses when the exhibit bundle was prepared.

Ms Taylor made submissions in respect of each of the following documents:

1. Email from Witness 3 to the NMC dated 14 July 2023

Ms Taylor submitted that this email related to grievances which had been raised by Miss Morgan. She submitted that in the registrant response bundle, Miss Morgan had raised alleged issues and confirmed her complaints against certain colleagues. Ms Taylor reminded the panel that it had also heard from Witness 8 about Miss Morgan's grievances. She submitted that Witness 3' email was relevant and that it would be fair to be admitted into evidence.

2. Various Action Plans for Miss Morgan

Ms Taylor submitted that there were six actions plans:

i. signed by Miss Morgan and Witness 8, and dated 26 June 2020;
ii. signed by Miss Morgan and Witness 3, and dated 26 June 2020 – this action plan had also been provided by Witness 3 as part of her evidence;
iii. signed by Witness 8 only and dated 2 July 2020;
iv. signed by Miss Morgan and Witness 8, and dated 9 July 2020;
v. signed by Miss Morgan and Witness 8, and dated 12 August 2020; and
vi. not signed or dated.

Ms Taylor submitted that the panel had heard reference to the action plans from various witnesses, and that Miss Morgan herself had made reference to performance management in the registrant response bundle. She submitted that the panel had

also seen another action plan from August 2019, which had been provided by Witness 2 as part of her evidence. Ms Taylor submitted that there was no dispute that Miss Morgan was under performance management, and all but two of these action plans had been signed by her. She submitted that they provided useful context and that it would be beneficial for the panel to see them and their relevance.

Ms Taylor submitted that some of the action plans had been signed by Witness 3 and Witness 8 and so they could have exhibited them as part of their evidence, but that was an oversight by the NMC. She submitted that these action plans were relevant and it was fair to admit them into evidence.

3. Fact-finding report dated 10 January 2020

Ms Taylor submitted that her application was to admit a redacted version of this report; removing the witness statement from an individual the panel had not heard from. She submitted that the fact-finding report had been compiled by Witness 8 and that she should have been asked to exhibit it. Ms Taylor submitted that the report included reference to what happened and Miss Morgan's mitigation. She submitted that the fact-finding report was relevant and it was fair to be admitted into evidence.

4. Statement FAO Witness 8 dated 6 May 2020

Ms Taylor submitted that this statement had been written for the attention of Witness 8, but it was not clear who it had been written by. She submitted that the contents of this statement did not provide any new information, but it contained reference to concerns that the panel had already heard from witnesses.

Ms Taylor then referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Ms Taylor submitted none of the documents were being relied upon solely to prove the charges, nor did they appear in the NMC's evidence matrix. She submitted that these documents corroborated what the panel had already heard and read.

Ms Taylor submitted that in the registrant response bundle, Miss Morgan had explained that she raised grievances and that she was under performance management. She submitted that there had been little challenge to the contents of this documentary evidence. Ms Taylor submitted that it was a matter for the panel to decide on what weight to place on the Case Management Form (CMF) in relation to which of the charges Miss Morgan had accepted and denied.

Ms Taylor submitted that Miss Morgan had advanced that the NMC witnesses were lying, but there was no suggestion that they had reason to fabricate the information in the documents. Ms Taylor stated that she had no submissions on the seriousness of the charges and the impact of any adverse findings, and that it was a matter for the panel to decide on.

Ms Taylor submitted that the NMC witnesses could have exhibited the documents that were relevant to them, and it was an oversight by the NMC not to do that. She submitted that the exhibit bundle had been sent to Miss Morgan and she did not raise issue with these documents being included, although her non-attendance and lack of representation had to be taken into account.

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

The panel gave the application in regard to the documentary evidence serious consideration. It noted that none of these documents had been attributed to the NMC's live witnesses, but they had been included in the exhibit bundle before the panel.

1. Email from Witness 3 to the NMC dated 14 July 2023

The panel was satisfied that the email was relevant to the concerns in this case. It noted that Miss Morgan had seen it, but made no objection to it, nor did she

comment on the veracity of the information in the email. The panel considered that Witness 3 had not been questioned on the email specifically, but she had provided evidence about Miss Morgan's grievances. The panel decided that it would be fair to admit the email into evidence, and therefore acceded to the application in respect of it.

2. Various Action Plans for Miss Morgan

The panel was satisfied that the action plans were relevant to the concerns in this case. It noted that these action plans had been referred to by Miss Morgan in her responses to the concerns. It considered Miss Morgan's performance management had also been referred to by various witnesses in live evidence. The panel therefore decided that it would be fair to admit the action plans into evidence, and therefore acceded to the application in respect of them.

3. Fact-finding report dated 10 January 2020

The panel noted that none of the information in the fact-finding report was sole and decisive evidence. It had regard to Colleague 4's local statement which had been included as part of the report and decided not to admit this page, because the NMC had made no effort to secure her attendance. It also decided not to admit the annotations included on the side of the report, as it was not clear who had written them. Notwithstanding these redactions, the panel came to the view that it would be fair and relevant to accept the fact-finding report into evidence.

4. Statement FAO Witness 8 dated 6 May 2020

The panel noted that this statement had been written for the attention of Witness 8. However, it was not clear who had written the statement. The panel decided that on this basis, it would be unduly prejudicial to Miss Morgan to admit this statement into evidence. It was of the view that it would not be fair or relevant. In these circumstances, the panel refused the application to admit the statement FAO Witness 8 into evidence.

The panel considered that Miss Morgan had been provided with a copy of the exhibit bundle, which included the documentary evidence it had decided to admit. In addition, the panel had already determined that Miss Morgan had chosen voluntarily to absent herself from these proceedings, so she was not in a position to cross-examine the witnesses in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel was disappointed that the relevant NMC witnesses had not been not taken to their respective documents, as their oral testimony included reference to issues in those documents. The panel considered recalling the specific witnesses relating to these documents, but having taken into account their oral testimony, it determined this was not a necessary direction.

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

Ms Taylor made an application that part of this case be held in partly in private on the basis that the witness evidence in this case makes reference [PRIVATE]. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

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

Having heard there will be refence [PRIVATE], the panel determined to go into private as and when such issues are raised in order to protect the privacy of Miss Morgan and any third party.

Detail of charge (as amended)

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:
   (a) On or before 5 November 2017 did not administer medication to a patient.
   (b) On or before 5 November 2017 did not dispose of medication properly.
   (c) On an unknown date in March 2018 left medication unattended in a patient's room.
   (d) On an unknown date in June 2018 left medication unattended on a trolley.
   (e) On 5 October 2018 failed to correctly administer medication to a patient.
   (f) On 5 October 2018 left a patient's medication on top of their locker.
   (g) On 5 October 2018 failed to administer sodium docusate to a patient.
   (h) On 5 October 2018 incorrectly administered phenobarbital to a patient at the wrong time.
   (i) Between 31 October 2018 and 5 November 2018 left medication unattended.
   (j) On or before 9 April 2019 left medication unattended and/or exposed.
   (k) On one or more occasions on or before 28 June 2019 left keys unattended and insecure.
   (l) On one or more occasions on or before 5 July 2019 rushed medication rounds.
   (m) On or before 5 July 2019 failed to calculate the correct medication to be administered to a patient.
   (n) On 15 July 2019 failed a medication assessment by:
      (i) Incorrectly attempting to administer the wrong dose of metformin to a patient.

(ii) Incorrectly attempting to administer medication to a patient without knowledge of the drug.

(o) On or before 3 December 2021 did not administer the following medication to Resident B at 09.00am:

(i) Co-beneldopa 25mg/100mg.

(ii) Paroxetine 20mg.

(p) On or before 3 December 2021 administered or attempted to administer insulin to Resident A prior to checking their blood sugar levels beforehand.

(q) On one or more occasions on or before 3 December 2021 left the door to the medication room open and/or unlocked.

2. Safe patient care and/or patient observations but not limited to the following:

(a) On 6 May 2018 inaccurately observed that the patient was mobile and/or able to re-position themselves when this was not the case.

(b) On or before 9 April 2019 incorrectly identified that a patient had a burst blister.

(c) On or before 5 July 2019 failed to recognise that a patient required 1 tablet to be administered.

(d) On or before 12 July 2019 failed to identity that a falls assessment was necessary when admitting a patient.

(e) On 15 July 2019 failed a medication competency assessment by:

i. Incorrectly identifying patient allergies.

ii. On one or more occasions did not assess the patient prior to administering paracetamol.

(f) On 27 April 2020, having left a patient’s FP10 in the printer, the patient did not receive their medication on time.

(g) On one or more occasions on or before 27 April 2020 did not complete allocated NEWS observations.

(h) On or before 27 April 2020 failed to escalate a NEWS score that required action to be taken.

(i) On 30 April 2020 did not complete all allocated patient observations.

(j) On 4 May 2020 did not immediately escalate to a doctor that a patient's glucose test was below 3mmols.

(k) On 4 May 2020 did not use the Algorithm to treat the patient whose glucose test was below 3mmols.

(l) On one or more occasions on or before 28 May 2020 demonstrated unsafe practice by using your mobile telephone whilst working.

(m) On one or more occasions on or before 28 May 2020 demonstrated poor hygiene control by consuming food from the patients' food trolley.

(n) On or before 12 June 2020 demonstrated poor infection control by placing a Covid-19 patient's property in the clean stores.

(o) On or before 27 October 2020 demonstrated poor hygiene and/or infection control by placing a patient's unsealed urine sample in the fridge.

(p) On 23 March 2021 did not secure a patient's catheter bag full of urine prior to mobilising them.

(q) On or before 3 December 2021 did not check Resident A's blood sugar levels prior to administering or attempting to administer insulin to them.

3. Record Keeping and/or documentation but not limited to the following:

(a) On an unknown date in March 2018 did not sign for patient medication.

(b) On an unknown date in March 2018 did not enter an omission code.

(c) On 6 May 2018 did not record in a patient's notes that you had reviewed them and/or actions that were taken by you.

(d) On 6 May 2018 did not record in the patient's notes that you had handed over your actions to night staff.

(e) On 5 October 2018 incorrectly signed off that a patient had received their medication.

(f) On or before 9 April 2019 incorrectly recorded that a patient had a burst blister.

(g) On or before 9 April 2019 thrown a patient's admission documentation, green Waterlow book away.

(h) On or before 9 April 2019 incorrectly replaced the green Waterlow book with the pressure ulcer book.

(i) On or before 9 April 2019 did not complete admission documentation correctly.

(j) On one or more occasions, on or before 9 April 2019 left documentation in the printer.

(k) On or before 9 April 2019 did not send social work referral documentation when required.

(l) On one or more occasions on or before 28 June 2019 did not check patient wrists bands.

(m)On one or more occasions on or before 28 June 2019 did not sign for the correct medication and/or at the correct times.

(n) On one or more occasions on or before 28 June 2019 incorrectly identified expiry dates on Blister Packs.

(o) On one or more occasions on or before 5 July 2019 incorrectly identified medication and/or Blister Pack expiry dates.

(p) On or before 12 July 2019 did not complete the falls assessment when admitting a patient.

(q) On 15 July 2019 failed a medication assessment by:

(i) On one or more occasion did not check medication labels against the MAR Charts.

(ii) On one or more occasions did not check expiry dates.

(iii) On one or more occasions did not check the MARS properly.

(iv) On one or more occasions provided the incorrect expiry date on Blister packs.

(v) On one or more occasions pre-signed medication that had yet to be administered.

(vi) On one or more occasions pre-signed for medication prior to locating the patient.

(vii) Not checking the date an insulin pen had been opened.

(r) On 3 December 2019 did not follow clear instructions in a patient’s notes on who to contact when an incident occurs.

(s) On 27 April 2020 left a patient’s FP10 in the printer.

(t) On 26 May 2020 faxed a tissue Viability for the wrong patient.

(u) On 26 May 2020 sent a wound swab that was labelled with another patient's details.

(v) On one or more occasions on or before 2 August 2020 did not maintain and/or keep patient care plans up to date.

(w) On or before 27 October 2020 incorrectly sent a patient's discharge letter to the GP before the patient had been discharged.

(x) On or before 3 December 2021 incorrectly signed the MAR chart indicating that the following medication had been administered Resident B at 09.00:

(i) Co-beneldopa 25mg/100mg

(ii) Paroxetine 20mg.

4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:

(a) On or before 5 November 2017 were rude to a patient's daughter.

(b) On one or more occasions on or before 9 April 2019 displayed unprofessional behaviour towards colleagues.

(c) On 9 April 2019 spoke abruptly to a patient.

(d) On or before 15 July 2019 informed colleagues that you were

'untouchable' or words to that effect.

(e) On 3 December 2019 behaved inappropriately towards colleagues.

(f) On 3 December 2019 incorrectly informed the patient's husband in relation to the patient's fall.

(g) On 7 October 2020 did not treat a patient's daughter with dignity and/or respect.

(h) On 14 October 2020 demonstrated a poor attitude towards ambulance service staff.

5. Safe Handovers but not limited to the following:

(a) On one or more occasions, on or before 9 April 2019 performed handovers poorly.

(b) On or before 12 July 2019 failed to handover to a nurse that the consultant had telephoned regarding a patient's medication.

(c) On 30 April 2020 did not hand over that you had only completed 10 out of 16 patient observations.

In light of the above, your fitness to practise is impaired by reason of your lack of competence

That you a registered nurse;

6. On 6 January 2020 incorrectly administered Clopidogrel to a patient at 18.00.

7. On 6 January 2020, prior to administering Clopidogrel to the Patient, failed to:

   (a) Check the prescription.

   (b) Ensure that the drug chart was clear.

   (c) Seek clarity and/or support from another colleague if unsure about the prescription and/or drug chart.

   (d) Check whether the medication had been previously administered.

8. On or around 3 April 2007 submitted a reference purporting to be from [Person B] a Band 6 Sister.

9. On or around 16 November 2007 submitted a reference purporting to be from [Person B] a Band 6 Sister.

10. Your actions in charges 8 and 9 were dishonest in that:

    (a) You knew that references were not completed by [Person B] but submitted them in any event.

(b) You were attempting to mislead Birmingham Community Healthcare NHS Foundation Trust that the references were from [Person B] a Band 6 Sister when you knew that they were not.

11. On one or more occasions incorrectly declared to the NMC that [Mr 1] was not your partner, namely:
    (a) On 27 January 2022.
    (b) On 28 January 2022.
    (c) On 30 January 2022.
    (d) 1 February 2022.

12. Your actions in charge 11 were dishonest because you were attempting to represent to the NMC that Mr 1 was not your partner, which you know is untrue.

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

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

13. On 13 April 2022 whilst undertaking a medication assessment observed by Colleague 1:

    a. On one or more occasions attempted to administer incorrect doses of medication to residents.
    b. On one or more occasions attempted to administer incorrect medication to residents.

c. On one or more occasions attempted to administer medication to residents at the incorrect prescribed time.
d. On one or more occasions was unable to measure the correct medication that was to be administered.
e. On one or more occasions failed to prepare medication that was due to be administered.
f. On one or more occasions failed to check expiry dates on medication.
g. On one or more occasions failed to check MAR charts before medication was to be administered.
h. On one or more occasions failed to check residents allergies.
i. On one or more occasions failed to correctly read medication administration instructions.
j. On one or more occasions failed to correctly identify residents by;
    i. Comparing the photograph found on their MAR charts.
    ii. The use of their medication boxes.
    iii. The use of their room numbers.
k. On one or more occasions failed to keep the medication trolley locked and/or left the keys in the medication trolley.
l. On one or more occasions was unable to calculate the medication correctly.

14. On or around 1 April 2022 failed to correctly apply a blood pressure cuff to a patient's arm.

15. On a date unknown whilst being supervised by Colleague 2:

a. On one or more occasions was unable to scan medications using the scanner.
b. On one or more occasions was unable to read the electronic medication management system correctly.
c. On one or more occasions attempted to dispense the incorrect amount of medication.

d. On one or more occasions was informed by Colleague 2 to read the prescription again regarding the dosage of medication that was required to be administered.

16. On dates unknown whilst being supervised by Colleague 3:

a. On one or more occasions potted incorrect doses of medication.
b. On one or more occasions incorrectly drew up the wrong dosage of medication.
c. On one or more occasions drew up the incorrect medication.

Hygiene and/or infection control when administering medication but not limited to the following:

17. On 13 April 2022 whilst undertaking a medication assessment observed by Colleague 1;

a. On one of more occasions left empty dirty medicine pots on the side of the preparation area.
b. On one or more occasions did not wash your hands prior to the medication round and/or during the medication round.
c. On one or more occasions did not always wear gloves and/or when potting medication.
d. On one or more occasions needed to be reminded on the correct PPE to use when entering rooms with Covid-19 residents.
e. On one or more occasions had to be reminded on how to wear the mask correctly.

And in light of the above your fitness to practise is impaired by reason of your lack of competence.

That you a registered nurse;

18. On or around 1 April 2022, whilst speaking with Colleague 2, behaved in an unprofessional and/or offensive manner by referring to a student nurse as being a *'spacker'* or words to that effect.

19. On a date unknown failed to maintain a resident's dignity by behaving in an unprofessional and/or unkind and/or patronising manner when administering medication to them, by stating words to the effect of, *'good girl, good girl take your medications.'*

20. On a date unknown behaved in an unprofessional and/or discriminatory manner, when referring to a resident who has Cerebral Palsy, by stating to Colleague 2 words to the effect of, *'She doesn't look like she doesn't have a learning disability.'*

21. On a date unknown failed to maintain a resident's dignity by behaving in an unprofessional and/or unkind and/or patronising manner whilst administering medication to them by;

    a. Stating to them in a baby voice words to the effect of, *'come on now, open your mouth, a bit wider, a bit wider.'*
    b. Pushing the teaspoon into the resident's mouth, which he had closed, causing the yogurt that contained the medication to spill on the resident's beard.

22. On a date unknown failed to maintain Resident A's dignity by behaving in an unprofessional and/or unkind and/or discriminatory and/or patronising manner towards them by;

    a. Stating words to the effect of, *'oh, it's the man with the golden boots'* when in fact Resident was a female resident.
    b. Stating words to the effect of, *'You little horror, you little horror.'*

23. On a date unknown, when Colleague 2 enquired whether you had given a resident a flush of water, incorrectly declared that you had provided the resident with a flush of water when you had not.

24. Your declaration in charge 23 were dishonest in that you was attempting to mislead Colleague 2 into believing that you had provided the resident a flush of water when you knew that this was untrue.

25. On a date unknown, when Colleague 2 enquired whether you had taken temperatures for one or more residents, incorrectly declared that you had taken them when you had not.

26. Your declaration in charge 25 were dishonest in that you was attempting to mislead Colleague 2 into believing that you had taken temperatures for one or more residents when you knew that this was untrue.

27. On a date unknown declared to Colleague 2 that you had hidden your diagnosis of arthritis in order to gain employment with Leonard Cheshire Disability.

28. Your declaration in charge 27 demonstrated a lack of integrity in that you hid your diagnosis in order to gain employment with Leonard Cheshire Disability for your own benefit.

29. On or around 1 March 2022 provided to Leonard Cheshire Disability contact details for a referee in the name of [Person A], purporting to be a Band 6 Sister employed at Birmingham Community NHS Trust.

30. Your actions in charge 29 were dishonest in that you mislead and/or was attempting to mislead Leonard Cheshire Disability into believing that [Person A] was a Band 6 Sister employed at Birmingham Community NHS Trust when you knew that this was untrue.

31. On or around 1 March 2022 submitted and/or caused to be submitted a reference to Leonard Cheshire Disability in the name of [Person A] purporting to be a Band 6 Sister employed by Birmingham Community NHS Trust.

32. Your actions in charge 31 were dishonest in that you mislead and/or was attempting to mislead Leonard Cheshire Disability into believing that a person by the name of [Person A] was employed as a Band 6 Sister with Birmingham Community NHS Trust when you knew that this was untrue.

33. On or before 28 March 2022 breached your interim conditions of practice order that was imposed on your registration on 2 July 2021 by;

   a. Failing to inform or notify the NMC that you had accepted employment as a nurse with Leonard Cheshire Disability within 7-days of accepting that employment.
   b. Failing to provide your NMC's case officer your employer's contact details.

34. Your actions in charge 33 demonstrated a lack of integrity in that you had a duty to inform the NMC that you had accepted employment with Leonard Cheshire Disability but failed to do so.

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

Background

Miss Morgan commenced working with the Birmingham Community Healthcare NHS Trust ('the Trust') in 2008 and was dismissed for gross misconduct in May 2021.

On 4 June 2021 the NMC received a referral from the Trust regarding Miss Morgan who was employed with them as a band 5 nurse on the Intermediate Care Unit.

It is alleged that on 6 January 2020, Miss Morgan wrongly administered Clopidogrel. The medication was prescribed to be given once a day at 08:00 and the patient had

already been given the medication at 08:00 but she had allegedly administered a second dose at 18:00.

The Trust were concerned as this alleged medication error was made just a few weeks after Miss Morgan had returned to medication administration following several previous medication errors, suspension from medication administration, further training and competencies and a longstanding performance management plan.

Miss Morgan commenced employment as a Staff Nurse at Haven Nursing Home (the Home) in November 2021. She worked two supervised shifts and on the third shift began working under indirect supervision. Miss Morgan made further medication errors during this shift and was dismissed.

The NMC were notified by the Trust that during the Disciplinary Hearing, the panel were reviewing Miss Morgan's personnel file and were concerned regarding the authenticity of the references provided when she commenced employment at the Trust. There are two references from a "Person A" and Mr 1.

Miss Morgan started working at Leonard Cheshire Disability (hereafter 'LCD'), at Newlands House, in March 2022.

The NMC received a referral from the Deputy Manager at Newlands House, LCD, Witness 15. She alleged that when Ms Morgan was employed with them as a Staff Nurse from 28 March 2022, a number of concerns were raised in relation to medication management, poor hygiene practices when administering medication, discriminatory language and a lack of duty of candour.

It is alleged that Miss Morgan was subject to five shadow shifts as part of her induction but due to concerns being raised was required to be shadowed for five further shifts. During this time further concerns were raised. Witness 15 carried out Miss Morgan's medication assessment and details the multiple competency issues witnessed. [PRIVATE] and did not attend two probationary meetings to discuss her competency and plan of action. Miss Morgan attended the third meeting, and they created a plan of action and put in place a date for further assessment. Ms Morgan

resigned with immediate effect after being employed at Newlands House for one month.

The NMC have gathered the employment references used for Miss Morgan's position at LCD. These appear to be fraudulent and provided in the name of her daughter and not a member of staff at Birmingham Community NHS Trust as suggested.

Decision and reasons on application to amend the charge

The panel took account of the preamble of charges which alleged that Miss Morgan "failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse". It was of the view that the charges following this were factual findings and the preamble required the panel make a determination on lack of competence at the facts stage and, if applicable again at stage 2.

The panel bore in mind that it had a duty to ensure that the mischief of the charges was considered. It also noted that in order to find lack of competency, the panel would need to have a sufficient sample of Miss Morgan's practice as a registered nurse. The panel noted that there were serious failings alleged in the charges and was concerned that if it could not find a sufficient enough sample, then the charges could fail on a technicality.

The panel invited Miss Taylor to make submissions on whether she would make amendments to the preamble and some of the charges that follow this preamble, to make them more factual.

After taking instructions, Miss Taylor submitted that the preamble quoted was standard for charges relating to a registrant's lack of competence. She also submitted that the charges do represent a sufficient sample and cited charges 1 to 5 which occurred over a four-year period and includes specific areas including medication management, patient care and patient observations. She submitted that charges 13 to 17 was over a shorter period while Miss Morgan was under

supervision. She submitted that this was a sufficient sample to demonstrate lack of competence.

Miss Taylor submitted that any amendment to the charges was a matter for the panel.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel determined that it would not, of its own volition amend the charges. It was of the view that it would have to consider whether the incidents alleged in charges 1 to 5 and 13 to 17 occurred and then consider if they were a fair sample of Miss Morgan's practice before making a determination. The panel was not satisfied that it would have to approach the aforementioned charges this way.

Decision and reasons on application to amend the charge

The panel, of its own volition, wanted to amend the wording of charges 24, 26, 30 and 32. The proposed amendments were to amend typographical errors. It invited submissions from Ms Taylor.

<u>Proposed amendments</u>

24. Your declaration in charge 23 ~~were~~ **was** dishonest in that you ~~was~~ **were** attempting to mislead Colleague 2 into believing that you had provided the resident a flush of water when you knew that this was untrue.

26. Your declaration in charge 25 ~~were~~ **was** dishonest in that you ~~was~~ **were** attempting to mislead Colleague 2 into believing that you had taken temperatures for one or more residents when you knew that this was untrue.

30. Your actions in charge 29 ~~were~~ **was** dishonest in that you mislead and/or was attempting to mislead Leonard Cheshire Disability into believing that [Person A]

was a Band 6 Sister employed at Birmingham Community NHS Trust when you knew that this was untrue.

32. Your actions in charge 31 ~~were~~ **was** dishonest in that you mislead and/or was attempting to mislead Leonard Cheshire Disability into believing that a person by the name of [Person A] was employed as a Band 6 Sister with Birmingham Community NHS Trust when you knew that this was untrue.

Ms Taylor did not oppose the proposed amendments.

The panel accepted the advice of the legal assessor.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Morgan and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

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

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

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

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

- Witness 1: Clinical Team Leader at the Trust;
- Witness 2: Senior Sister at the Trust.
- Witness 3: Matron at the Trust;
- Witness 4: Registered Manager at the Home;
- Witness 5: HR Business Partner at the Trust;
- Witness 6: Sister at the Trust;
- Witness 7: Sister at the Trust;
- Witness 8: Band 6 Bank Registered Nurse at the Trust;
- Witness 9: Registered Mental Health Nurse at the Home;
- Witness 10: Associate Director of Allied Health Professions within Coventry and Warwickshire Trust;
- Witness 11: Office Manager/Personal Assistant at the Trust;
- Witness 12: Independent Forensic Document Examiner;

- Witness 13: CEO at the Trust;
- Witness 14: Deputy Manager at the Home;
- Witness 15: Deputy Manager at LCD;
- Colleague 2: Registered Nurse at LCD;
- Colleague 3: Registered Nurse at Newlands House Care Home;
- Witness 16: Registered Nurse at Newlands House Care Home;
- Witness 17: Senior Registration and Revalidation Officer at the NMC;
- Witness 18: Assistant HR Business Partner at the Trust;

The panel heard and accepted the advice of the legal assessor.

In so far as the charges relate to competency, namely charges 1 to 5, the panel determined that it would first consider whether it was satisfied, on the evidence before it, that each incident relevant to the individual charges had occurred. Only those incidents which are found to have occurred would be taken forward for the panel to determine whether they were a fair sample of Miss Morgan's nursing practice.

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

Charge 1a

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

   (a) On or before 5 November 2017 did not administer medication to a patient.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"…I was also aware that just before I commenced in the role there was an incident in which the registrant failed to give a patient her medication... I exhibit the outcome letter…but as I wasn't involved in the incident I do not have any further information about this."*

The panel took account of the outcome letter, dated 15 November 2017, referenced in Witness 2's witness statement. It noted that the letter was addressed to Miss Morgan. The letter stated:

> *"…*
>
> 2. *Why you did not witness the tablets being taken.*
>
> - *You state the client refused her medication 3 times and you did try to get the client to take the medication."*

The panel noted that, according to the letter, Miss Morgan had explained that the patient had refused the medication three times. However, it was mindful that this amounted to hearsay because the author of the letter had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the letter. It also bore in mind that the letter was the only contemporaneous evidence to support the charge.

The panel noted that it appeared that Miss Morgan had accepted the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge come from the account of Witness 2. However, she did not observe the allegation described within this sub-charge. Additionally, the outcome letter was hearsay and the contents could not be tested by the panel. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 1b

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (b) On or before 5 November 2017 did not dispose of medication properly.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"…I was also aware that just before I commenced in the role there was an incident in which the registrant…discarded the medication incorrectly... I exhibit the outcome letter…but as I wasn't involved in the incident I do not have any further information about this."*

The panel took account of the outcome letter, dated 15 November 2017, referenced in Witness 2's witness statement. It noted that the letter was addressed to Miss Morgan. The panel noted a material conflict within the letter. While it stated:

"…

1. *That you stated that if the client is capable of eating then she is capable of taking her tablets and it was reported to the Nurse In Charge that day that you threw the tablets in the bin.*

- *You have apologised for this and state it was a mistake. I have given you a copy of the Policy to read through and understand.*

However later in the same letter it stated:

3. *Why you did not dispose of the tablets appropriately.*

- *You apologised for this and state it was a mistake. I have asked you to refer back to the Policy.*

The letter then stated:

4. *The daughter said that you were rude and had an attitude when she asked you why her mother's medication was still in a pot in her room."*

The panel noted that it appeared that Miss Morgan had not disposed of medication correctly because she had apologised to the author. However, as it noted in charge

1a, it was mindful that the letter amounted to hearsay and there was no way to test the veracity of the contents within the letter.

The panel also noted that the author of the letter referred Miss Morgan to the policy. It took account of the Medicines Management Policy of the Trust which referred to controlled drugs. However, the panel did not know what type of medication Miss Morgan had allegedly disposed of.

The panel noted that it appeared that Miss Morgan had accepted the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge come from the account of Witness 2. However, she did not observe the allegation described within this sub-charge. The panel noted that the letter was an outcome of a meeting held on 5 November 2017 where there appeared to be evidence which is not before the panel. As the author of the letter had not attended the hearing, the contents cannot be tested by the panel. There is no other contemporaneous evidence before the panel to support the charge.

Without contemporaneous evidence to determine what medication Miss Morgan was alleged to have disposed of, it could not determine if doing so was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 1c

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (c) On an unknown date in March 2018 left medication unattended in a patient's room.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"In March 2018, I am unsure of the exact date, a medication audit releveled [sic] patient medication had not been signed for and no omission code was entered on one of the days. Medication had also been left unattended in patient's room. This was dealt with by informal discussion and as above this should have been in the registrant's personnel file. If it is not then I do not have a copy."*

The panel did not have much information about this charge beyond what Witness 2 had stated in her witness statement. With no criticism to Witness 2, it noted that the details she provided regarding the allegation lacked detail and specificity. The panel do not have a copy of Miss Morgan's personnel file, referenced in Witness 2's witness statement, which is said to contain the informal discussion in relation to the allegation. It also noted that there was no contemporaneous documentation to support the sub-charge.

The panel noted that it appeared that Miss Morgan had accepted the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Without contemporaneous evidence to determine if Miss Morgan left medication unattended, it could not determine if doing so was failing to demonstrate the

standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this charge not proved.

Charge 1d

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (d) On an unknown date in June 2018 left medication unattended on a trolley.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> ***"June 2018***
>
> *In June, I do not know the exact date the registrant again left medication unattended on a trolley in the corridor and was subsequently suspended from medication administration pending a competency assessment."*

The panel took account of a letter from Witness 2 to Miss Morgan, dated 3 August 2018, which detailed the outcome of a one-to-one performance review meeting between Witness 2 and Miss Morgan. The letter references discussion Witness 2 had with Miss Morgan regarding the importance of medication storage. There was no

information before the panel with regards to Miss Morgan leaving medication unattended in a trolly and whether or not it could have just been a mistake. The panel noted that that this letter was the only contemporaneous evidence it had to support the charge.

The panel noted that it appeared that Miss Morgan had accepted the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Without contemporaneous evidence to determine if Miss Morgan left medication unattended on a trolley, it could not determine if doing so was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 1e, 1f, 1g, 1h

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (e) On 5 October 2018 failed to correctly administer medication to a patient.
    (f) On 5 October 2018 left a patient's medication on top of their locker.
    (g) On 5 October 2018 failed to administer sodium docusate to a patient.
    (h) On 5 October 2018 incorrectly administered phenobarbital to a patient at the wrong time.

These sub-charges are found not proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"On 5 October 2018 the registrant made further drug errors, she failed to correctly administer patient medication and she left medication on top of the locker. All patients have a medication locker in their room and this is where the medications are stored for each patient. As the medication was left on the top of the locker*
>
> *There were two concerns; firstly the patient was not administered their prescribed medication and secondly if there was a wondering [sic] patient, they could have picked it up and took the medication. If a patient refused to take the medication then the correct procedure would be to lock the medication inside the locker until the patient agrees to take the medication or to destroy them. It was also raised that sodium docusate was omitted and the registrant had failed to follow the correct procedure in respect of a patient's controlled drug (phenobarbital), the medication was issued at the wrong time and that the medication was incorrectly signed off as the patient having received it."*

The panel noted that Witness 2 was not a direct witness to the allegations described in the sub-charges. The panel have no information before it to determine who exactly witnessed the allegations or who informed Witness 2. Witness 2 in her witness statement continued:

> *"We didn't retain the documentation, we recorded the error in the registrant's performance plan and the registrant was again suspended from drug administration pending further investigation."*

The panel noted that it did not have sight of Miss Morgan’s performance plan referenced in Witness 2’s witness statement.

The panel also took account of a letter from Witness 2 to Miss Morgan, dated 5 November 2018, which detailed the outcome of a one-to-one performance review meeting between Witness 2 and Miss Morgan. However neither this letter, nor any other information before the panel, particularises the allegations described in the sub-charges. There is no other contemporaneous evidence support to support the sub-charges.

The panel noted that it appeared that Miss Morgan had accepted the sub-charges within her CMF, with the exception of sub-charge 1h. However, it also noted that the CMF had not been signed or dated.

Without contemporaneous evidence to determine if Miss Morgan had acted as had been alleged in the sub-charges, it could not determine if doing so was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges not proved.

Charge 1i

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (i) Between 31 October 2018 and 5 November 2018 left medication unattended.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan’s CMF.

Witness 2 in her witness statement stated:

> *“There had been an incident since our last 1:1 (I am unsure of the exact date) in which the registrant had left medication unattended again.”*

The panel noted that Witness 2 was not a direct witness to this. It also noted that there is no evidence before the panel to support the sub-charge.

Without contemporaneous evidence to determine if Miss Morgan had left medication unattended between 31 October 2018 and 5 November 2018, it could not determine if doing so was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 1j

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (j) On or before 9 April 2019 left medication unattended and/or exposed.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan’s CMF.

Witness 2 in her witness statement stated:

> *"I exhibit an email from [Witness 7] dated 9 April 2019 …one of the Band 6 Nurses who worked alongside the registrant. This describes how the general feeling across the Band 6's is that the registrant was becoming increasingly difficult to work alongside…*
>
> *…The email also describes a number of other errors including…leaving medication unattended. Again, these were all the types of things I was seeing when I worked with the registrant which I would feedback to her during the shift when appropriate or at our 1:1's. They were not serious enough to warrant formal investigation and we was trying to manage this through the Performance Management Plan."*

The panel also took account of the email referenced above from Witness 7 to Witness 2. It stated that Witness 6 had asked Miss Morgan why Witness 6 had been reported for leaving tablets on the side and not her.

The panel also took account of a letter from Witness 2 to Miss Morgan, dated 5 November 2018, which detailed the outcome of a one-to-one performance review meeting between Witness 2 and Miss Morgan. However neither this letter, the aforementioned email from Witness 7, nor any other information before the panel, particularises the allegations described in the sub-charges. There is no other contemporaneous evidence support to support the sub-charges.

The panel noted that it did not have sight of Miss Morgan's Performance Management Plan referenced in Witness 2's witness statement.

Without contemporaneous evidence to determine if Miss Morgan had left medication unattended and/or exposed on or before 9 April 2019, it could not determine if doing so was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 1k

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (k) On one or more occasions on or before 28 June 2019 left keys unattended and insecure.

The panel found that the incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"We discussed the errors made within the medication round that I had prevented from occurring, such as leaving medication keys unattended on tables…"*

The panel bore in mind that Witness 2 stated in her oral evidence that she was directly supervising Miss Morgan at the time of this alleged incident which made her a direct witness. She also stated that nurses were expected to keep medication keys on their person attached to their uniform or in their pocket. She stated that the risk of leaving keys unattended is that patients could access the medication rooms and potentially overdose.

The panel took account of the outcome letter, dated 28 June 2019, of a performance review meeting between Witness 2 and Miss Morgan on 28 June 2019. It stated:

> *"We discussed the errors made within the medication round that I have prevented from occurring such as leaving keys unattended on tables…"*

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter corroborated the details in Witness 2's witness statement. In light of this the panel was satisfied that the incident alleged in the charge, namely that Miss Morgan left keys unattended and insecure on one or more occasions on or before 28 June 2019, had occurred.

At this stage, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 1l

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

   (l) On one or more occasions on or before 5 July 2019 rushed medication rounds.

The panel found that the incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"I met with the registrant for our next Performance Management 1:1 on 5 July 2019… During this meeting the registrant said she was still struggling and I discussed that at times, when the registrant is focused, her work is to a satisfactory level but this was unfortunately not consistent. I remained concerned with the registrant's ability to check the medication and the expiry dates properly and rushing the rounds which was resulting in the registrant still making potential errors (were I not to stand in)."*

The panel bore in mind that Witness 2 stated in her oral evidence that she was directly supervising Miss Morgan at the time of this alleged incident which made her a direct witness.

The panel took account of the outcome letter, dated 5 July 2019, of a performance review meeting between Witness 2 and Miss Morgan on 5 July 2019. It stated:

> *"I also explained that I am still concerned that…rushing the medication rounds…will cause you to make mistakes and I need to see more improvement when completing medication rounds."*

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter corroborated the details in Witness 2's witness statement. In light of this the panel was satisfied that the incident alleged in the charge, namely that Miss Morgan rushed medication rounds on one or more occasions on or before 5 July 2019, had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 1m

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (m) On or before 5 July 2019 failed to calculate the correct medication to be administered to a patient.

The panel found that the incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"I met with the registrant for our next Performance Management 1:1 on 5 July 2019… I was also concerned that the registrant was still unable to complete basic medication calculations.."*

The panel bore in mind that Witness 2 reiterated this in her oral evidence and stated that she was directly supervising Miss Morgan at the time of this alleged incident which made her a direct witness. She stated that Miss Morgan could not accurately calculate dosages. She cited an example where Miss Morgan was going to

administer two tablets to a patient where milligrams were indicated. She stated that Miss Morgan could not adjust according to the prescription.

The panel took account of the outcome letter, dated 5 July 2019, of a performance review meeting between Witness 2 and Miss Morgan on 5 July 2019. It stated:

> *“I am also concerned regarding your medication calculations. There was an incident where you needed to administer 62.5mg and the tablets was supplied in 50/12.5 mg you was unable to recognise the patient would need 1 tablet”*

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter corroborated the details in Witness 2’s witness statement. In light of this the panel was satisfied that the incident alleged in the charge, namely that Miss Morgan failed to calculate the correct medication to be administered to a patient on or before 5 July 2019, had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charge 1n

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

(n) On 15 July 2019 failed a medication assessment by:

- (i) Incorrectly attempting to administer the wrong dose of metformin to a patient.
- (ii) Incorrectly attempting to administer medication to a patient without knowledge of the drug.

The panel found that these incidents occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"[The Lead Nurse in Medicines Management] carried out the medication competency assessment on 15 July 2019…*
>
> *…I exhibit the feedback email from [The Lead Nurse in Medicines Management] with the concerns she had about this assessment...This describes how the registrant failed this due to a number of issues including; not checked medication labels against the MARS; attempting to administer a wrong dose of metformin (which is an instant fail)…*
>
> *…Another concern raised was that towards the end of the assessment the registrant began pre-signing for medication that she was yet to administer or even when she hadn't located the patient. This is completely against Trust medication policy and can led to medication errors being made…"*

The panel took account of the Medication Competency Assessment dated 16 July 2019. In the section entitled "Administering the medication" there is a sub-heading entitled "Activity". The second part of this "Activity" assessed whether Miss Morgan could select medication and check that it is appropriate and correct to prevent incorrect dosage and to comply with the NMC standards for medicines management.

Under the “Assessment” heading The Lead Nurse in Medicines Management has written “Fail”. She continued:

> *“Metaformin [sic] boxes state 500mg take two tablets twice a dat [sic]. Chart written (incorrectly) as 500 mg.*
>
> *BD – not identified by staff member Datix will be completed for wrong dose on chart”*

Additionally, in the section entitled "Administering the medication” there is a sub-heading entitled "Activity”. The first part of this “Activity” assessed whether Miss Morgan could check patients prescription sheet for a number of items including, but not limited to their name, address and allergies. This, according to the assessment was to prevent incorrect dosage and to comply with the NMC standards for medicines management. Under the “Assessment” heading The Lead Nurse in Medicines Management has written “Fail”. She continued:

> *“Did not identify that one patient had allergies…”*

The panel also noted that it appeared that Miss Morgan had denied both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned Medication Competency Assessment and the email dated 19 July 2019 from the Lead Nurse in Medicines Management, sent to Miss Morgan (which Witness 2 was copied into) summarising her concerns corroborated the details in Witness 2’s witness statement. In light of this the panel was satisfied that the incident alleged the incident alleged in both charges 1n(i) and 1n(ii) had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the

standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 1o

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (o) On or before 3 December 2021 did not administer the following medication to Resident B at 09.00am:
    - (i) Co-beneldopa 25mg/100mg.
    - (ii) Paroxetine 20mg.

The panel found that these incidents occurred.

In reaching this decision, the panel took account of the evidence of Witness 4, Witness 9, Witness 14 and Miss Morgan's CMF.

Witness 4 in her witness statement stated:

> *"The first concern was that RGN, [Witness 9] informed [Witness 14] on 3rd December date that she had noticed during the morning medication round that Resident B had had their medication signed for the previous day but that this hadn't actually been administered. I exhibit this MAR Chart…This shows that at 9am the registrant had signed to say that she had administered. The missing medication was CoBeneldopa and Paroxetine."*

Witness 4 reiterated this in her oral evidence. Witness 9 and Witness 14 supported Witness 4's account in their respective witness statements.

Witness 14 in her witness statement stated:

> *"On 03 December 2019, I recall a nurse called [Witness 9] informing me of her concerns regarding the registrant failing to administer Co-Benedopa [sic] medication to a resident with Parkinson's.*
>
> *At the time of the incident, we had electronic medication trays and it would be evident if anyone had missed their medication. It was noted that the medication in question was still in the tray, therefore the registrant failed to administer it to the resident."*

Witness 9 in her witness statement stated:

> *"All I know is that medication had been signed for as given by Karen on the MAR chart, but had not been administered. Co-Benedopa [sic], which is medication for Parkinson's Disease was supposed to be given at 6am by Karen, who was on night duty at the time. I would be responsible for the 9am medication."*

The panel bore in mind that Witness 4, in her oral evidence, stated that Miss Morgan worked three-day shifts per week and not night shifts. Therefore, Miss Morgan would not have been on a night shift contrary to what Witness 9 stated in her witness statement. However, the panel found consistency with the aforementioned witnesses, namely that Miss Morgan had not administered Co-beneldopa or Paroxetine.

The panel took account of the Resident B's MAR chart referenced in Witness 4's witness statement. It noted that there was a signature Witness 4 attributed to Miss Morgan for Co-beneldopa and Paroxetine at 09:00 for 2 December 2021. It bore in mind that Witness 4 in her oral evidence did not recognise the signature as belonging to Miss Morgan. However, she could not attribute the signature to any of the other staff members that were working there at the time.

The panel noted that it had taken account of other documentation with Miss Morgan’s signature on it. It was of the view that the signature found on other documentation was consistent with the signature found on the aforementioned MAR chart.

The panel also noted that Witness 4 in her witness statement stated:

> *...We knew the registrant hadn’t administered the medication because all of our drugs are kept in ‘bio-pots’ which come pre-packed in sealed pots with the name of the resident and the drug. They are similar to blister packs. The seal of this medication was still intact with the medication inside. The registrant should not have signed for the mediation before she had administered it.”*

The panel accepted the Witness 4’s evidence where she stated that the medication was kept in blister packs, despite the MAR chart stating otherwise.

The panel also noted that it appeared that Miss Morgan had denied both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 4, Witness 9 and Witness 14 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned MAR chart corroborated the details in Witness 4, Witness 9 and Witness 14 witness statements. In light of this the panel was satisfied that the incident alleged the incident alleged in both charges 1o(i) and 1o(ii) had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charge 1p

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

   (p) On or before 3 December 2021 administered or attempted to administer insulin to Resident A prior to checking their blood sugar levels beforehand.

The panel found that these incidents occurred.

In reaching this decision, the panel took account of the evidence of Witness 9 and Miss Morgan's CMF.

Witness 9 in her witness statement stated:

> *"The second incident involved a diabetic resident… saw Karen coming out of a resident's room and there was no contour device on the medication tray. I casually asked Karen if everything was OK and whether she checked the resident's blood sugar levels. She was shocked and said that she did not know she had to check the blood sugar levels first."*

The panel noted that Witness 9 was a direct witness to the alleged incident.

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF. Additionally she had written on the CMF, in respect of this charge *"Blood Sugar was checked"* However, it also noted that the CMF had not been signed or dated.

The panel took account of an email, dated 12 January 2022, Miss Morgan sent to the NMC, in respect of this charge. She stated:

"She told me that I had given a resident insulin without doing a blood sugar . This allegation is also unfounded . I was asked by the nurse do give a resident
his insulin I went back to the nurse and asked her if she wanted me to do his blood sugar as I did not want to prick him twice. We checked insulin dose together. His blood sugar was normal. I have had a lot of experience working with Diabetic residents. I know how important it is to check the blood sugars regularly. [PRIVATE]."

The panel was not persuaded by Miss Morgan's account. It could not comprehend Miss Morgan's statement where she stated, *"I did not want to prick him twice."* It was of the view a registered nurse would not have to measure the blood sugar of a resident twice before administering insulin.

In another email to the NMC dated 20 January 2022, Miss Morgan stated:

"I did not know whether or not she had checked his blood sugars so I went back and I asked her. She had not done his blood sugar so I returned back to his room and I did his blood sugar which was normal. The insulin was checked with the nurse and me before it was administered. I informed the nurse the result of the blood sugar. I have done nothing wrong."

The panel accepted the evidence of Witness 9, which it deemed to be credible, reliable and consistent. It was satisfied that the incident alleged in charge 1p had occurred. The panel noted the two different version of events put forward by Miss Morgan but preferred the evidence of Witness 9.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 1q

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

1. Medication management and/or medication administration but not limited to the following:

    (q) On one or more occasions on or before 3 December 2021 left the door to the medication room open and/or unlocked.

The panel found that these incidents occurred.

In reaching this decision, the panel took account of the evidence of Witness 9 and Miss Morgan's CMF.

Witness 4 in her witness statement stated:

> *"Another concern we had was that all medication is kept in a locked medication trolley inside a medication room that is key coded. The registrant had to be told on a number of occasions that she had left the door open. We had decorators in at the time, and the decorator told [Witness 14] that the registrant had asked him for the code to the clinical room as she forgotten this."*

Witness 14 reiterated this in her oral evidence.

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF. Additionally she had written on the CMF, in respect of this charge *"The haven nursing home was being decorated – door were all left open"* However, it also noted that the CMF had not been signed or dated.

The panel took account of an email, dated 12 January 2022, Miss Morgan sent to the NMC, in respect of this charge. She stated:

“The incident around leaving the treatment room open is also not true. I have read [Witness 3] statement and she said there was a painter there painting the door all day. The door was left open much of the day. She sad [sic] I am unsafe in my practice? How is this? All the drug trolleys are locked by the nurses and all the CD cupboards are locked. There Was always a nurse present when the painter was painting the door.

[Witness 3] said I had asked someone to open the clinical door because I had forgotten the number. I remember on my 3 rd day the code to the clinical room was not turning properly other nurses were having problems too. I did forget the code. What is wrong with asking someone for assistance. I also suffer with a disability Rheumatoid Arthritis my joints in my fingers were painful and I was having problems turning the door.” [sic]

The panel noted that Miss Morgan appeared to accept the charge in her response. She initially stated the painter had left the door open. However, she later stated she had forgotten the code.

The panel accepted the evidence of Witness 14 which it deemed to be credible, reliable and consistent. In light of this the panel was satisfied that the incident alleged in charge 1q had occurred. The panel noted the two different version of events put forward by Miss Morgan, neither addressed the mischief of the charge, and preferred the evidence of Witness 14.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charge 2a

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(a) On 6 May 2018 inaccurately observed that the patient was mobile and/or able to re-position themselves when this was not the case.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

"There was another incident on 6 May 2018 which a patient developed a large deep tissue injury. A Safeguarding investigation was opened and all staff that worked with this patient between 6-10 May were interviewed. It was discovered a HCA had raised this very early on to the registrant, on 6 May 2018 but there was no evidence any action had been taken and ultimately this deteriorated. The registrant was asked to attend an investigation meeting with [the Matron]…"

The panel bore in mind that Witness 2 was not a direct witness to the alleged incident. It took account of the Safeguarding Investigation Outcome Letter dated 22 June 2018, referenced in Witness 2's witness statement. It noted that the letter was addressed to Miss Morgan. The letter stated:

"Your statement also records that she was able to reposition herself at night and this was your reasoning for not putting an air mattress in place, unfortunately this is also in accurate as this lady was not able to initiate regular changes of position due to her cognitive impairment.

…

As part of the investigation I have spoken to all staff that looked after this patient from 6th May 2018 to the 10th May 2018"

The panel was mindful that this amounted to hearsay because the author of the letter had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the letter.

The panel focused on what was said within the aforementioned contemporaneous letter as opposed to the outcome of the investigation. It was of view that this letter was clearly related to the allegations in the charge.

The panel also noted that it appeared that Miss Morgan had denied the charge within her CMF.

The panel accepted the contemporaneous Safeguarding Investigation Outcome Letter dated 22 June 2018 and was satisfied that the incident alleged in charge 2a had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 2b

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:
   (b) On or before 9 April 2019 incorrectly identified that a patient had a burst blister.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"…I admitted a patient who had dry skin. The next day, Karen recorded this admission as a "burst blister" and thrown the admission documentation away."*

The panel took account of an email Witness 7 had sent to Witness 2, on 9 April 2019. In the email, Witness 7 stated that she had admitted a patient whose heel had excessive dry skin which was documented but Miss Morgan had documented it as a burst blister the next day.

The panel noted that Witness 7 in her oral evidence stated that changes to a patient's skin condition can change quickly. Witness 7 also stated that she had not returned to check if the dry skin blister on the patients heel she had identified had developed into a blister. As a result, the panel was of the view that neither Witness 7 nor the NMC could provide evidence to suggest that Miss Morgan was incorrect in identifying that the patient had a burst blister.

The panel noted that it appeared that Miss Morgan had denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Nevertheless, in the absence of evidence to the contrary, namely that Miss Morgan had incorrectly identified that a patient had a burst blister, it was not satisfied that this was indicative of Miss Morgan failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse. It also bore in mind that there is no other evidence to support the charge.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the account of Witness 7. However, she confirmed that she had not returned to the patient to see

whether or not a blister had developed. Therefore, she could not say that Miss Morgan was incorrect in identifying that the patient had a burst blister. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2c

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 2. Safe patient care and/or patient observations but not limited to the following:
>
> (c) On or before 5 July 2019 failed to recognise that a patient required 1 tablet to be administered.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

The panel took account of the outcome letter, dated 5 July 2019, of a performance review meeting between Witness 2 and Miss Morgan on 5 July 2019. It stated:

> *"I am also concerned regarding your medication calculations. There was an incident where you needed to administer 62.5mg and the tablets was supplied in 50/12.5 mg you was unable to recognise the patient would need 1 tablet"*

The panel noted that it appeared that Miss Morgan had not accepted nor denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent. In light of this the panel was satisfied that the incident alleged in charge 2c had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 2d

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 2. Safe patient care and/or patient observations but not limited to the following:
> (d) On or before 12 July 2019 failed to identity that a falls assessment was necessary when admitting a patient.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"I don't have a copy of these emails but the first was in relation to incomplete paperwork despite telling the Band 6 Nurse it was completed and when this was raised to her the registrant had said she didn't know she needed to complete a falls assessment on admission. The registrant said to me during the meeting that she had meant to say she had 'nearly' completed it and that she was aware the risk assessment documents needed completing".*

The panel bore in mind that Witness 2 was not a direct witness to the charge.
The panel also took account of a letter from Witness 2 to Miss Morgan, dated 15 July 2019, which detailed the outcome of a one-to-one weekly performance meeting between Witness 2 and Miss Morgan on 12 July 2019. This letter refers to two emails Witness 2 had received from two Band 6 nurses about Miss Morgan admitting a patient with the paperwork being incomplete. It stated:

> *"When the Band 6 nurse challenged you about completing the falls assessment she stated you seemed unaware that you needed to complete it on admission."*

The panel bore in mind that it did not have the two emails from the band 6 nurses referred to in the aforementioned letter. However, it noted that the letter specifically discusses the incident and Miss Morgan had responded to the incident. Within the letter Miss Morgan is referenced as saying she was helping the healthcare assistants with the meals and when also appeared to confirm that she was aware the risk assessment documents needed to be completed.

The panel accepted that Miss Morgan had a duty to complete the falls assessment because other members of staff, namely 2 band 6 nurses, had stated that Miss Morgan had to do it. Miss Morgan also appeared to have accepted that she knew she had to complete the falls assessment.

The panel also noted that it appeared that Miss Morgan had not accepted nor denied the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the contents of the aforementioned contemporaneous letter and was satisfied that the incident alleged in charge 2d had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charges 2e(i) and 2e(ii)

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(e) On 15 July 2019 failed a medication competency assessment by:

i. Incorrectly identifying patient allergies.
ii. On one or more occasions did not assess the patient prior to administering paracetamol.

The panel found that this incident occurred.

The panel bore in mind that this sub-charge is related to the same incident in sub-charge 1n. In light of this, it considered the same evidence, namely the Medication Competency Assessment dated 16 July 2019 provided by Witness 2 and Miss Morgan's CMF.

Within the aforementioned Medication Competency Assessment, next to the section entitled "Administering the medication" there is a sub-heading entitled "Activity". The first part of this "Activity" assessed whether Miss Morgan could check patients prescription sheet for a number of items including, but not limited to their name, address and allergies. This, according to the assessment was to prevent incorrect dosage and to comply with the NMC standards for medicines management. Under the "Assessment" heading The Lead Nurse in Medicines Management has written "Fail". She continued:

"Did not identify that one patient had allergies…"

Weight not checked before administering paracetamol 1G."

The panel also noted that it appeared that Miss Morgan had accepted both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the aforementioned Medication Competency Assessment and the email dated 19 July 2019 from the Lead Nurse in Medicines Management, sent to Miss Morgan (which Witness 2 was copied into) summarising her concerns corroborated the details in Witness 2's witness statement. In light of this the panel was satisfied that the incident alleged the incident alleged in both charges 2e(i) and 2e(ii) had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 2f

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2 Safe patient care and/or patient observations but not limited to the following:
   (f) On 27 April 2020, having left a patient's FP10 in the printer, the patient did not receive their medication on time.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"On 27 April 2020 the registrant left an FP10, which is a patient prescription, in the printer which meant this patient wasn't sent his medication from the pharmacy on time, this breached IG policy and potentially breached controlled stationary protocol. To my knowledge there were no missed doses of medication. The registrant stated she had been distracted and forgot, and that this was not done on purpose."*

The panel noted that Witness 3, the sole witness to the incident, in her witness statement stated, *"To my knowledge there were no missed doses of medication."* The panel had no evidence before it to suggest that the patient did not receive their medication on time.

The panel also noted that it appeared that Miss Morgan had accepted this sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

In the absence of evidence to the contrary, the panel was not satisfied that Patient A had received their medication late on 27 April 2020. Accordingly, the panel therefore found this sub-charge not proved.

Charge 2g

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

   (g) On one or more occasions on or before 27 April 2020 did not complete allocated NEWS observations.

The panel found that this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"There was also another incident raised to [Witness 8] that day that the registrant had not reported to the staff on duty that she hadn't completed the NEWS2 Observations she had been delegated ... I completed a fact finding with her regarding the FP10 and the observations on 14 May 2020"*

The panel took account of Witness 3's Fact Finding Report referenced in her witness statement. It stated:

> *On the 27/4/20 staff raised to [Witness 8] that [Miss Morgan] had not reported that she had not finished carrying out NEWS2 on all the patients delegated to her, and that [Miss Morgan] does not escalate NEWS2 when the patient scores.*

The panel also took account of an email sent by a member of staff to Witness 8, dated 28 April 2020 which stated that Miss Morgan is missing out on some service user observations. The panel was mindful that this amounted to hearsay because the author of the email had not attended to give evidence at this hearing nor provided a formal witness statement.

The panel also noted that it appeared that Miss Morgan denied the sub- charge within her CMF. She had also written, in relation to the sub-charge, "Misheard what was asked of me". However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the aforementioned Fact-Finding report from Witness 3. However, the panel was of the view that this was not sufficiently specific nor was it supported by the NEWS charts

for patients which had allegedly been omitted by Miss Morgan. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2h

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 2. Safe patient care and/or patient observations but not limited to the following:
>
> (h) On or before 27 April 2020 failed to escalate a NEWS score that required action to be taken.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"There was also another incident raised to [Witness 8] that day that the registrant had not reported to the staff on duty that she hadn't…escalated a score that required action to be taken. I completed a fact finding with her regarding the FP10 and the observations on 14 May 2020."*

The panel took account of Witness 3's Fact Finding Report referenced in her witness statement. It stated that Witness 8 had to check that there had been one particular occasion when a patient was scoring 2 on NEWS which was out of the ordinary for the patient and Miss Morgan took no action to escalate to the Doctor or report to the nurse caring for the patient.

The panel also took account of Stage 2 Formal Review Meeting Outcome Letter dated 12 June 2020. which was sent by Witness 3 to Miss Morgan. It confirmed that the allegation in described in the sub-charge was an “area of concern” to Witness 3.

The panel also took account of an email sent by a band 5 staff nurse to Witness 8, dated 28 April 2020 which stated that Miss Morgan is not escalating “if the service users are NEWSING”. The panel was mindful that this amounted to hearsay because the author of the email had not attended to give evidence at this hearing nor provided a formal witness statement. However, the contents of the email was supported by the aforementioned contemporaneous Fact Finding Report and Stage 2 Formal Review Meeting Outcome Letter.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous Fact Finding Report and the Stage 2 Formal Review Meeting Outcome Letter dated 12 June 2020 corroborated the details in Witness 3 witness statement. In light of this the panel was satisfied that the incident alleged in charge 2h had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charge 2i

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(i) On 30 April 2020 did not complete all allocated patient observations.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3, Witness 8 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"On 30 April 2020, [Witness 8] had asked the registrant to complete 16 patients' observations as they were short staffed on the ward. This enabled the nurses to spend their time carrying out the medication for all these patients. When [Witness 8] checked later on the registrant had only completed 10 of the 16 but had never informed anyone of this. When the registrant was asked about this she stated it was too many for 1 person to complete but she had no explanation as to why she hadn't told anyone or asked for help."*

Witness 8 in her witness statement stated:

> *"On 30 April 2020, Karen was asked to complete observations for 16 patients on the Unit, but she only completed observations for 10 patients. As I stated in this report, Karen informed me that she had already completed All the observations and that they were normal."*

Witness 8 reiterated this in her oral evidence. She stated that she had checked the observations Miss Morgan had made at the end of her shift because she did not have complete trust in Miss Morgan. Witness 8 stated that it was not the first time she had checked but this was the most significant number. She stated that Miss Morgan felt that completing observations for 16 patients was too many. Witness 8 disagreed with this. She stated if Miss Morgan believed that 16 observations was too many, then she would have expected her to raise this with her, another member of

the team or escalate to the matron. Witness 8 stated that Miss Morgan did not do this.

The panel also took account of Stage 2 Formal Review Meeting Outcome Letter dated 12 June 2020. which was sent by Witness 3 to Miss Morgan. It confirmed that the allegation in described in the sub-charge was an “area of concern” to Witness 3. The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 and Witness 8 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous Stage 2 Formal Review Meeting Outcome Letter dated 12 June 2020 corroborated the details in Witness 3 and Witness 8’s witness statements. In light of this the panel was satisfied that the incident alleged in charge 2i had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charges 2j and 2k

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(j) On 4 May 2020 did not immediately escalate to a doctor that a patient’s glucose test was below 3mmols.

(k) On 4 May 2020 did not use the Algorithm to treat the patient whose glucose test was below 3mmols.

The panel found that these incidents occurred.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"On 5 May 2020, one of the doctors raised verbally to [Witness 8] (there is no documentation of their concern) that the registrant had carried out a blood glucose test on a Diabetic patient, which was below 3 mmols, meaning the patient was hypoglycaemic. The registrant should have immediately escalated this so the patient could be given glucose and if necessary escalated to a doctor. However, the registrant did not do this and did not inform the doctor for 30 minutes. By this time the patient could have slipped into a diabetic coma.*
>
> *When I asked the registrant during the fact finding on 14 May 2020 why she did not act on this reading, she stated that she should have given something to raise the blood glucose levels, like "Coke". I asked why she would give Coke, and she became flustered and said, "Not Coke, glucose gel". I asked her if she was aware of the Algorithm to treat Hypoglycaemia, and she stated that she knew there was a print out in the Blood Glucose Orange Box, which tells you what to do, but she could not tell me why she had not followed it on this occasion. The registrant said she would do this next time."*

The panel took account of Witness 3's Fact Finding Report referenced in her witness statement. With regards to charge 2j, the report stated:

> *"On the 4/5/20 the Dr reported to [Witness 8] verbally that [Miss Morgan] had carried out a capillary blood glucose test on a Diabetic patient, which was below 3 mmols, so the patient was hypoglycaemic. [Miss Morgan] did not treat*

with glucose or repeat the test and told the Doctor 30 minutes after taking the reading. By this time the patient could have slipped into a diabetic coma….

When I asked why she did not act on this reading [Miss Morgan] stated that she should have given something to raise the blood glucose levels, like "Coke". I asked why she would give Coke, and she became flustered and said, "not Coke, glucose gel". I asked her if she was aware of the Algorithm to treat Hypoglycaemia, and she stated that she knew there was a print out in the Blood Glucose Orange Box, which tells you what to do, but she could not tell me why she had not followed it on this occasion. [Miss Morgan] stated she should have done, and would next time."

The panel noted that Miss Morgan had made statements within the fact finding report. However, there is no reference to her immediately escalating to the Doctor that the patient's glucose test was below 3mmols nor was there a reference to her using an algorithm to the treat the patient,

The panel also noted that it appeared that Miss Morgan had denied both sub-charges within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous fact finding report corroborated the details in Witness 3's witness statement. In light of this the panel was satisfied that the incident alleged both charges 2j and 2k had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 2l

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(l) On one or more occasions on or before 28 May 2020 demonstrated unsafe practice by using your mobile telephone whilst working.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

"During this meeting we also discussed concerns that had been raised across the ward that the registrant spent a lot of time on her phone whilst on shift. The registrant stated she only used her phone to check the date when she is completing her documentation."

The panel took account of the Feedback Letter following Fact Finding dated 28 May 2020 addressed to Miss Morgan from Witness 8. It stated that the use of a mobile phone should only be used on duty to access the British National Formulary. The panel bore in mind that it had not seen any written policy regarding the accepted use of mobile phones at the Trust. Additionally, within the letter, Miss Morgan stated that she used her phone to check the date whilst completing documentation.

However, when the panel took account of both the Witness statement and the aforementioned feedback letter, it could not ascertain how the use of a mobile phone contributed to unsafe practice.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

In the absence of evidence to the contrary the panel was not satisfied Miss Morgan using her mobile phone was indicative of her failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse. It also bore in mind that the feedback letter was the only contemporaneous evidence to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2m

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(m) On one or more occasions on or before 28 May 2020 demonstrated poor hygiene control by consuming food from the patients' food trolley.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"There were also concerns raised that the registrant takes food from the tea-time trolley before this had been given out to patients. The registrant accepted she did take food but only after it has been offered to patients. I advised the registrant this needed to stop immediately."*

The panel also noted that it appeared that Miss Morgan had accepted both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel took account of the Feedback Letter following Fact Finding dated 28 May 2020 addressed to Miss Morgan from Witness 8. It stated that it was unacceptable to consume patients' food and this was unprofessional, sets a poor example to colleagues and contravenes Food Hygiene Standards.

However, when the panel took account of both the Witness statement and the aforementioned feedback letter, it noted that there was no evidence before it to demonstrate how Miss Morgan's actions demonstrated poor hygiene control. It noted that the feedback letter referred to a Food Hygiene Standards Policy but the panel did not have sight of that policy.

In the absence of evidence to the contrary the panel was not satisfied Miss Morgan's alleged conduct in the charge was indicative of her failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse. It also bore in mind that the feedback letter was the only contemporaneous evidence to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2n

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 2. Safe patient care and/or patient observations but not limited to the following:

(n) On or before 12 June 2020 demonstrated poor infection control by placing a Covid-19 patient's property in the clean stores.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"There had also been an incident, which was discussed with [Miss Morgan] during the Stage 2 formal review meeting on 12 June 2020…in which the registrant mixed a patient's property, who had tested positive for Covid-19 with the clean stores on the Unit. When challenged by a HCA about this, the registrant said she would sort it out the next day and didn't see the issue when this was contested. I asked the registrant about this and she denied this incident, stating that the HCA was trying to get her into trouble and she should be asked about some of her own practices."*

The panel took account of the Feedback Letter following Fact Finding dated 28 May 2020 addressed to Miss Morgan from Witness 8. It confirmed that what was described in the sub-charge had been reported to Witness 8.

The panel noted that Witness 3 was not a direct witness to this charge and the HCA appeared to have reported the matter to Witness 3. However, the HCA had not attended to give evidence nor did the panel have a witness statement or any cotemporaneous evidence from them.

The panel also took account of an email, dated 17 June 2020, Miss Morgan had sent to Witness 3 in response to the allegation in the charge. She stated that the store cupboard already had items belonging to the patient in it. She stated that there were two patients and one had passed away. So she disposed of the items belonging to the deceased patient the bin and stored the items belonging to the other patient in the patients bathroom.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

In the absence of evidence to the contrary the panel was not satisfied Miss Morgan's alleged conduct in the charge was indicative of her failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel noted that there is no contemporaneous evidence to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2o

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 2. Safe patient care and/or patient observations but not limited to the following:
>
> (o) On or before 27 October 2020 demonstrated poor hygiene and/or infection control by placing a patient's unsealed urine sample in the fridge.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"I have been referred to an email I sent to [Witness 8], the new unit manager…My concern at the time was that an agency nurse had found a*

urine sample in the fridge, which had not been sealed and brought this to me. MSU is a “Midstream Specimen Urine”. This is bad practise [sic] as it can lead to cross infection and the sample was missing from the form.”

The panel bore in mind that Witness 7 was not a direct witness to what was described in the charge. It noted that an agency nurse had reported the matter, but she, nor any other witness, did not see Miss Morgan place the urine sample into the fridge. Nevertheless, this agency nurse had not attended to give evidence nor did the panel have a witness statement or any cotemporaneous evidence from them.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

In the absence of evidence to the contrary the panel was not satisfied Miss Morgan’s alleged conduct in the charge was indicative of her failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel noted that there is no contemporaneous evidence to support the charge.

The panel therefore found this sub-charge not proved.

Charge 2p

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(p) On 23 March 2021 did not secure a patient’s catheter bag full of urine prior to mobilising them.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"On 23 March 2021 there was another incident involving the registrant raised by [the Sister]. I exhibit this email…The registrant was mobilising a patient with a catheter full of urine, not tied to his leg, which could have resulted in the catheter being traumatically pulled out, and causing pain and bleeding for the patient...*
>
> *The registrant then emailed me, stating that she knew [the Sister] was going to call me about her performance and she wanted to say that this was due to her falling over that morning and banging her head when she was putting her bins out."*

The panel took account of the contemporaneous email sent from the Witness 3, dated 23 March 2021, to Miss Morgan. She relayed to Miss Morgan what she had heard from the Sister expressing concerns about her performance with "aspects of care" that would be considered "basic care needs".

The panel also took account of the email from Miss Morgan, dated 23 March 2020, referenced in Witness 3's witness statement. Miss Morgan stated that she believed the Sister had informed Witness 3 about her performance and said that it was down to not feeling well on the day.

The panel noted that Witness 3 was not a direct witness to this charge and the Sister appeared to have reported the matter to Witness 3. Additionally, the Sister had not attended to give evidence nor did the panel have a witness statement or any cotemporaneous evidence from them. The information from the Sister therefore amounted to hearsay. However, the panel was satisfied that the emails supported the details contained within Witness 3's witness statement.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous emails corroborated the details in Witness 3's witness statement. In light of this the panel was satisfied that the incident alleged charge 2p had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 2q

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

2. Safe patient care and/or patient observations but not limited to the following:

(q) On or before 3 December 2021 did not check Resident A's blood sugar levels prior to administering or attempting to administer insulin to them.

The panel found that this incident occurred.

The panel noted that this sub-charge was related to the same incident in sub-charge 1p. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 9 and Miss Morgan's CMF.

It reminded itself that Witness 9 was a direct witness to the incident confirmed that Miss Morgan told her that was not aware that she had to check the blood levels prior to administering insulin.

As with charge 1p, the panel could not comprehend the response from Miss Morgan and found Witness 9's evidence to be credible, reliable and consistent.

For the same reasons as charge 1p, the panel determined that the incident in charge 2q occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3a and 3b

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
    (a) On an unknown date in March 2018 did not sign for patient medication.
    (b) On an unknown date in March 2018 did not enter an omission code

The panel found these sub-charges not proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. The panel also noted that this sub-charge was the same incident in sub-charge 1c. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 2 and Miss Morgan's CMF.

As with charge 1c, the panel reminded itself that it did not have much information about this charge beyond what Witness 2 had stated in her witness statement which

was not sufficiently specific. It also reminded itself that it did not have access to Miss Morgan's personnel file referenced in Witness 2's witness statement, and noted that there is contemporaneous documentation to support either of the sub-charges.

The panel also noted that it appeared that Miss Morgan had ticked both "yes" and "no" for sub-charge 3a and ticked "yes" for sub charge 3b within her CMF. However, it also noted that the CMF had not been signed or dated.

Nevertheless, for the same reasons as charge 1c, without contemporaneous evidence to determine if the actions described in the sub-charges occurred, it could not determine if not doing so was a failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges not proved.

Charge 3c and 3d

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
    (c) On 6 May 2018 did not record in a patient's notes that you had reviewed them and/or actions that were taken by you.
    (d) On 6 May 2018 did not record in the patient's notes that you had handed over your actions to night staff.

The panel found that these incidents occurred.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. The panel also noted that these sub-charges are related to the same incident in sub-charge 2a.

The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 2 and Miss Morgan's CMF.

As with charge 2a, the panel reminded itself that while Witness 2 was not a direct witness to the incident, the Safeguarding Investigation Outcome Letter dated 22 June 2018, referenced in Witness 2's witness statement was related to the sub-charges.

The panel also noted that it appeared that Miss Morgan had accepted both parts the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

For the same reasons as charge 2a, the panel determined that the incident in sub-charges 3c and 3d occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3e

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (e) On 5 October 2018 incorrectly signed off that a patient had received their medication.

The panel found this sub-charge not proved.

The panel also noted that this sub-charge is related to the same incidents in sub-charges 1e, 1f, 1g and 1h. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 2 and Miss Morgan's CMF.

As with sub-charges 1e, 1f, 1g and 1h, the panel reminded itself that Witness 2 was not a direct witness to the allegations described in charge 3e nor did it have any information before it to determine who informed Witness 2 of the allegations.

The panel also did not have sight of a MAR chart to determine whether Miss Morgan incorrectly signed off that a patient had received their medication.

The panel also noted that it appeared that Miss Morgan had accepted the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Nevertheless, for the same reasons as sub-charges 1e, 1f, 1g and 1h, without contemporaneous evidence to determine if the actions described in the sub-charge occurred, it could not determine if incorrectly signing off that a patient had received their medication was failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 3f

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (f) On or before 9 April 2019 incorrectly recorded that a patient had a burst blister.

The panel found this sub-charge not proved.

The panel noted that this sub-charge was related to the same incident in sub-charge 2b. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 7 and Miss Morgan's CMF.

As with charge 2b, the panel reminded itself that Witness 7 confirmed that she had not actually returned to the patient to see whether or not a blister had developed. Therefore, she could not say that Miss Morgan was incorrect in recording that the patient had a burst blister.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

For the same reasons as charge 2b, without contemporaneous evidence to determine if the actions described in sub-charge 3f occurred, it could not determine if not doing so was a failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 3g

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (g) On or before 9 April 2019 thrown a patient's admission documentation, green Waterlow book away.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"Secondly, I admitted a patient who had dry skin. The next day, Karen recorded this admission as a "burst blister" and thrown the admission documentation away.*
>
> *She had replaced the Waterlow documentation with a pressure ulcer book. A Waterlow book is used to assess a patient's likelihood of getting pressure sores and suffering from pressure damage. It asks a series of questions, answers to which you will score, which will give a result that will determine how high the risk was for patient to develop a pressure sore. By replacing the pressure book, she did the correct thing, but my concern was that she had thrown the admission documentation away. Nurses are not supposed to discard admission documentation even if errors are made. When I asked her about this, she shrugged her shoulders and admitted that she had thrown my admission documentation away."*

Witness 7 reiterated this in her oral evidence. It also took account of a contemporaneous email from Witness 7 sent to Witness 2 dated 9 April 2019. In this email Witness 7 stated that Miss Morgan had thrown the admission documentation away and "thrown the green Waterlow book away and replaced it with the pressure ulcer one". The email also stated that Miss Morgan response when confronted about this was "shrugged shoulders".

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 7 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous email corroborated the details in Witness 7's witness statement. In light of this the panel was satisfied that the incident alleged in charge 3g had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the

standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3h and 3i

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (h) On or before 9 April 2019 incorrectly replaced the green Waterlow book with the pressure ulcer book.
   (i) On or before 9 April 2019 did not complete admission documentation correctly.

The panel found the sub-charge not proved.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

The panel took account of the same section of Witness 7's witness statement quoted in sub-charge 3g. It also took account of the same contemporaneous email from Witness 7 also quoted in sub-charge 3g.

The panel bore in mind that in charge 2b, which is in relation to the same incident considered in this sub-charge, Witness 7 stated in oral evidence that she had not returned to check if the dry skin on the patient's heel she had identified had developed into a blister. Therefore, it could not find that Miss Morgan was incorrect in identifying that the patient had a burst blister.

The panel noted that Miss Morgan's actions alleged in the sub-charge would have been the correct thing to do if a blister had been identified. However, the panel had been unable to determine whether or not the patient had a blister.

In light of the above, the panel therefore could not determine if Miss Morgan had incorrectly replaced the green Waterlow book with the pressure ulcer book.

With regards to charge 3i, the panel bore in mind that Witness 7, as stated in her witness statement, she completed the admission documentation. Within her aforementioned contemporaneous email, she stated "Admission documentation is not completed properly". However, this admission documentation is not before the panel so it could not ascertain whether or not Miss Morgan had completed the admission documentation, if she had completed it incorrectly or any evidence to suggest why it is incorrect.

The panel also noted that it appeared that Miss Morgan had accepted sub-charge 3h within her CMF but had not accepted nor denied sub-charge 3i. However, it also noted that the CMF had not been signed or dated.

Nevertheless, without contemporaneous evidence to determine whether or not the patient had a blister, it could not determine whether or not Miss Morgan's actions described in sub-charge 3h was correct or not. It therefore could not determine if by replacing the green Waterlow book with the pressure ulcer book was a failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse. Additionally, the panel did not have sight of the admissions documentation so it could not determine if sub-charge 3i occurred.

The panel therefore these sub-charges not proved.

Charge 3j

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:

(j) On one or more occasions, on or before 9 April 2019 left documentation in the printer.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

The panel took account of a contemporaneous email from Witness 7 sent to Witness 2 dated 9 April 2019. Witness 7 within the email stated, "When printing documentation, half is left in the printer".

However, had no indication as to what the documentation is or any evidence to indicate to the panel how Witness 7 knows that it was Miss Morgan who had left the documentation in the printer.

The panel also noted that it appeared that Miss Morgan had accepted the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Nevertheless without sufficient evidence to determine if the actions described in the sub-charge occurred, it could not determine if leaving documentation in the printer was a failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charge 3k

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:

(k) On or before 9 April 2019 did not send social work referral documentation when required.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

The panel took account of a contemporaneous email from Witness 7 sent to Witness 2 dated 9 April 2019. Witness 7 within the email stated, "Completed a social work referral documented it as done, but did not send". However, the social work referral is not before the panel and the evidence to suggest that Miss Morgan did not send it was sufficiently specific for the panel to determine the mischief of the sub-charge had occurred.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

Nevertheless, without sufficient evidence to determine if the actions described in the sub-charge occurred, it could not determine if leaving documentation in the printer was a failure to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found this sub-charge not proved.

Charges 3l and 3m

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:

(l) On one or more occasions on or before 28 June 2019 did not check patient wrists bands.

(m) On one or more occasions on or before 28 June 2019 did not sign for the correct medication and/or at the correct times.

The panel found that this incident occurred.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. The panel also noted that these sub-charges were the same incident in sub-charge1k. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 2 and Miss Morgan's CMF.

As with charge 1k, the panel reminded itself that while Witness 2 was directly supervising Miss Morgan at the time of the alleged incident which made her a direct witness. It took account of the outcome letter, dated 28 June 2019, of a performance review meeting between Miss Morgan and Witness 2 referenced in Witness 2's witness statement. It stated:

> *"We discussed the errors made within the medication round that I have prevented from occurring such as…checking wrist bands and signing not for the right medication at the right time."*

The panel also noted that it appeared that Miss Morgan had denied sub-charge 3l but accepted sub-charge 3m within her CMF. However, it also noted that the CMF had not been signed or dated.

As with charge 1k, the panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter corroborated the details in Witness 2's witness statement. It therefore determined that the incidents described in both sub-charges occurred.

For the same reasons as charge 1k, the panel determined that the incident in sub-charges 3l and 3m occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3n

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (n) On one or more occasions on or before 28 June 2019 incorrectly identified expiry dates on Blister Packs.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"On 28 June 2019 I met with the registrant for another 1:1 performance review meeting. I exhibit the outcome letter...During this meeting I discussed with the registrant the concerns I still had with the registrant's medication administration, specifically her ability to check the expiry dates on the blister packs which the registrant was making mistakes on most occasions I asked. I again informed the registrant that she needed to get her eyes checked and she said she had just had an eye test and didn't require stronger glasses."*

The panel bore in mind that Witness 2 stated in her oral evidence that she was directly supervising Miss Morgan at the time of this alleged incident which made her a direct witness.

The panel took account of the outcome letter, dated 28 June 2019, of a performance review meeting between Witness 2 and Miss Morgan on 28 June 2019. This letter reaffirmed what Witness 2 stated in her witness statement. Within the letter Witness 2 stated that she believed Miss Morgan had problems checking the expiry dates on the Blister packs and advised Miss Morgan to have her eyes tested.

The panel also noted that it appeared that Miss Morgan had accepted both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2, which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter corroborated the details in Witness 2's witness statement. In light of this the panel was satisfied that the incident alleged in the sub-charge had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3o

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (o) On one or more occasions on or before 5 July 2019 incorrectly identified medication and/or Blister Pack expiry dates.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

The panel took account of the outcome letter, dated 5 July 2019, of a performance review meeting between Witness 2 and Miss Morgan on 5 July 2019. It stated:

> *"I remain concerned that you are unable to see the blister packs and I strongly advise you to have your eyes tested again".*

The panel bore in mind that Witness 2 stated in her oral evidence that she was directly supervising Miss Morgan at the time of this alleged incident which made her a direct witness.

The panel also noted that it appeared that Miss Morgan had denied the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous outcome letter, dated 5 July 2019 appeared to corroborate the panel's findings in charge 3n since the similar incident occurred on 28 June 2019. In light of this the panel was satisfied that the incident alleged the incident alleged in sub-charge 3o had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3p

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (p) On or before 12 July 2019 did not complete the falls assessment when admitting a patient.

The panel found that this incident occurred.

The panel also that this sub-charge was the same incident in sub-charge 2d. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 2 and Miss Morgan's CMF.

As with charge 2d, the panel reminded itself that Witness 2 was not a direct witness to the incident. However, it took account a letter from Witness 2 to Miss Morgan, dated 15 July 2019, which detailed the outcome of a weekly performance meeting between Witness 2 and Miss Morgan on 12 July 2019. This letter refers to two emails Witness 2 had received from two Band 6 nurses about Miss Morgan admitting a patient with the paperwork being incomplete. While the panel did not have sight of the two emails, it noted that the letter specifically discussed the incident and determined that Miss Morgan had an opportunity to respond.

As with charge 2d, the panel accepted that Miss Morgan had a duty to complete the falls assessment because other members of staff, namely 2 band 6 nurses, had stated that Miss Morgan had to do it. Miss Morgan also appeared to have accepted that she knew she had to complete the falls assessment.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

For the same reasons as charge 2d, the panel determined that the incident described in the sub-charge occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3q

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:

   (q) On 15 July 2019 failed a medication assessment by:

   (i) On one or more occasion did not check medication labels against the MAR Charts.

   (ii) On one or more occasions did not check expiry dates.

   (iii) On one or more occasions did not check the MARS properly.

   (iv) On one or more occasions provided the incorrect expiry date on Blister packs.

   (v) On one or more occasions pre-signed medication that had yet to be administered.

   (vi) On one or more occasions pre-signed for medication prior to locating the patient.

   (vii) Not checking the date an insulin pen had been opened.

The panel found that these incidents occurred.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"[The Lead Nurse Medicines Management] carried out the medication competency assessment on 15 July 2019…*

I exhibit the feedback email from [The Lead Nurse Medicines Management] with the concerns she had about this assessment… This describes how the registrant failed this due to a number of issues including; not checked medication labels against the MARS; attempting to administer a wrong dose of metformin (which is an instant fail); not identifying patient allergies; attempting to administer medication without knowledge of what the drug was; not checking expiry dates; and not checking the MARs properly.

A concern was also raised that when [The Lead Nurse Medicines Management] asked the registrant to read a date from the blister pack she actually quoted a date that had been cut off Another concern raised was that towards the end of the assessment the registrant began pre-signing for medication that she was yet to administer or even when she hadn't located the patient. This is completely against Trust medication policy and can led to medication errors being made. The registrant also was only able to answer correctly one of the medication calculations correctly."

The panel took account of the Medication Competency Assessment dated 16 July 2019.

With regards to charge 3q(i), on a document entitled "Record of Assessment of Competence in administering medication", it appeared that Miss Morgan had been assessed as needing further training. Under the sub-heading entitled "Reason for Decision" it stated, "One medication administration charge did not match the labels on the box (not identified by staff member)".

With regards to 3q(ii), in the section entitled "Administering the medication" there is a sub-heading entitled "Activity". The second part of this "Activity" assessed whether Miss Morgan could select medication and check that it is appropriate and correct to prevent incorrect dosage and to comply with the NMC standards for medicines management. Under the "Assessment" heading The Lead Nurse in Medicines Management has written "Fail" and annotated "Expiry dates not accurately checked ' appeared' to read an expiry date on one blister when none was present".

With regards to charge 3q(iii), the panel noted the contemporaneous Medication Competency Assessment where The Lead Nurse in Medicines Management has annotated “Did not actively check patient information on ‘2nd’ chart”. The panel accepted this.

With regards to charge 3q(iv), within the same section considered for charge 3q(iii), the Lead Nurse in Medicines Management has annotated “Did not identify that cholecalciferol was in blister pack – was going to order more”.

With regards to charge 3q(v) and 3q(vi) in the section entitled "Administering the medication” there is a sub-heading entitled "Activity”. The fourth part of this “Activity” is in reference to signing the medicine chart for medication administered. The Lead Nurse in Medicines Management has annotated “started to sign charts before medication administered when patient not even in the room”.

With regards to charge 3q(vii), within the same section considered for charge 3qii, the Lead Nurse in Medicines Management has annotated “Insulin – date of opening not checked”.

The panel also noted that it appeared that Miss Morgan had accepted 3(i), 3(ii), 3(iii) and 3(iv), denied sub-charge 3(vi) and had not accepted nor denied 3(vii) and 3(v) within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Medication Competency Assessment corroborated the details in Witness 2 witness statement. In light of this the panel was satisfied that the incidents alleged in each part of this sub-charge had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan’s practice.

Charge 3r

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (r) On 3 December 2019 did not follow clear instructions in a patient's notes on who to contact when an incident occurs.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3, Witness 8 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"The registrant had reduced 2 new administrative staff on the unit to tears due to bullying and aggressive behaviour which she then outright denied. There was also another incident in which the registrant telephoned a patient's husband to inform them that their wife had had a fall despite clear instruction in their notes to only contact the son. The registrant offered no apology and showed no recognition of her mistake."*

The panel took account of an email sent by Witness 3, dated 4 December 2019, which was sent to the Chief Nurse outlining the concerns alleged in the sub-charge. This email confirmed what is within Witness 3's witness statement. Within the email, Witness 3 stated that Miss Morgan called the patients husband to inform him of a fall, however, this was contrary to the instruction on admission documents associated with the patient. The patient's son was to be informed.

Witness 8 was copied into the aforementioned email which she confirmed in her witness statement.

The panel also noted that it appeared that Miss Morgan had accepted the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 and Witness 8 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous email, dated 4 December 2019 corroborated the details in Witness 3 and Witness 8's witness statements. In light of this the panel was satisfied that the incident alleged in sub-charge 3r had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3s

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (s) On 27 April 2020 left a patient's FP10 in the printer.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3, Witness 8 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"On 27 April 2020 the registrant left an FP10, which is a patient prescription, in the printer which meant this patient wasn't sent his medication from the pharmacy on time, this breached IG policy and potentially breached controlled*

stationary protocol… I completed a fact finding with her regarding the FP10 and the observations on 14 May 2020"

The panel took account of Witness 3's Fact Finding Report referenced in her witness statement. It stated that on 27 April 2020, Miss Morgan had left an FP10 in the printer.

The panel took account of Witness 3's Feedback Letter following Fact Finding, dated 28 May 2020 which was addressed to Miss Morgan. It referenced "Leaving an FP10 prescription on the photocopier" and stated that Witness 3 had advised Miss Morgan that she had "compromised the Information Governance Policy by leaving confidential documentation in a public area and also breached the Medicines Management Policy by leaving controlled stationary unattended."

The panel also took account of an email sent by a band 5 staff nurse to Witness 8, dated 28 April 2020 which stated that on 27 April 2020, Miss Morgan had "left an FP10 in the printer". The panel was mindful that this amounted to hearsay because the author of the email had not attended to give evidence at this hearing nor provided a formal witness statement. However, the contents of the email was supported by the aforementioned contemporaneous feedback letter from Witness 3.

Witness 8 in her witness statement confirmed that she had completed the aforementioned Fact Finding report with Witness 3.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 and Witness 8 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous Fact Finding Report and the Feedback Letter following Fact Finding corroborated the details in Witness 3 and Witness 8 in their witness statements. In light of this the panel was satisfied that the incident alleged in sub-charge 3s had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charges 3t and 3u

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (t) On 26 May 2020 faxed a tissue Viability for the wrong patient.
   (u) On 26 May 2020 sent a wound swab that was labelled with another patient's details.

The panel found that these incidents occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 3, Witness 6 and Miss Morgan's CMF.

Witness 6 in her witness statement stated:

> *"I have been referred to…an email that I sent to [Witness 3]. I recall that at handover, I was told that Patient DT had leg ulcers, a swab had been taken and that the Tissue Viability Nurse ("TVN") had been informed.*
>
> *Following handover, I reviewed Patient DT and I noticed there was discolouration in their legs and asked for a doctor to review this patient. I do not recall the name of the patient nor the doctor. I cannot recall who I took handover from. I realised that Patient DT had a rash and not a leg ulcer. I did some further investigation and found that the patient who had the leg ulcers*

and wound was Patient DS, a different patient. Patient DS was in the room next door Patient DT…

…In order to complete a TVN referral, a nurse would have to fill in details, such as the name, address for the patient, their NHS number and their date of birth. On entry in the nursing notes, Karen documented it in the wrong patient's notes."

The panel took account of an email from Witness 6 to Witness 3, dated 27 May 2020, referenced in Witness 6's witness statement. The email confirmed what Witness 6 had stated in her witness statement.

Witness 3 confirmed that she received the aforementioned email from Witness 6. Witness 6 in her oral evidence accepted that it could be easy to mix up patient notes as they were all kept close together. The panel accepted that these errors could occur, however that would put a registered nurse on notice to be extra vigilant when completing documentation.

The panel also noted that it appeared that Miss Morgan had accepted sub-charge 3t and denied sub-charge 3u within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 6 and Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous email corroborated the details in Witness 6 and Witness 3 witness statements. In light of this the panel was satisfied that the incident alleged the incident alleged in the sub-charges had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3v

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (v) On one or more occasions on or before 2 August 2020 did not maintain and/or keep patient care plans up to date.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"Every week on a Saturday, nurses were given their care plans to update. Each nurse was responsible for 2 to 3 care plans. I noticed that Karen hadn't completed care plans when they were supposed to be completed. When I looked at the care plans again, I realised that the care plans had been updated and Karen had backdated the dates. I think that she was afraid of not having completed them...*
>
> *Expectancy at Ann Marie Howes is that your 'own' care plans are updated weekly."*

The panel took account of an email, dated 2 August 2020, sent by a Witness 7 to Witness 8, referenced in Witness 7's witness statement. The email confirmed what Witness 7 stated in her witness statement. Within the email, Witness 7 stated that she checked the care plans weekly and she had informed Miss Morgan that she needed to keep them up to date. Witness 7 also stated that Miss Morgan had told her that she was updating her care plans which had not been updated in three to four weeks.

The panel also noted that it appeared that Miss Morgan had neither accepted nor denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 7 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous email corroborated the details in Witness 7's witness statements. In light of this the panel was satisfied that the incident alleged in sub-charge 3v had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3w

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:
   (w) On or before 27 October 2020 incorrectly sent a patient's discharge letter to the GP before the patient had been discharged.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

"I have been referred to…an email I sent to [Witness 8], the new unit manager…The second concern I discuss in the email is surrounding another patient in Room 10. The patient's discharge had been delayed and was still

an inpatient, but Karen had sent the discharge letter to the GP. I asked her to phone GP and asked to destroy it as patient was still an inpatient. We only look after inpatients. GP letters are discharge letters from the unit updating GP's of reason for admission and current discharge medication. Letters are only sent on discharge once patient has gone."

The panel took account of an email, dated 28 October 2020, sent by Witness 7 to Witness 8, referenced in Witness 7's witness statement. The email confirmed what Witness 7 stated in her witness statement. Within the email, Witness 7 stated that when she looked for the discharge letter, she had found that the original had already been sent to the GP. Witness 7 stated that she had advised Miss Morgan not to send discharge letters until the patient was discharged.

The panel also noted that it appeared that Miss Morgan had accepted both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 7 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous email corroborated the details in Witness 7's witness statements. In light of this the panel was satisfied that the incident alleged in sub-charge 3w had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 3x

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

3. Record Keeping and/or documentation but not limited to the following:

(x) On or before 3 December 2021 incorrectly signed the MAR chart indicating that the following medication had been administered Resident B at 09.00:

(i) Co-beneldopa 25mg/100mg

(ii) Paroxetine 20mg.

The panel found that this incident occurred.

The panel considered these parts of this sub-charge separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. The panel also noted that these sub-charges were the same incident in sub-charge1o. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 4, Witness 9, Witness 14 and Miss Morgan's CMF.

As with charge 1o, the panel reminded itself that while Witness 9 and Witness 14 supported Witness 4's account in their respective witness statements and found that they were consistent, namely that Miss Morgan had not administered Co-beneldopa or Paroxetine.

As with charge 1o, the panel took account of Resident B's MAR chart and noted that there was a signature Witness 4 attributed to Miss Morgan for Co-beneldopa and Paroxetine at 09:00 for 2 December 2021. The panel accepted this as Miss Morgan's because it was similar to signatures found on other documentation.

The panel also noted that it appeared that Miss Morgan had denied both parts of the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 4, Witness 9 and Witness 14 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned MAR chart corroborated the details in Witness 4, Witness 9 and Witness 14 witness statements. In light of this the panel was satisfied that the incident alleged the incident alleged in both sub-charges 3x(i) and 3x(ii) occurred.

For the same reasons as charge 1o, the panel determined that the incident in both parts of sub-charges 3x(i) and 3x(ii) occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 4a

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:
>
> > (a) On or before 5 November 2017 were rude to a patient's daughter.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"I was also aware that just before I commenced in the role there was an incident in which the registrant failed to give a patient her medication, discarded the medication incorrectly and was rude to the patient's daughter. I exhibit the outcome letter…but as I wasn't involved in the incident I do not have any further information about this."*

The panel took account of the outcome letter, dated 15 November 2017, referenced in Witness 2's witness statement. It noted that the letter was addressed to Miss Morgan. The letter stated that the patient's daughter said Miss Morgan was "rude

and had an attitude when she asked you why her mother's medication was still in a pot in her room".

However, similarly to charges 1a and 1b, the panel was mindful that the aforementioned letter amounted to hearsay because the author of the letter had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the letter. It also bore in mind that the letter was the only contemporaneous evidence to support the charge.

The panel also noted that it appeared that Miss Morgan had denied the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge come from the account of Witness 2. However, she did not observe the allegation described within this sub-charge. Additionally, the outcome letter was hearsay and the contents could not be tested by the panel. There is no other contemporaneous evidence before the panel to support the charge.

In the absence of evidence to the contrary the panel was not satisfied that Miss Morgan allegedly being rude to a patient's daughter was failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse. It also bore in mind that the letter was the only contemporaneous evidence to support the charge.

The panel therefore found this sub-charge not proved.

Charge 4b

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:

(b) On one or more occasions on or before 9 April 2019 displayed unprofessional behaviour towards colleagues.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"I exhibit an email from [Witness 7] dated 9 April 2019…one of the Band 6 Nurses who worked alongside the registrant. This describes how the general feeling across the Band 6's is that the registrant was becoming increasingly difficult to work alongside. Communication with colleagues had been an issue since I managed the registrant with staff finding her to be unapproachable, unprofessional and often angry and defensive when concerns were raised so this wasn't something I didn't know."*

The panel took account of an email from Witness 7, dated 9 April 2019 to Witness 2. It mentioned that Miss Morgan had become difficult to work with. However, the panel noted that it had no further details as to what was unprofessional about Miss Morgan's behaviour to colleagues. While there is a reference to communication, there is no information before the panel to determined what was said, how it was said, how it was investigated and how it was managed.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the aforementioned contemporaneous email from Witness 7. However, the panel noted that it had no further details as to what was unprofessional about Miss Morgan's

behaviour to colleagues. While there is a reference to communication, there is no information before the panel to determined what was said, how it was said, how it was investigated and how it was managed. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 4c

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:
>
> (c) On 9 April 2019 spoke abruptly to a patient.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"I have been referred to…an email I had sent to [Witness 2] about issues I was having with Karen. I can confirm the content of this email is accurate. In this email, I discuss an incident with a patient, where she was abrupt to them in the dining area. When I spoke with Karen about this later, she became defensive. I can't recall any further details aside from what I have written due to the time that has passed. I would like to add that I cannot recall the name of the patient."*

The panel took account of an email, dated 9 April 2019, sent by Witness 7 to Witness 2, referenced in Witness 7's witness statement. The email confirmed what

Witness 7 stated in her witness statement. Within the email, Witness 7 stated that Miss Morgan spoke abruptly to a patient in the dining area.

The panel also noted that it appeared that Miss Morgan had denied the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the aforementioned contemporaneous email from Witness 7. However, the panel noted that it had no further details as to exactly what was said to the patient, how it was said, how it was investigated and how it was managed. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 4d

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:
>
> (d) On or before 15 July 2019 informed colleagues that you were *'untouchable'* or words to that effect.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 2, Witness 7 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"By this point it was only me who was directly supporting the registrant, the band 6's had been supporting the registrant during Stage 1 of the Performance Plan however, they were all raising how difficult they were finding this as the registrant would get very defensive with them… The Band 6's also raised that the registrant had directly told them she would get them in trouble and that she was 'untouchable'."*

Witness 7, in her witness statement stated that a number of staff had reported Miss Morgan as displaying *"displaying aggressive and challenging behaviour, as well as informing staff that she was "untouchable".*

The panel took account of an email from Witness 3 to Witness 8 dated 30 April 2020 which stated that Miss Morgan is "telling the team that she is…untouchable"

The panel noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the aforementioned contemporaneous email and the witness statements of Witness 2 and Witness 7. However, it appeared to the panel that neither Witness 2 nor Witness 7 were direct witnesses to what had been alleged in the sub-charge and are reporting what other members of staff had said about Miss Morgan. The aforementioned email is also reporting what other members of staff had said about Miss Morgan. It was mindful that this amounted to hearsay because those members staff who had allegedly heard Miss Morgan call herself untouchable had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the accounts.

The panel noted that it had no further details regarding what Miss Morgan was alleged to have said, how it was investigated and how it was managed. There is no other contemporaneous evidence before the panel to support the charge.

The panel found this sub-charge not proved.

Charge 4e

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

> 4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:
>
> (e) On 3 December 2019 behaved inappropriately towards colleagues.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"The registrant had reduced 2 new administrative staff on the unit to tears due to bullying and aggressive behaviour which she then outright denied. There was also another incident in which the registrant telephoned a patient's husband to inform them that their wife had had a fall despite clear instruction in their notes to only contact the son. The registrant offered no apology and showed no recognition of her mistake."*

The panel took account of an email, dated 4 December 2019, from Witness 3 which Witness 8 was copied into. The email confirmed what Witness 3 stated in her witness statement. Within the email, Witness 3 stated that she had spoken with

Witness 8 regarding an incident involving Miss Morgan which had reduced to tears due to her bullying and unprofessional behaviour.

The panel also took account of the outcome letter from the Formal Stage 2 Review of Action Plan Meeting, dated 17 December 2020, addressed to Miss Morgan. This letter confirmed that Witness 8 had discussed the matter within the sub-charge with Miss Morgan and she received witness statements from those who had directly observed the incident. The letter stated that Witness 8 had reviewed these statements, found that Miss Morgan had acted unprofessionally and would progress Miss Morgan to "stage 3 of the Policy". Miss Morgan's response was recorded in the letter where she stated that it was "miscommunication" and was of the belief that she had acted professionally and felt that the decision was unfair.

The panel also noted that it appeared that Miss Morgan had denied the sub- charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned email and cotemporaneous outcome letter corroborated the details in Witness 7's witness statements. The panel was of view that this letter was clearly related to the allegations in the sub-charge. In light of this the panel was satisfied that the incident alleged in sub-charge 4e had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 4f

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:

(f) On 3 December 2019 incorrectly informed the patient's husband in relation to the patient's fall.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

The panel noted that these sub-charges were the same incident in sub-charge3r. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 3 and Miss Morgan's CMF.

As with charge 3r, the panel reminded itself of Witness 3's email dated 4 December 2019 which stated that stated that Miss Morgan called the patients husband to inform him of a fall, however, this was contrary to the instruction on admission documents associated with the patient. The patient's son was to be informed.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

For the same reasons as charge 3r, the panel determined that the incident in sub-charge 4f occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 4g and Charge 4h

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

4. Communication with patients and/or patients' relatives and/or staff but not limited to the following:

(g) On 7 October 2020 did not treat a patient's daughter with dignity and/or respect.

(h) On 14 October 2020 demonstrated a poor attitude towards ambulance service staff.

The panel found that these incidents occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is broadly similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"There was another incident which occurred on 7 October 2020… The daughter of a patient had raised a complaint about the registrant's behaviour and attitude, this was witnessed by [a] bank administrator. Her behaviour was described as 'vicious' and 'disgusting'. When I met with the registrant for a fact-finding meeting on the 19 October 2020, the registrant denied this incident and stated she didn't feel she had behaved in an inappropriate way but should have offered a better explanation at the time.*
>
> *…*
>
> *On 14 October 2020 there had also been another incident in which the registrant received a complaint from West Midland Ambulance Service in relation to the registrant poor attitude that day. The registrant also denied this allegation, and said there was an agency nurse who witnessed this incident and could support this. When I reviewed the roster and agency bookings I was unable to substantiate this as there were no agency staff on duty that day."*

The panel took account of the Fact Finding Report of a fact-finding meeting dated 19 October 2020. The report corroborated what Witness 3 stated in her witness statement in regard to both sub-charges. With regards to charge 4g, the bank administrator stated that the patient's daughter did not want Miss Morgan looking after her mother as a result of Miss Morgan's actions. With regard sub-charge 4h, it stated that Miss Morgan's actions in the situation was in a "very rude and disrespectful manner in front of the patients".

The panel also noted that it appeared that Miss Morgan had denied sub-charge 4g and had neither accepted nor denied sub-charge 4h within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel accepted the evidence of Witness 3 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned fact finding report corroborated the details in Witness 7's witness statements. In light of this the panel was satisfied that the incident alleged in sub-charge 3w had occurred.

As the panel did with charge 1k, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 5a

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

5. Safe Handovers but not limited to the following:

(a) On one or more occasions, on or before 9 April 2019 performed handovers poorly.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 2, Witness 7 and Miss Morgan's CMF.

Witness 7 in her witness statement stated:

> *"I have been referred to…an email I had sent to [Witness 2] about issues I was having with Karen. I can confirm the content of this email is accurate…I can't recall any further details aside from what I have written due to the time that has passed. I would like to add that I cannot recall the name of the patient."*

The panel took account of an email, dated 9 April 2019, from Witness 7 to Witness 2 referenced in Witness 7's witness statement. However, the panel noted that the email was not specific enough regarding the allegation described in the sub-charge. It just described the handovers as "poor". The panel also noted that Witness 2 in her witness statement confirmed matter was *"not serious enough to warrant formal investigation and we was trying to manage this through the Performance Management Plan."*

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the aforementioned contemporaneous email from Witness 7. However, the panel noted that it had no further details as to why the handover was poor, and Witness 2 stated that it was not serious enough for a formal investigation. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 5b

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

5. Safe Handovers but not limited to the following:
   (b) On or before 12 July 2019 failed to handover to a nurse that the consultant had telephoned regarding a patient's medication.

The panel found this sub-charge not proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and Miss Morgan's CMF.

Witness 3 in her witness statement stated:

> *"The second incident raised by a different Band 6 was that the registrant took a call from a consultant who was returning the call of this Band 6 Nurse (I can't recall who this was now as I do not have the email). The registrant had said to the Consultant that the patient was fine despite this not being her patient and the Band 6 awaiting the call back following concerns with the patient's medication. The registrant didn't inform the Band 6 Nurse of the call, who only found out when she called the Consultant again and he informed her of this."*

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's evidence to support the sub-charge comes from the witness statement of Witness 3. However, the panel do not have information regarding the patient's medication or the content of the conversation between the consultant and Miss Morgan. Therefore, there was no specific evidence to establish Miss Morgan's duty to handover to another nurse that the consultant had telephoned regarding a patient's medication. There is no contemporaneous evidence before the panel to

support the charge. Additionally, Witness 2 could not remember who the Band 6 nurse was in relation to the alleged incident.

The panel therefore found this sub-charge not proved.

Charge 5c

That you, between November 2017 and December 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in the following areas:

5. Safe Handovers but not limited to the following:
   (c) On 30 April 2020 did not hand over that you had only completed 10 out of 16 patient observations.

The panel found that this incident occurred.

The panel also noted that this sub-charge is related to the same incident in charge 2i. The panel noted that evidence it based its decision on was from the same source, namely the evidence of Witness 3, Witness 8 and Miss Morgan's CMF.

As with sub-charge 2i, the panel reminded itself that Witness 8 stated in oral evidence that Miss Morgan felt that completing observations for 16 patients was too many. Witness 8 also stated that if this was the case she would have expected Miss Morgan to raise this with her, another member of the team or escalate to the matron. Witness 8 stated that Miss Morgan did not do this.

As with sub-charge 2i, the panel found that the Stage 2 Formal Review Meeting Outcome Letter dated 12 June 2020, which was sent by Witness 3 to Miss Morgan, confirmed the allegation described in the sub-charge was an "area of concern" to Witness 3.

The panel also noted that it appeared that Miss Morgan had denied the sub-charge within her CMF. However, it also noted that the CMF had not been signed or dated.

For the same reasons as charge 2i, the panel determined that the incident in sub-charge 5c occurred and would make a decision as to whether they amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

The panel had considered all the charges and found that the incident had occurred in charges 1k, 1l, 1m, 1n(i), 1n(ii), 1o(i), 1o(ii), 1p, 1q, 2a, 2c, 2d, 2e(i), 2e(i), 2h, 2i, 2j, 2k, 2p, 2q, 3c, 3d, 3g, 3l, 3m, 3n, 3o, 3p, 3q(i), 3q(ii), 3q(iii), 3q(iv), 3q(v), 3q(vi), 3q(vii), 3r, 3s, 3t, 3u, 3v, 3w, 3x(i), 3x(ii), 4e, 4f, 4g, 4h and 5c. It was satisfied that this was a fair sample of Miss Morgan's practice from 2017 to 2021 to determine whether or not these amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel next considered whether, of the charges where it found the incident had occurred, there were commonalities in the dates, or the nature of the fallings indicated in the charges. The panel determined that the charges could be clustered into the following areas of practice; Medicine Management; Interpersonal communication and Patient centred Care.

Charges 2a, 3c, 3d

The panel found these sub-charges not proved

The panel noted that these sub-charges were the same incident that occurred on one particular day, namely on 6 May 2018. It was of the view that because these incidents had occurred well before the incidents in 2019, sub-charges 2a, 3c and 3d do not represent a fair sample of Miss Morgan's practice in a reasonable time frame, namely between November 2017 and December 2021, to demonstrate that Miss Morgan failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges not proved.

Charges 2d, 3g, 3p, 3r, 4e and 4f

The panel found these sub-charges not proved

The panel noted that these sub-charges relate to patient care, documentation and interpersonal communication. It also noted that they occurred on three days, namely 9 April, 12 July and 3 December across a 12-month period in 2019. It also noted Miss Morgan had been absent from work for a couple of months during this period in 2019. Additionally, when these incidents did occur, she was closely supervised.

The panel was of the view that these failings occurring on four days do not represent a fair sample of Miss Morgan's practice in a reasonable time frame, namely between November 2017 and December 2021, to demonstrate that Miss Morgan failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges not proved.

Charges 1k, 1l, 1n(i), 1n(ii), 2c, 2e(i), 2e(ii), 3o, 3q(i), 3q(ii), 3q(iii), 3q(iv), 3q(v), 3q(vi), 3q(vii), 3l, 3m and 3n

The panel found these sub-charges proved

The panel noted that these sub-charges relate to medications management which occurred on 28 June, 5 July and 15 July across a 12-month period in 2019, which the panel determined would have represented a fair sample of Miss Morgan's work at that time.

The panel was of the view that these failings do represent a fair sample of Miss Morgan's practice in a reasonable time frame to demonstrate that she had failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges proved.

Charges 2h, 2i, 2j, 2k, 3s, 3t, 3u, 3v, 3w, 4g, 4h and 5c.

The panel found these sub-charges proved

The panel noted that these sub-charges related to documentation, patient care and interpersonal communication which occurred on 27 April, 30 April, 4 May, 26 May, 2 August, and 7, 14 and 27 October across a six month period in 2020, which the determined would have represented a fair sample of Miss Morgan's work at that time.

The panel bore in mind that from June 2020 Miss Morgan was working part time and therefore these incidents were more representative during this period. [PRIVATE]. This further reduced the amount of shifts Miss Morgan worked during this period.

In light of the above, the panel was of the view that these failings do represent a fair sample of Miss Morgan's practice in a reasonable time frame to demonstrate that she had failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges proved.

Charges 1o, 1p, 1q, 2p, 2q, 3x(i) and 3x(ii)

The panel found these sub-charges proved

The panel noted that these sub-charges related to documentation errors and medication administration which occurred on 23 March and 3 December across a 12-month period in 2021.

The panel bore in mind that from May to November 2021 Miss Morgan was not working. Therefore, these incidents arose over a two-month period. When Miss Morgan returned, her medication administration was always supervised.

In light of the above, the panel was of the view that these failings do represent a fair sample of Miss Morgan's practice in a reasonable time frame to demonstrate that she had failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges proved.

Charge 6

That you a registered nurse;

> 6. On 6 January 2020 incorrectly administered Clopidogrel to a patient at 18.00

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and Miss Morgan's CMF.

The panel took account of the MAR chart which showed the medication "Clopidogrel". It appeared to the panel that the medication had already been administered at 08:00 on 6 January 2020. It also noted that 08:00 had been circled to indicate that the medication was to be administered at that time only. However, Miss Morgan's signature indicated that she had administered a second dose at 18:00.

The panel also took account of the contemporaneous interview notes for the investigation on 8 June 2020, 30 June 2020 and 23 July 2020 where various members of staff were interviewed about the incident. The Sister confirmed that she

found the error on 7 January 2020 and reported the incident in a Datix. Witness 8 confirmed that the Sister had reported to her that the patient had Clopidogrel administered twice. Witness 7 also confirmed that she had heard the Sister had suspected that Miss Morgan administered the medication during the evening shift.

Within the same interview notes, Miss Morgan stated that the medication had been "written up for 8am", but then stated "someone had put a line down to say that they didn't give it at 8am and they had initialled it for 6pm". She stated that she had meant to write "intentionally omitted" and that the whole process was "really confusing". However, later in the interview notes for 10 December 2020 she appeared to accept that she had made an error stating that she was responsible for her actions and she should have looked at the MAR chart.

The panel also noted that it appeared that Miss Morgan had accepted the charge within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel was persuaded by the evidence of Witness 1 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous interview notes corroborated the details in Witness 1's witness statement. The panel preferred the evidence of Witness 1 and was not persuaded by Miss Morgan's response.

The panel therefore find this charge proved.

Charge 7

That you a registered nurse;

7. On 6 January 2020, prior to administering Clopidogrel to the patient, failed to:

(a) Check the prescription.

(b) Ensure that the drug chart was clear.

(c) Seek clarity and/or support from another colleague if unsure about the prescription and/or drug chart.
(d) Check whether the medication had been previously administered.

The panel found these sub-charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 1 and Miss Morgan's CMF.

The panel took account of the interview notes dated 10 December 2020, Miss Morgan appeared to have accepted that she did fail to act as described in the sub-charges. She stated "I am responsible for my actions. For this drug error I did a reflection and did reflective practice for my revalidation…I should have looked at the chart, it was difficult to read…I should have gone slower or gone to someone…"

The panel noted that it appeared that Miss Morgan had denied sub-charges 7a, 7b, 7c and had neither accepted nor denied sub-charge 7d within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel was persuaded by the evidence of Witness 1 who provided the aforementioned interview notes. It was satisfied that these were credible and reliable evidence.

The panel therefore find these sub-charges proved.

Charge 8 and Charge 9

That you a registered nurse;

8. On or around 3 April 2007 submitted a reference purporting to be from [Person B] a Band 6 Sister
9. On or around 16 November 2007 submitted a reference purporting to be

from [Person B] a Band 6 Sister

The panel found both charges proved.

The panel considered both charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 5 and Miss Morgan's CMF.

Witness 5 in her witness statement stated:

> *"The registrant was going through a Disciplinary process which led to a disciplinary hearing in May 2021. The disciplinary panel were going through the registrant's personal file during their deliberation meeting, to gather facts to inform a referral to the NMC as part of the panel outcome…*
>
> *The way the reference process worked at the time of Karen's appointment is that the applicant was required to submit 2 Referees… The registrant provided three referees [a] (Matron), [a] [Person B] and [a] (nonhealthcare related employer)…*
>
> *… In summary we were concerned that the references provided [the Band 6 Sister]… were not authentic and Karen had completed at least one of these herself"*

The panel took account of the Fact Finding Report and Appendices refenced, by Witness 5 in her witness statement, and noted two reference requests. The "Name of Referee" on both requests was the name of Person B, the alleged Band 6 Sister, referenced in the charge. The "Applicant Name" on both requests was Miss Morgan therefore the panel was assured that the request for a reference was for her. Both reference requests had been signed on 3 April 2007 and 16 November 2007 respectively.

The panel took account of an email sent to Miss Morgan from the NMC, dated 27 January 2022 asking if the Person A worked at George Elliot NHS Trust was her line

manager for 2 and a half years. Miss Morgan responded in an email dated, 27 January 2022. Within this email she stated "[Person B] is not my daughter…[Person B] might have left nursing all together and moved on to a different job.

The panel bore in mind that the Witness 12, a handwriting expert, confirmed that it was more likely than not that the handwriting on the reference request was in fact Miss Morgan's.

The panel also bore in mind that Person B did not appear on the NMC register or when the Trust searched their records.

The panel noted that it appeared that Miss Morgan had denied both charges within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel was persuaded by the evidence of Witness 5 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous Fact Finding Report and Appendices corroborated the details in Witness 5's witness statement.

The panel therefore find both charges proved.

Charge 10

That you a registered nurse;

10. Your actions in charges 8 and 9 were dishonest in that:

    (a) You knew that references were not completed by [Person B] but submitted them in any event.

    (b) You were attempting to mislead Birmingham Community Healthcare NHS Foundation Trust that the references were from [Person B] a Band 6 Sister when you knew that they were not.

The panel found both sub-charges proved.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67.* It had to now determine what Miss Morgan's actual state of mind was as to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary honest and decent people.

The panel reminded itself that Witness 12, a handwriting expert, confirmed that it was more likely than not that the handwriting on the reference request was in fact Miss Morgan's rather than Person B's. It also bore in mind that Person B's name did not appear on the NMC register or in a search by the Trust.

The panel considered that Miss Morgan would have known that Person B had not completed the reference provided because that name was not registered on the NMC register nor did it appear when the Trust searched on their system. Despite this Miss Morgan submitted the references anyway.

In light of this, the panel was satisfied that this was dishonest and an ordinary decent member of the public would consider this to be dishonest.

The panel also took account of Miss Morgan's application form for South Birmingham Primary Care Trust. It noted that she provided Person B's name for one of the references. Further, there is a declaration which stated,

> *"I declare that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that any false or omitted information may result in dismissal or other disciplinary action if I am appointed."*

The panel noted that Miss Morgan had signed the declaration on 27 August 2007.

In light of this, the panel was satisfied that Miss Morgan had intentionally attempted to mislead Birmingham Community Healthcare NHS Foundation Trust because she knew that the references provided were not from Person B.

In light of this, the panel was satisfied that this was dishonest and an ordinary decent member of the public would consider this to be dishonest.

The panel concluded that on the balance of probabilities Miss Morgan's actions in relation to charges 8 and 9, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were dishonest.

Charge 11

That you a registered nurse;

11. On one or more occasions incorrectly declared to the NMC that [Mr 1] was not your partner, namely:

(a) On 27 January 2022.

(b) On 28 January 2022.

(c) On 30 January 2022.

(d) 1 February 2022.

The panel found these sub-charges proved.

In reaching this decision, the panel took account of the evidence of Witness 5 and Miss Morgan's CMF.

The panel considered the same section of Witness 5's statement in charge 8 above. It further noted that Witness 5 stated:

"In relation to [Mr 1]:

- *The registrant has listed [Mr 1] as her emergency contact and where asked to provide the relationship she has written 'partner'.*
- *…*

- *This reference was made in relation to the registrant working in a professional capacity for [Mr 1] at Suck Cess Tanker Services. The Company was checked out by NHS Local Counter Fraud Services and they confirmed the Company records on Companies House had [Mr 1].”*

The panel took account of the Fact-Finding Report and Appendices referenced by Witness 5 in her witness statement. It noted that Miss Morgan had completed a form where she had listed Mr 1 as her emergency contact and written ‘partner’ next to his name.

The panel also took account of the screenshot of Miss Morgan’s NMC Register entry on Wiser. It noted that the company address for Mr 1’s business is the same address listed for Miss Morgan from 1997 to 2004.

The panel took account of an email sent to Miss Morgan from the NMC, dated 27 January 2022 asking if the reference from Mr 1 refers to her partner. Miss Morgan responded in an email dated, 27 January 2022. Within this email she stated “[Ms 16] is not my ex partner…” In another email on the same day, she stated that Mr 1 was not her ex-partner and had never been her partner. The panel noted that she reiterated that Mr 1 was not her partner in subsequent emails to the NMC dated 28 January 2022, 30 January 2022 and 1 February 2022.

The panel also noted that it appeared that Miss Morgan had denied all the sub-charges within her CMF. However, it also noted that the CMF had not been signed or dated.

The panel was persuaded by the evidence of Witness 5 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned contemporaneous Fact Finding Report and Appendices corroborated the details in Witness 5’s witness statement.

The panel therefore find all the sub-charges proved.

Charge 12

That you a registered nurse;

> 12. Your actions in charge 11 were dishonest because you were attempting to represent to the NMC that Mr 1 was not your partner, which you know is untrue.

The panel found this charge proved.

The panel took account of the test for dishonesty outlined in charge 10.

The panel reminded itself that Miss Morgan had provided a reference to Birmingham Community Healthcare NHS Foundation Trust purported to be from Mr 1. On the reference, next to “Occupation”, “Businessman/Director” had been written. Additionally, the name of the organisation he owns had been written. However, on another form Mr 1 had been referenced as her emergency contact and she had written ‘partner’ next to his name.

Despite Miss Morgan referring to Mr 1 as her ‘partner’ in numerous emails sent to the NMC, namely on 27 January 2022, 28 January 2022, 30 January 2022 and 1 February 2022 Miss Morgan denied that Mr 1 was her partner.

The panel also took account of the screenshot of Miss Morgan’s NMC Register entry on Wiser. It noted that the company address for Mr 1’s business, which is also the name of the organisation the is the same address listed for Miss Morgan from 1997 to 2004.

The panel considered that Miss Morgan would have known that Mr 1 was her partner because she stated he was in her new starter’s information form for her application to Birmingham Community Healthcare NHS Foundation Trust which she completed and signed. By then denying this to the NMC, the panel was satisfied that this was dishonest and an ordinary decent member of the public would consider this to be dishonest.

The panel concluded that on the balance of probabilities Miss Morgan's actions in relation to charge 11, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were dishonest.

The panel therefore found this charge proved.

Charges 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k and 13l

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

13. On 13 April 2022 whilst undertaking a medication assessment observed by Colleague 1:

(a) On one or more occasions attempted to administer incorrect doses of medication to residents.
(c) On one or more occasions attempted to administer medication to residents at the incorrect prescribed time.
(d) On one or more occasions was unable to measure the correct medication that was to be administered.
(e) On one or more occasions failed to prepare medication that was due to be administered.
(f) On one or more occasions failed to check expiry dates on medication.
(h) On one or more occasions failed to check residents allergies.
(i) On one or more occasions failed to correctly read medication administration instructions.
(k) On one or more occasions failed to keep the medication trolley locked and/or left the keys in the medication trolley.

(l) On one or more occasions was unable to calculate the medication correctly.

The panel found that these incidents occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 15 in her witness statement stated:

> *"I decided to do a medication competency assessment with the registrant myself after these 10 shifts so I could see first-hand whether there were any concerns. This was done on 13 April 2022...*
>
> *The registrant was; attempting to administer incorrect doses…which was not prescribed for that time; wasn't able to measure medication in liquid form properly; wasn't preparing all of the medication meaning some would have been missed had I not intervened; was unorganised in her approach; was not checking expiry dates; was leaving dirty medicine posts on the side of the preparation area with other residents full boxes of medication; wasn't ensuring she had the right equipment to hand;…wasn't checking residents allergies; wasn't reading administration instructions; wasn't locking the medication trolley; left the medication keys in the door;…and was unable to count medication. All of these concerns mirrored those raised by the other nurses during the shadow shifts."*

The panel took account of the Medication Competency Assessment dated 13 April 2022. It noted that Witness 15 had recorded observations in red text and in black text. It appeared to the panel that the observations recorded in red was where Miss Morgan had failed, and those observations recorded in black were where Miss Morgan had succeeded. The panel noted the following was recorded in red:

With regards to charge 13a, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "I observed and intervened with the wrong

medications. Lamotrigine 25mg instead of lamotrigine 100mg."

With regards to charge 13c, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Medications were not administered in a timely manner meaning 1 residents' medication due 18.00 were not administered until 19.30."

With regards to charge 13d, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Measuring liquids gave me course for concern Karen despite been advised would hold the pot in the air to measure liquids often the pot was at an angle. Karen would tell me that this was the prescribed amount on placing the pot on a hard service I advised Karen to get down to look, Karen was reluctant to do this meaning without me there to double check the quantities residents would have medications administered under the correct dose as each time there was not sufficient quantity was in the pot." [sic]

With regards to charge 13e, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Not all the medications required were prepared I needed to point out missed sodium valporate for 1 resident and missed budesonide for another resident."

With regards to charge 13f, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Expiry dates on boxes were not checked." and "Karen was not observed to be turning the medication box or bottle over to read the expiry date."

With regards to charge 13h, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Karen quickly skipped through the information page without reading to ensure she was familiar with allergies and preferences."

With regards to charge 13i, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Although Karen did not always read the instructions on how to administer medications in a person—centred manner.

Additionally, on told to spoon liquid medications for a resident she decided halfway through administration that she would tip the liquid in to the resident's mouth from the pot."

With regards to charge 13k, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Karen did not lock her trolley and did not consistently close the doors to the trolley during the medication round. There was another member of staff in the clinic room who was able to ensure the safety of the medications although this was not discussed or arranged. Karen lost track of her keys leaving them in the trolley door."

With regards to charge 13l, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Karen told me a resident required 3 x 5mls for there [sic] dose of lactulose and also told me this would be 10mls."

The panel did not have sight of a response from Miss Morgan regarding these sub-charges.

The panel accepted the evidence of Witness 15 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Medication Competency Assessment corroborated the details in Witness 15's witness statement. In light of this the panel was satisfied that the incidents alleged in each part of this sub-charge had occurred.

At this stage, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charges 13b, 13g and 13j

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

On 13 April 2022 whilst undertaking a medication assessment observed by Colleague 1:

(b) On one or more occasions attempted to administer incorrect medication to residents.

(g) On one or more occasions failed to check MAR charts before medication was to be administered.

(j) On one or more occasions failed to correctly identify residents by;
- (i) Comparing the photograph found on their MAR charts.
- (ii) the use of their medication boxes.
- (iii) The use of their room numbers.

The panel found these sub-charges not proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 15.

Witness 15 in her witness statement stated:

"I decided to do a medication competency assessment with the registrant myself after these 10 shifts so I could see first-hand whether there were any concerns. This was done on 13 April 2022...

The registrant was; attempting to administer…incorrect medication…which was not prescribed for that time; …wasn't checking the MAR Charts before administration;…wasn't able to identify the right residents using the photos on

the MAR, medication boxes and room numbers;…All of these concerns mirrored those raised by the other nurses during the shadow shifts.”

The panel considered the same Medication Competency Assessment dated 13 April 2022 in charges 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k and 13l above. It reminded itself of how it appeared Witness 15 had recorded observations in red text and in black text. The panel noted the following was recorded in black:

With regards to charge 13j(i), under the heading entitled “Comments/Discussion”, Witness 15 has recorded the following “Karen used the pictures on the EMMs, pictures on the medication boxes and room numbers to identify the correct residents.”

With regards to charges 13j(ii) and 13j(iii), under the heading entitled “Comments/Discussion”, Witness 15 has recorded the following “Karen was able to identify the right person using pictures on the MAR, medication boxes and room numbers.”

In light of the above, in regards to charges 13j(i), 13j(ii) and 13j(iii) the panel was of the view that the contemporaneous Medication Competency Assessment supported the fact that Miss Morgan had successfully completed the tasks she was alleged to have failed to do.

With regards to charge 13b and 13g, while the panel noted that Witness 15 had stated this had occurred in her witness statement, there was no contemporaneous evidence before the panel to support the allegations.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC’s evidence to support the sub-charge comes from the account of Witness 15 and the aforementioned Medication Competency Assessment. The panel does not believe Witness 15 was trying to mislead the panel. However, it noted that the NMC had not provided the panel with information that supports the allegations described in the sub charges. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found these sub-charges not proved.

Charge 14

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

> 14. On or around 1 April 2022 failed to correctly apply a blood pressure cuff to a patient's arm.

The panel found that this incident occurred.

In reaching this decision, the panel took account of the evidence of Colleague 2.

The panel took account of Colleague 2's local statement, dated 5 May 2022, referenced in her witness statement. Colleague 2 stated she wrote this after her experience of working with Miss Morgan. It stated:

> *"I first met Karen when I arrive to work Friday 1 April 2022…Later that day I was attending a patient who had high respiration rate and was generally unwell with Covid. I asked Karen to take the residents blood pressure for me whilst I did the other observations. Karen was unable to do this task…"*

Colleague 2 reiterated this in her oral evidence.

The panel did not have sight of a response from Miss Morgan regarding this charge.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous

local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge. In light of this the panel was satisfied that the incident alleged in charge 14 had occurred.

At this stage, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 15

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

15. On a date unknown whilst being supervised by Colleague 2:

(a) On one or more occasions was unable to scan medications using the scanner.

(b) On one or more occasions was unable to read the electronic medication management system correctly.

(c) On one or more occasions attempted to dispense the incorrect amount of medication.

(d) On one or more occasions was informed by Colleague 2 to read the prescription again regarding the dosage of medication that was required to be administered.

The panel found that these incidents occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 2.

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. It stated:

> *"On another date whilst Karen was shadowing me, I allowed Karen to do the medications under my supervision. Karen repeatedly was unable to scan the medications with the scanner after I showed her several times. Karen did not read the EMMS (electronic medication management system) prescriptions correctly on numerous occasions. I had to stop Karen and change the dose of medications she was attempting to dispense. Karen would pour liquid medications into the measuring plastic pots without reading the dose. I had to repeatedly tell Karen to read the prescription again and amend her medication such as pouring 5-10mls more or less of medication. Karen was holding the pot in the air, i explained this was not accurate and she needed to put the pot level on the trolley.*
> *Karen met my instructions with animosity and stated she stated that could not see the pots when they were on the trolley. I suggested Karen use a syringe, but Karen stated she could not do this because of her arthritis. Karen also struggled with the PEG syringes."*

Colleague 2 reiterated this in her oral evidence.

The panel did not have sight of a response from Miss Morgan regarding these sub-charges.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge. In light of this the panel was satisfied that the incident alleged within all the sub-charges of charge 15 had occurred.

At this stage, the panel determined that the incident occurred and would go on to make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 16

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

16. On dates unknown whilst being supervised by Colleague 3:
    (a) On one or more occasions potted incorrect doses of medication.
    (b) On one or more occasions incorrectly drew up the wrong dosage of medication.
    (c) On one or more occasions drew up the incorrect medication.

The panel found that this incident occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 3 and Miss Morgan.

Colleague 3 in her witness statement stated:

> *"Karen was under supervision for all of the shifts she worked and I spent quite some time showing her where everything what and explaining what equipment we use and how it is used…*

…Karen…, would repeatedly make potential errors because she was potting or drawing up the incorrect dosage….

… There were also some occasions when she would read the machine and then start drawing up the wrong medication and I recall I actually said once "what are you reading?" because I couldn't understand how she had made the error."

Colleague 3 reiterated this in her oral evidence. It noted that she was a direct witness to the allegation, stated that she had completed four shifts with her and saw no improvement in that period. It bore in mind that she stated that her memory of the incident was vivid because she was shocked at what she had witnessed. It also bore in mind that Colleague 3 started to become upset when recalling this incident. The panel was of the view that Colleague 3 spoke with specificity in her oral evidence.

The panel did not have sight of a response from Miss Morgan regarding these sub-charges.

The panel accepted the evidence of Colleague 3 which it deemed to be credible, reliable and consistent. It was of the view that Colleague 3 had no bias against Miss Morgan. In light of this the panel was satisfied that the incident alleged in the sub-charges of charge 16 occurred.

The panel accepted that there was a real potential for these errors to occur using the actions described in the charge, however that would put a registered nurse on notice to be extra vigilant when administering medication and a registered nurse would not administer medication in this way.

At this stage, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

Charge 17

That you, between 28 March 2022 and 5 May 2022 failed to demonstrate the standards of knowledge, skill and judgement required to practise without restriction as a Band 5 nurse in the following areas:

Medication management and/or medication administration but not limited to the following:

17. On 13 April 2022 whilst undertaking a medication assessment observed by Colleague 1;

(a) On one of more occasions left empty dirty medicine pots on the side of the preparation area.
(b) On one or more occasions did not wash your hands prior to the medication round and/or during the medication round.
(c) On one or more occasions did not always wear gloves and/or when potting medication.
(d) On one or more occasions needed to be reminded on the correct PPE to use when entering rooms with Covid-19 residents.
(e) On one or more occasions had to be reminded on how to wear the mask correctly.

The panel found that these incidents occurred.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 15 in her witness statement stated:

> *"I decided to do a medication competency assessment with the registrant myself after these 10 shifts so I could see first-hand whether there were any concerns. This was done on 13 April 2022...*

The registrant was….leaving dirty medicine posts on the side of the preparation area with other residents full boxes of medication…

Another concern I had was with the registrant's hygiene practices during the medication assessment. The registrant did not wash her hands prior to the medication round or at any point during the assessment. The registrant wore gloves sometimes but not all the time which meant there was a risk of cross infection. I observed the registrant open a capsule with no gloves and pick up a tablet and put it back into a medication pot without gloves and was about to administer this to a resident. The registrant did sanitise her hands once but this was towards the end of the medication round. I also had to remind her what PPE she needed to wear when entering rooms with covid positive residents and on 4 occasions had to remind her how to wear her mask correctly."

The panel took account of the Medication Competency Assessment dated 13 April 2022 for the following:

With regards to charge 17a, under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Karen did not clean her work area following medication administration. Trolley was sticky with lactulose she had spilt. Jugs were washed by a colleague, and I tidied the rubbish away."

With regards to charges, 17b, 17c, 17d and 17e under the heading entitled "Comments/Discussion", Witness 15 has recorded the following "Karen did not maintain good hand hygiene —Karen did not wash her hands prior to the round or at any point during the round Karen was wearing gloves at times but not always when required to prevent cross infection. I observed Karen open a capsule with no gloves and pick up a tablet from the trolley that had missed the medicine pot without gloves. Karen sanitised her hands once during the round towards the end. Karen required to be reminded which PPE to wear for entering rooms of covid positive patients and to wear her mask correctly x 4."

The panel did not have sight of a response from Miss Morgan regarding these sub-charges.

The panel accepted the evidence of Witness 15 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Medication Competency Assessment corroborated the details in Witness 15's witness statement. In light of this the panel was satisfied that the incidents alleged in each part of this sub-charge had occurred.

At this stage, the panel determined that the incident occurred and would make a decision as to whether this amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse once it had a sufficient sample of Miss Morgan's practice.

The panel had considered all the charges and found that the incident had occurred in charges 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k, 13l, 14, 15a, 15b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d and 17e. It was satisfied that this was a fair sample of Miss Morgan's practice in 2022 to determine whether or not these amounted to a failing to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel next considered whether, of the charges where it found the incident had occurred, there were commonalities in the dates, or the nature of the fallings indicated in the charges. The panel determined that the charges could be clustered into the following areas of practice; Medicine Management; Interpersonal communication and Patient centred Care.

Charges 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k, 13l, 14, 15a, 15b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d and 17e.

The panel found these sub-charges proved

The panel noted that these sub-charges relate to medications management, patient care and interpersonal communication which occurred over 13 days in total from 28 March 2022 and 13 May 2022.

The panel was of the view that these failings do represent a fair sample of Miss Morgan's practice in a reasonable time frame to demonstrate that she had failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse.

The panel therefore found these sub-charges proved.

Charge 18

That you a registered nurse;

> 18. On or around 1 April 2022, whilst speaking with Colleague 2, behaved in an unprofessional and/or offensive manner by referring to a student nurse as being a *'spacker'* or words to that effect.

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Colleague 2, Witness 15 and Miss Morgan.

Witness 16 in her witness statement stated:

> *"At the very beginning of this first shift, I began the medication round and Karen began discussing how it was her second day and she hadn't been allowed to do anything yesterday. I explained it was quite usual on your first day to shadow and observe. Karen then went on to say how the Student Nurse had been crying the day before. I engaged briefly and stated that it was a shame as the student nurse was doing well last week but I reminded her that I was trying to concentrate on the medication round. Karen then said the reason she [the student nurse] was crying was "because she is a spacker". I*

could not believe what I had heard and thought I must have made a mistake so I asked Karen to repeat herself to ensure I had heard her correctly to which she replied, "because she is a spacker, that's why she was crying".

Witness 16 also reiterated this in her oral evidence which the panel found to be compelling. It also bore in mind that she was a direct witness to the incident.

Witness 15, in her witness statement, confirmed that Colleague 2 reported the incident to her.

In an email to the NMC dated 4 October 2023, Miss Morgan stated:

> *"I was accused of calling a student nurse a 'skank' I told [Witness 15] that I had never heard of this name before. In fact the person who was being unkind to the student nurse was the agency nurse… I never spoke to the student nurse [the agency nurse] had called the student nurse ' a waste of space and lazy . The student nurse was crying most of the time but instead of the trained nurses support and kindness they ridiculed her. This was the environment I experienced also"* [sic]

The panel preferred the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that Witness 15's witness statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

The panel therefore found this charge proved.

Charge 19

That you a registered nurse;

> 19. On a date unknown failed to maintain a resident's dignity by behaving in an unprofessional and/or unkind and/or patronising manner when administering

> medication to them, by stating words to the effect of, *‘good girl, good girl take your medications.’*

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Colleague 2.

In order to find this charge proved, the panel had to be satisfied that Miss Morgan had a duty maintain a resident’s dignity. It determined that treating people as individuals and upholding their dignity was one of the fundamental tenets of the nursing profession that Miss Morgan would have known and is reflected in the NMC Code of Conduct.

The panel was therefore satisfied that Miss Morgan had a duty to maintain a resident’s dignity. In light of this, the panel then went on to consider whether Miss Morgan had failed in this duty.

Colleague 2 in her witness statement stated:

> *“On a day where Karen was giving medication under my direct supervision, I explained that the individual we were going to next had cerebral palsy and had full mental capacity and does not have a learning disability… As Karen gave this person their medications she started saying “good girl, good girl take your medications.*
>
> *The Individual found this patronising, I could tell they were upset from their body language.”.*

Colleague 2 was a direct witness this incident.

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. It stated:

"As Karen gave this person their medications she started saying 'good girl, good girl take your medications'. The individual found this patronising."

The panel did not have sight of a response from Miss Morgan regarding this charges.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

In light of the above, the panel was satisfied that Miss Morgan had failed to maintain a resident's dignity by behaving in an unprofessional and/or unkind and/or patronising manner when administering medication to them, by stating words to the effect of, 'good girl, good girl take your medications.'

The panel therefore found this charge proved.

Charge 20

That you a registered nurse;

> 20. On a date unknown behaved in an unprofessional and/or discriminatory manner, when referring to a resident who has Cerebral Palsy, by stating to Colleague 2 words to the effect of, 'She doesn't look like she doesn't have a learning disability.'

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Colleague 2 and Miss Morgan's CMF.

The panel considered the same section of Colleague 2's witness highlighted in charge 19. She also stated:

> *"As we went back into the clinic room Karen said, "she doesn't look like she doesn't have a learning disability". I responded to Karen "what does someone with a LD look like?" Karen said she did not have any experience of learning disabilities, I explained that we treat all people with respect and dignity regardless of their diagnosis. I just found this an unprofessional comment to make especially for a nurse working in a learning disability home."*

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. It stated:

> *"As we went back into the clinic room Karen said, "she doesn't look like she doesn't have a learning disability'. I questioned Karen on this and said what does someone with a [Learning Disability] look like? Karen said she does not have any experience of learning difficulties."*

The panel did not have sight of a response from Miss Morgan regarding this charge.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

In light of the above, the panel was satisfied that Miss Morgan had behaved in an unprofessional and/or discriminatory manner, when referring to a resident who has Cerebral Palsy, by stating to Colleague 2 words to the effect of, 'She doesn't look like she doesn't have a learning disability.'

The panel therefore found this charge proved.

Charge 21

That you a registered nurse;

21. On a date unknown failed to maintain a resident's dignity by behaving in an unprofessional and/or unkind and/or patronising manner whilst administering medication to them by;

c. Stating to them in a baby voice words to the effect of, *'come on now, open your mouth, a bit wider, a bit wider.'*
d. Pushing the teaspoon into the resident's mouth, which he had closed, causing the yogurt that contained the medication to spill on the resident's beard.

The panel found these sub-charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 3 and Miss Morgan.

As with charge 19 above, the panel was satisfied that Miss Morgan had a duty to maintain a resident's dignity. It then moved on to consider if Miss Morgan had failed in this duty.

Colleague 3 in her witness statement stated:

> *"I asked [him] if he would like me to go through each of his medications before Karen administered them and he said yes so I did this. Karen then proceeded to give the gentlemen his medication and started talking in a baby voice saying "come on now, open your mouth, a bit wider, a bit wider". The gentleman looked horrified and closed his mouth and the medication fell onto him so she had to pick them up.*

I said "Karen please stop, he has full capacity, he understands everything that you and I do". Karen didn't stop and pushed the teaspoon into his mouth which he had closed, meaning that the yogurt and the medication was now down his beard which was quite long and thick. I had to clean him up and I apologised to him and re-did his medication myself."

Colleague 3 reiterated this in her oral evidence. It bore in mind that she was a direct witness to the incident.

The panel took account of the same contemporaneous local statement of Colleague 3 who stated, in her witness statement. It stated:

"Two of our service users were upset by the way in which Karen communicated with them. They expressed disappointment that they had been treated with disrespect and spoke to as If they lacked capacity."

In an email to the NMC dated 4 October 2023, Miss Morgan stated:

"I was accused of talking a funny way with a resident something about "opening his mouth"? I don't actually remember this.
However one persons assumption that I was talking a ' funny way' is actually debatable. I have never worked with residents who have physically and mentally disabilities before so my experience there was challenging !" [sic]

The panel preferred the evidence of Witness 17 which it deemed to be credible, reliable and consistent. While it considered that aforementioned cotemporaneous local statement lacked specificity, it found her oral evidence to be compelling and noted that she had a clear memory of the incident.

The panel therefore found both sub-charges proved.

Charge 22

That you a registered nurse;

22. On a date unknown failed to maintain Resident A's dignity by behaving in an unprofessional and/or unkind and/or discriminatory and/or patronising manner towards them by;

c. Stating words to the effect of, *'oh, it's the man with the golden boots'* when in fact Resident was a female resident.
d. Stating words to the effect of, *'You little horror, you little horror.'*

The panel found these sub-charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 3 and Miss Morgan.

As with charge 19 above, the panel was satisfied that Miss Morgan had a duty to maintain a resident's dignity. It then moved on to consider if Miss Morgan had failed in this duty.

Colleague 3 in her witness statement stated:

> *"The second incident was in relation to a resident who is still at the Home called Resident A. Resident A has Cerebral Palsy and prior to this incident Karen had accompanied me to see on around 3 separate occasions. Each time I explained to Karen before we went into her room that Resident A has full mental capacity...*
>
> *…I explained that some of our residents choose to have their medication in quite unusual ways and Resident A liked us to almost throw it to the back of her throat. I said this has all been risk-assessed. When we went into the room, Karen looked at and said to me "oh, it's the man with the golden boots". Resident A is clearly a lady and this was the fourth time Karen had met Resident A so she would have known this.*

…

At teatime we went back to see and again I said to Karen on this occasion you will give her medication and explained again about how she had them. Resident A only had 2 small tablets to be administered. Karen potted them whilst I watched and then I said put them as far to the back of her throat as possible but Resident A closed her mouth, which sometimes happens so you pick them up and try again. However, Karen started saying "you little horror, you little horror", Resident A was clearly upset and it was horrible to watch. Resident A then refused to take her medication and by this point they had fallen on the floor so had to be disposed of.

Colleague 3 reiterated this in her oral evidence. The panel bore in mind that she was a direct witness to the incident.

The panel did not have sight of a response from Miss Morgan regarding these sub-charges.

The panel accepted the evidence of Witness 17 which it deemed to be credible, reliable and consistent. It found her oral evidence to be compelling and noted that she had a clear memory of the incident.

The panel therefore found both sub-charges proved.

Charge 23

That you a registered nurse;

23. On a date unknown, when Colleague 2 enquired whether you had given a resident a flush of water, incorrectly declared that you had provided the resident with a flush of water when you had not.

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Colleague 2.

Colleague 2 in her witness statement stated:

> *"There was one occasion when I asked Karen to give a resident a flush of water. Later I came back and asked Karen If she had done this task to which she replied "yes". I said "are you sure?" and Karen again said she had done it. I stated that the individual's jug was dry which indicated to me she had not completed this task. Karen then said "oh ok yes. I have not done it". I had said to Karen on so many occasions when I worked with her, if you can't do something or don't have enough time just tell me, so there was no need to be untruthful."*

The panel bore in mind that Colleague 2 was a direct witness to the incident.

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. It stated:

> *"On another occasion when I had seen Karen carry out a PEG flush, I asked Karen to give a resident a flush of water via the JEG. Later I came back and aske Karen if she had done this task to which she replied yes. I said are you sure and Karen again said she had done it. I stated that the individual's jug was dry which indicated to me she had not completed this task. Karen then said on ok yes, I have not done It. This made me question Karen's integrity."*

The panel did not have sight of a response from Miss Morgan regarding this charge.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

The panel therefore found this charge proved.

Charge 24

That you a registered nurse;

> 24. Your declaration in charge 23 was dishonest in that you were attempting to mislead Colleague 2 into believing that you had provided the resident a flush of water when you knew that this was untrue.

The panel found this charge proved.

The panel took account of the test for dishonesty outlined in charge 10.

The panel also bore in mind that it found charge 23 proved, in that Miss Morgan incorrectly declared to Colleague 2 that she had provided the resident with a flush of water when she had not.

The panel bore in mind that in Colleague 2, in her witness statement and contemporaneous local statement, stated that Miss Morgan had told her she had completed the task of providing the resident with a flush of water despite the residents jug being dry. This indicated to Colleague 2 that the task had in fact not been done.

In light of this, the panel could find no plausible reason for telling Colleague 2 that she had completed the aforementioned task when it was clear she had not. It was clear to the panel that Miss Morgan was in fact attempting to mislead Colleague 2.

The panel concluded that on the balance of probabilities Miss Morgan's actions in relation to charge 23, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were dishonest.

The panel therefore found this charge proved.

Charge 25

That you a registered nurse;

> 25. On a date unknown, when Colleague 2 enquired whether you had taken temperatures for one or more residents, incorrectly declared that you had taken them when you had not.

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and Miss Morgan's CMF.

Witness 2 in her witness statement stated:

> *"Then on another occasion, on another date (I cannot recall exactly when) I asked Karen to complete the daily temperatures of everyone for me. Karen went off to complete the task and returned approximately 5 minutes later explaining everyone was ok and no one had a temperature. I asked if she had done everyone's temperature as that was very fast. Karen said yes, she had. I asked if she had done one of the residents, who I will refer to as resident 'X' as they were currently having personal care as I had just been with them to which Karen replied, 'Oh no I haven't done hers yet'. Karen then walked over to the temperature chart and crossed out the temperature she had written down for that individual…*
>
> *I later asked 4 other residents If Nurse Karen had taken their temperature to which they all replied 'no', yet they had a recording documented."*

The panel bore in mind that Colleague 2 was a direct witness to the incident.

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. Colleague 2, within this statement, reiterated the same details found in her witness statement.

The panel did not have sight of a response from Miss Morgan regarding this charge.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

The panel therefore found this charge proved.

Charge 26

That you a registered nurse;

> 26. Your declaration in charge 25 was dishonest in that you were attempting to mislead Colleague 2 into believing that you had taken temperatures for one or more residents when you knew that this was untrue.

The panel found this charge proved.

The panel took account of the test for dishonesty outlined in charge 10.

The panel also bore in mind that it found charge 25 proved, in that Miss Morgan incorrectly declared to Colleague 2 that she had taken temperatures for one or more residents when she had not.

The panel bore in mind that in Colleague 2, in her witness statement and contemporaneous local statement, stated that Miss Morgan had told her she had taken the temperatures of the residents and crossed their names indicating that she had. However when she asked the residents if Miss Morgan had taken their temperatures, they informed her that Miss Morgan had not. This indicated to Colleague 2 that the task had in fact not been done.

In light of this, the panel could find no plausible reason for telling Colleague 2 that she had completed the aforementioned task when it was clear she had not. It was clear to the panel that Miss Morgan was in fact attempting to mislead Colleague 2.

The panel concluded that on the balance of probabilities Miss Morgan's actions in relation to charge 25, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were dishonest.

The panel therefore found this charge proved.

Charge 27

That you a registered nurse;

> 27. On a date unknown declared to Colleague 2 that you had hidden your diagnosis of arthritis in order to gain employment with Leonard Cheshire Disability.

The panel found this charge proved.

In reaching this decision, the panel took account of the evidence of Colleague 2.

Colleague 2 in her witness statement stated:

> *"During another conversation with Karen, she disclosed to me that she had hidden her diagnosis of arthritis so she would get the job. Karen stated she was physically struggling to complete the expectations of the job. I stated that she should not be dishonest as you must disclose the truth to which Karen said, "yes I suppose I should""*

The panel bore in mind that Colleague 2 was a direct witness to the incident.

The panel took account of the same contemporaneous local statement of Colleague 2 mentioned in charge 14 above. Colleague 2, within this statement, reiterated the same details found in her witness statement.

The panel did not have sight of a response from Miss Morgan regarding this charge.

The panel accepted the evidence of Colleague 2 which it deemed to be credible, reliable and consistent. It was of the view that Colleague 2, in her oral evidence was fair and showed no bias towards Miss Morgan. It was satisfied that the aforementioned cotemporaneous local statement corroborated the details in Colleague 2's witness statements. The panel was of view that the local statement was clearly related to the allegations in the charge.

The panel therefore found this charge proved.

Charge 28

That you a registered nurse;

28 Your declaration in charge 27 demonstrated a lack of integrity in that you hid your diagnosis in order to gain employment with Leonard Cheshire Disability for your own benefit.

The panel found this charge not proved.

The panel also bore in mind that it found charge 27 proved factually, in that Miss Morgan had hidden her diagnosis of arthritis in order to gain employment with Leonard Cheshire Disability.

The panel bore in mind that in Colleague 2, in her witness statement and contemporaneous local statement, stated that Miss Morgan he disclosed to her that she had hidden her diagnosis of arthritis so she would get the job.

The panel took account of an email, dated 4 October 2023, Miss Morgan had sent the NMC. It stated:

> *"As I mentioned before in my previous response to the NMC at the time I did not believe that my condition would affect my performance. I was on pain killers which I had in the morning before I arrived for work."*

The panel noted that Miss Morgan was entitled to not disclose her diagnosis of arthritis to her employer. It also noted that Miss Morgan had stated, in her email, that she did not believe her condition would affect her performance as a registered nurse. Additionally, it noted that it had no evidence before it which demonstrated that Miss Morgan had an obligation to disclose her diagnosis of arthritis.

The panel therefore concluded that Miss Morgan did not lack integrity by not disclosing her diagnosis of arthritis.

The panel therefore found this charge not proved.

Charge 29 and 31

That you a registered nurse;

29. On or around 1 March 2022 provided to Leonard Cheshire Disability contact details for a referee in the name of [Person A], purporting to be a Band 6 Sister employed at Birmingham Community NHS Trust.
31. On or around 1 March 2022 submitted and/or caused to be submitted a reference to Leonard Cheshire Disability in the name of [Person A] purporting to be a Band 6 Sister employed by Birmingham Community NHS Trust.

The panel found both of these charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 15.

Witness 15 in her witness statement stated:

> *"I exhibit the registrant's application form…and her references…The registrant's most recent employment was listed as Birmingham Community NHS Trust where she has stated she worked from December 2007 to May 2021…*
>
> *The registrant's reference for her employment Community NHS Trust was [Person A], Band 6 Sister. The process for obtaining references is the applicant provides contact information for the referee and we then contact them with a link to a portal where they complete a form with pre-set questions. The email address for [Person A] was not an NHS email address or a professional email address but this is not necessary as part of our due diligence."*

The panel took account of the references provided by Miss Morgan referenced in Witness 15's witness statement. The name of the referee is listed as "Person A". Additionally, next to the heading "Referee type" "Person A" is listed as a "previous employer" and her job title is a "Band 6" and the "Employer" is listed as "Birmingham community NHS Trust". Person A's contact details, namely her address, postcode, contact number and email address have been provided. Person A has also purportedly answered questions pertaining to Miss Morgan's employment at Birmingham community NHS Trust.

The panel took account of Miss Morgan's job application form referenced in Witness 15's witness statement. Within the job application form, under the heading "Referees" "Person A" as a "Band 6" working at "Birmingham community NHS Trust".

The panel did not have sight of a response from Miss Morgan in response to these charges.

The panel accepted the evidence of Witness 15 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous

job application form and reference corroborated the details in Witness 15's witness statements. The panel was of view that the job application form and reference was clearly related to the allegations in the charge.

The panel therefore found these charges proved.

Charge 30 and 32

That you a registered nurse;

30. Your actions in charge 29 was dishonest in that you mislead and/or was attempting to mislead Leonard Cheshire Disability into believing that [Person A] was a Band 6 Sister employed at Birmingham Community NHS Trust when you knew that this was untrue.
32. Your action in charge 31 was dishonest in that you mislead and/or were attempting to mislead Leonard Cheshire Disability into believing that a person by the name of [Person A] was employed as a Band 6 Sister with Birmingham Community NHS Trust when you knew that this was untrue

The panel found these sub-charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 15, Witness 17 and Miss Morgan. The panel also took account of the test for dishonesty outlined in charge 10.

The panel also bore in mind that it found charge 29 and 31 proved, in that Miss Morgan provided to Leonard Cheshire Disability a reference and contact details for a referee in the name of Person A, purporting to be a Band 6 Sister employed at Birmingham Community NHS Trust.

Witness 17 in her witness statement stated:

“We do not have any registrant’s called [Person A] on our register. I have searched on Wiser and MSD. I produce…a screenshot of the search results in MSD and Wiser.”

The panel took account of the screenshot referred to in Witness 17’s witness statement and was satisfied that Person A was not on the NMC Register.

Miss Morgan in an email to the NMC, dated 2 February 2022, referred to Person A as her daughter. She also cited a middle name for Person A.

Witness 17 in his witness statement stated that there was no registrant for Person A, with the middle name, on the NMC register. The panel had sight of the screenshot referred in Witness 17’s witness statement and was satisfied that Person A, with the middle name included, was not on the NMC Register.

The panel considered that Miss Morgan would have known that Person A was not a registered Band 6 Sister when she provided the reference because that name was not registered on the NMC register. Despite this Miss Morgan submitted the reference anyway.

In light of this, the panel was satisfied that Miss Morgan had intentionally attempted to mislead to mislead Leonard Cheshire Disability into believing that Person A was a Band 6 Sister employed at Birmingham Community NHS Trust when she knew that this was untrue.

In light of this, the panel was satisfied that this was dishonest and an ordinary decent member of the public would consider this to be dishonest.

The panel concluded that on the balance of probabilities Miss Morgan’s actions in relation to charge 29, based on the test in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were dishonest.

The panel therefore found these charges proved.

Charge 33

That you a registered nurse;

33. On or before 28 March 2022 breached your interim conditions of practice order that was imposed on your registration on 2 July 2021 by;

    c. Failing to inform or notify the NMC that you had accepted employment as a nurse with Leonard Cheshire Disability within 7-days of accepting that employment.
    d. Failing to provide your NMC's case officer your employer's contact details.

The panel found these sub-charges proved.

The panel considered these sub-charges separately, but as the evidence in relation to each is similar, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Witness 15 and Miss Morgan.

In order to find these sub-charges proved, the panel had to be satisfied that Miss Morgan had a duty do what had been described in sub-charges 32a and 32b. It took account of the NMC decision letter to Miss Morgan regarding the interim order dated 5 July 2021. It noted that condition 5a and 5b informed Miss Morgan of her duties described in sub-charges 32a and 32b. The panel was of the view that Miss Morgan would have known about her obligation to do this, as the conditions were sent to her.

The panel was therefore satisfied that Miss Morgan had a duty. In light of this, the panel then went on to consider whether Miss Morgan had failed in this duty.

The panel took account of an NMC outcome letter sent to Miss Morgan regarding the interim order dated 7 January 2022 [should be 7 February 2022]. It informed Miss Morgan that her existing conditions of practice order had been continued.

Witness 15 in her witness statement stated:

"On 6 April 2022, I asked the registrant if she notified the NMC of her employment and she said 'not yet' and I told her she needed to do this as this was one of her conditions.

Miss Morgan in an email to the NMC, dated 25 April 2022, stated:

"Just to let you know that I started employment as a RGN with Leonard Cheshire home for residents with Disabilities on the 28/03/22. The reason I have not informed the NMC sooner is because I wanted to concentrate and settle into my new role."

The panel was satisfied that Miss Morgan had not informed the NMC of her employment within the seven days required in her interim conditions of practice order.

The panel did not have sight of a response from Miss Morgan in relation to these charges.

The panel accepted the evidence of Witness 15 which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned cotemporaneous letters from the NMC corroborated the details in Witness 15's witness statement. The panel was of view that the NMC letters were clearly related to the allegations in the sub-charges.

The panel therefore found these sub-charges proved.

Charge 34

That you a registered nurse;

34. Your actions in charge 33 demonstrated a lack of integrity in that you had a duty to inform the NMC that you had accepted employment with Leonard Cheshire Disability but failed to do so.

The panel found this charge proved.

In reaching this decision, the panel took account of the same evidence it considered for charge 33.

The panel also bore in mind that it found sub-charges 33a and 33b proved, in that Miss Morgan failed to inform or notify the NMC that she had accepted employment as a nurse with Leonard Cheshire Disability within 7-days of accepting that employment. Additionally, it had also found that Miss Morgan had failed to provide her NMC case officer her employer's contact details.

The panel was of the view that the duty to inform the NMC of what is described in charges 33a and 33b was clear in her interim conditions of practice order. It was clear to the panel that Miss Morgan did not adhere to the conditions and as a result failed in her duty to her regulator.

In light of the above, the panel found that Miss Morgan demonstrated a lack of integrity in that she had a duty to inform the NMC that she had accepted employment with Leonard Cheshire Disability but failed to do so.

The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved in respect of charges 1k, 1l, 1n(i), 1n(ii), 1o, 1p, 1q, 2c, 2e(i), 2e(ii), 2p, 2q, 3l, 3m, 3n 3o, 3q(i), 3q(ii), 3q(iii), 3q(iv), 3q(v), 3q(vi), 3q(vii), 3u, 3v, 3w, 3x(i), 3x(ii), 5c, 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k, 13l, 14, 15a, 15b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d and 17e amount to a lack of competence and whether the charges found proved in respect of charges 6 , 7a, 7b, 7c, 7d, 8, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 18, 19, 20, 21a, 21b, 22a, 22b, 23, 24, 25, 26, 27, 29, 30, 31, 32, 33a, 33b and 34 amount to misconduct and, if so, whether Miss Morgan's fitness to practise is currently impaired by reason of lack

of competence and/or misconduct. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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.

Submissions on lack of competence

Ms Taylor referred the panel to the NMC guidance entitled "Lack of competence" (reference: FTP-2b) and cited the section that stated a lack of competence "usually involves an unacceptably low standard of professional performance, judged on a fair sample of the [the registrant's] work, which could put patients at risk."

Ms Taylor submitted that Miss Morgan had demonstrated a lack of knowledge, skill and judgement showing she was incapable of safe and effective practice. She submitted that unless it was exceptionally serious, a single serious clinical incident would not indicate a general lack of competence on the part of a nurse.

Ms Taylor submitted that the panel had a fair sample of Miss Morgan's work across three employers. She reminded it that it had determined that the facts found proved were a fair sample of Miss Morgan's practice and set out which failings represented a fair sample of Miss Morgan's practice for both cases.

Ms Taylor invited the panel to take the view that the facts found proved amount to a lack of competence. She directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, Miss Morgan's actions amounted to a lack of competence.

Submissions on misconduct

Ms Taylor referred the panel to the NMC guidance entitled “Misconduct” (reference: FTP-2a). She referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a *‘word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’*

Ms Taylor referred the panel to the cases of *Calhaem v GMC [2007] EWHC 2606 (Admin)* and *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*.

Ms Taylor invited the panel to take the view that the facts found proved amount to misconduct as Miss Morgan’s actions fell below the standards expected of a registered nurse. She directed the panel to specific paragraphs within ’The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (the Code) and identified where, in the NMC’s view, Miss Morgan’s actions amounted to misconduct.

Submissions on impairment

Ms Taylor 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).

Ms Taylor also referred the panel to the NMC guidance entitled “Impairment” (reference: DMA-1). She submitted that the guidance sets out that a panel, when considering if a nurse is impaired, should start by considering “Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”. She submitted that the answer to this question was no which meant that Miss Morgan’s fitness to practice was impaired.

Ms Taylor submitted that each of the four limbs in the case of *Grant* are engaged.

Ms Taylor referred the panel to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). She submitted that there are significant concerns that this type of behaviour could be easily repeated if Miss Morgan were to continue working in regulated activity. She submitted that this was especially given the scope and variety of concerns regarding Miss Morgan's practice and conduct.

With regards to insight, Ms Taylor submitted that Miss Morgan had demonstrated little, if any, insight. She submitted that there was no real evidence of remorse demonstrated by Miss Morgan and her actions suggested underlying attitudinal issues which, she submitted, were harder to address than clinical practice concerns.

Ms Taylor submitted that there had been no meaningful and developed insight, remorse or strengthened practice which addresses the specific concerns that have been raised. She submitted that Miss Morgan remains a risk to the health, safety and wellbeing of patients and the public and the NMC says a finding of impairment is required on that basis.

Ms Taylor invited the panel to find Miss Morgan's fitness to practice impaired on both public protection and public interest grounds.

Decision and reasons on lack of competence and/or misconduct

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to serious misconduct and/or lack of competence. Secondly, only if the facts found proved amount to serious misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Miss Morgan's fitness to practise is currently impaired as a result of that serious misconduct and/or lack of competence.

When determining whether charges 1k, 1l, 1n(i), 1n(ii), 1o, 1p, 1q, 2c, 2e(i), 2e(ii), 2p, 2q, 3l, 3m, 3n 3o, 3q(i), 3q(ii), 3q(iii), 3q(iv), 3q(v), 3q(vi), 3q(vii), 3u, 3v, 3w, 3x(i), 3x(ii), 5c, 13a, 13c, 13d, 13e, 13f, 13h, 13i, 13k, 13l, 14, 15a, 15b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d and 17e amount to lack of competence and whether 6 , 7a, 7b, 7c, 7d, 8, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 18, 19, 20, 21a, 21b, 22a, 22b,

23, 24, 25, 26, 27, 29, 30, 31, 32, 33a, 33b and 34 amount serious misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Miss Morgan's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

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

1.3 avoid making assumptions and recognise diversity and individual choice

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.6 recognise when people are anxious or in distress and respond compassionately and politely

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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 co-operatively

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

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

Lack of competence

The panel reminded itself that it had found that the incidents had occurred and that it had a fair sample of Miss Morgan’s practice. It then moved on to consider whether the facts found proved were serious enough to amount to a lack of competence.

The panel bore in mind, when reaching its decision, that Miss Morgan should be judged by the standards expected of a band 5 registered nurse and not by any higher or more demanding standard.
The panel accepted that there were four areas of concern, namely:

- Patient Care;
- Medications Management;
- Record keeping; and
- Interpersonal Communication.

The panel was of the view that these were wide-ranging concerns that related to fundamental and basic aspects of nursing practice.

The panel particularly noted that the facts found proved, between 28 March 2022 and 13 May 2022 over 13 days in total, occurred over a short period of time. It bore in mind that the concerns had been raised with Miss Morgan repeatedly. Despite numerous examples of medications training and assessments, Miss Morgan demonstrated little to no progress and was therefore unable to meet the standard required of a Band 5 Staff Nurse.

In light of this, the panel was satisfied that Miss Morgan failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as band 5 nurse.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Miss Morgan’s practice was below the standard that one would expect of the average registered nurse acting in Miss Morgan’s role.

In all the circumstances, the panel determined that Miss Morgan's performance demonstrated a lack of competence.

Misconduct

When considering charge 6 individually, the panel was of the view that Miss Morgan had made a single mistake. It also bore in mind that she had stated that the whole process of recording on the MAR chart was "really confusing". It was of the view that, in isolation, a single medications administrations error would not be considered deplorable by fellow practitioners and did not amount to serious misconduct.

With regards to charges 7a, 7b and 7c, the panel bore in mind that medications administration was a fundamental aspect of nursing care. It was of the view that Miss Morgan's failings were a departure from safe reasonable practice despite local safeguards put in place to ensure that the correct medication was administered to the correct patient.

In light of this, the panel therefore determined that Miss Morgan's actions in charge 7 fell seriously short of the conduct and standards expected of a band 5 registered nurse and amounted to serious misconduct.

When considering charges 8, 9 and the associated dishonesty in charges 10 and 11 individually, the panel was of the view that Miss Morgan's actions were a serious departure from the Code. Miss Morgan submitted fraudulent references to gain employment and signed a declaration stating that the references were true to the best of her knowledge and belief knowing that this was not true. Miss Morgan had also written numerous times to her regulator, the NMC, that one of her referees, Mr 1 was not her partner when she knew otherwise. It considered that Miss Morgan gaining employment using false referees had the potential to place patients at a potential risk of harm and the employer to a reputational risk. The panel was of the view that the dishonesty suggested underlying attitudinal concerns.

In light of the above, the panel considered Miss Morgan's actions in charges 8, 9, 10 and 11 individually fell significantly short of the conduct and standards expected of a

registered nurse, would be considered deplorable by fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

When considering charge 18, the panel considered that Miss Morgan's actions to be unprofessional and a serious departure from the Code. It was of the view that Miss Morgan had failed to act as a role model of professional behaviour for colleagues. She referred to a student nurse as a 'spacker' which is a derogatory and offensive term which derives from the diagnosis of someone with spastic cerebral palsy.

In light of the above, the panel considered Miss Morgan's actions in charge 18 individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

When considering charges 19, 20, 21 individually, the panel was of the view that Miss Morgan's actions were unprofessional and a serious departure from the Code. With regards to charge 19, the panel bore in mind that Miss Morgan had been told that the patient had full capacity and did not have a learning disability. However, despite this, when administering the medication she started saying "good girl, good girl take your medications." Colleague 2 stated in her witness statement that the patient found this patronising.

With regards to charge 20, the panel was of the view that Miss Morgan's actions were unprofessional and demonstrated discriminatory conduct. It was of the view that to assume somebody had a learning disability, solely based on their appearance, could amount to discriminatory conduct and did in this instance. Miss Morgan's comments demonstrated a failure to treat the patient with respect and dignity regardless of their diagnosis.

Similarly, the panel considered Miss Morgan's actions in charges 21a and 21b to be unprofessional and demonstrated discriminatory conduct. Again, Miss Morgan knew that the patient had full capacity and despite this she failed in her duty to maintain

the dignity of the resident by behaving in a patronising manner when she administered the medication.

Again, with charge 22, the panel considered that Miss Morgan’s actions were unprofessional and demonstrated discriminatory conduct.

The panel was of the view that Miss Morgan had failed to uphold the dignity of the patients in these charges and her actions also suggested underlying attitudinal issues.

In light of the above, the panel considered Miss Morgan’s actions in charges 19, 20, 21 and 22 individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

When considering charges 23 and the associated dishonesty in charge 24, individually, the panel bore in mind that water flushing prevents feeding tubes from being blocked and provides the resident with essential hydration. Miss Morgan did not provide the resident with a flush of water which had the potential to cause that resident serious harm. Additionally, Miss Morgan then lied about her actions to Colleague 2 and tried to mislead her into believing that she had provided the flush of water. It was of the view that any nurse who had assumed Miss Morgan had provided the resident with a flush of water would not believe they had to.

In light of the above, the panel considered Miss Morgan’s actions in charges 23 and 24 individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

When considering charges 25 and the associated dishonesty in charge 26, separately, the panel was of the view that by Miss Morgan declaring she had taken all of the temperatures required and that there were no concerns, when she had not,

would have induced her colleagues to believe that there were no concerns for the patients. This would have given colleagues false assurances given that the temperatures were not taken for a large proportion of the patients. The panel was of the view that this presented a significant patient safety issue.

In light of the above, the panel considered Miss Morgan's actions in charges 25 and 26 individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

With regards to charge 27, the panel did not find that this amounted to misconduct. It was of the view that while Miss Morgan had withheld her diagnosis of arthritis from her employer, as she was entitled to do.

When considering charges 29, 31 and the associated dishonesty of charges 30 and 32 individually, the panel considered Miss Morgan's actions to be unprofessional and a serious departure from the Code. It was of the view that providing false references to gain employment placed patients at a serious risk of harm.

In light of the above, the panel considered Miss Morgan's actions in the aforementioned charges individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

When considering charges 33a,33b and the associated dishonesty of charge 34, individually, the panel bore in mind that Miss Morgan, following a comprehensive risk assessment, had an interim conditions of practice order imposed on her nursing practice. The panel also bore in mind that interim orders are designed to protect the public. It was of the view that Miss Morgan's failure to comply with the conditions undermined the ability of the NMC to undertake its primary function in keeping the public safe.

In light of the above, the panel considered Miss Morgan's actions in the aforementioned charges individually fell significantly short of the conduct and standards expected of a registered nurse, would be considered deplorable by the public and fellow practitioners and were serious departures from the Code, amounting to serious professional misconduct.

The panel bore in mind that it had not considered charge 6 to be serious misconduct. However, it was of the view that collectively with the other charges related to medications administration namely charges 7a, 7b, 7c, charge 6 amounted to serious misconduct.

The panel therefore determined that the charges found proved, with the exception of charge 27, collectively amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and lack of competence, Miss Morgan's 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.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be

honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

For reasons already set out above, the panel considered that limbs a, b, c and d were engaged by Miss Morgan's lack of competence and misconduct in this case.

With regards to lack of competence, the panel was of the view that Miss Morgan's failure to address the main areas of concern identified by the panel, namely medications management, record keeping, patient care and interpersonal communication had the potential to place patients at an unwarranted risk of harm. This was because she was unable to achieve the standard required of a band 5 nurse despite extensive support and supervision.

The panel found that Miss Morgan's lack of competence had breached the fundamental tenets of the nursing profession. It also bore in mind that the public would lose faith in the medical profession and therefore brought the reputation of the medical profession into disrepute.

With regards to misconduct the panel found that Miss Morgan's actions, particularly in relation to her clinical failings and dishonesty had in the past put patients at risk. In relation to the misconduct charges, the panel found that Miss Morgan's failings breached fundamental tenets of nursing practice and that her misconduct was liable to bring the nursing profession into disrepute.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel recognised that it must make an assessment of Miss Morgan's fitness to practise as of today. It referred to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in her nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the

misconduct and lack of competence and considered whether Miss Morgan had provided evidence of insight and remorse.

Regarding insight the panel noted that Miss Morgan, in her CMF, had accepted and denied the charges in relation to misconduct and lack of competence for the first NMC referral. It recognised her right to contest the charges.

With regards to insight the panel was of the view that Miss Morgan, through email correspondence and in her CMF, had not accepted responsibility for her actions and had not demonstrated any remorse or insight for any of the charges the panel found proved. It noted that she continually blamed everyone else for her failings. It also noted that her reflective pieces were actually just her account of why the failings occurred with no personal accountability.

The panel bore in mind that addressing the charges in relation to lack of competence concerns would require Miss Morgan to recognise them, reflect on them, and develop insight into what she did and how she would avoid making the same mistakes again. The panel noted that there was no recognition from Miss Morgan that her lack of competence was a problem nor the impact it could have had on patients, colleagues and the nursing profession.

With regards to misconduct, the panel noted that Miss Morgan had not recognised the impact of her failings in the administration of Clopidogrel would have had on the patient and sought to minimise the risk of harm. The panel determined this was a clear example where Miss Morgan had missed an opportunity to strengthen her practice with regards to medications management. The panel also did not have detailed recognition of the impact of her failings pertaining to her unprofessional behaviour and in maintaining residents' dignity in charges 19, 20 and 21. Further, with regards to charge 18, there was no recognition of the impact her derogatory comments would have had on the student nurse.

Miss Morgan also demonstrated no insight on the impact her actions with regards to providing false references would have had on patients and the nursing profession.

Further, the panel do not have any information which would demonstrate how Miss Morgan would approach similar circumstances in the future in relation to any of the charges the panel found proved.

In light of the above, the panel determined that it had no evidence Miss Morgan had any insight in relation to her serious misconduct or lack of competence.

The panel was satisfied that the serious misconduct and lack of competence in this case is capable of being addressed. The panel carefully considered the evidence before it in determining whether or not Miss Morgan had taken steps to strengthen her practice in relation to the serious misconduct and lack of competence identified.

With regards to lack of competence, the panel bore in mind that support was put in place to address the areas of concern over an extended period of time and across three employers. It also bore in mind Miss Morgan had an interim conditions of practice order imposed to help strengthen her practice. Despite the extensive support, Miss Morgan was unable to improve her practice and the failings continued.

With regards to misconduct, particularly the administration of Clopidogrel, the panel saw this as remediable. However, Miss Morgan saw opportunities to strengthen her practice as personal attacks and harassment. In these circumstances, the panel was of the view that these failings are less likely to be remediable for Miss Morgan going forward.

The panel also considered that Miss Morgan's behaviour with regards to charges 18, 19, 20, 21 and 22 and the charges were attitudinal and therefore more difficult to remediate.

Misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However, in the panel's judgment, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all highly relevant to any consideration of the risk of repetition, as is the nature and duration of the dishonesty itself.

The panel found instances of dishonesty relating to references for job applications on numerous occasions which made it clear that this was not a one-off isolated incident. These were repeated instances of dishonesty over a significant period of time. The panel had no evidence of insight or remorse but rather evidence to suggest Miss Morgan had tried to conceal her actions or deny them.

The panel also noted that Miss Morgan’s dishonesty was also apparent in her patient care. It considered that the impact of this was evident because her colleagues had stated that they did not have complete trust in Miss Morgan in completing tasks. This placed an additional burden on her colleagues who felt the need to check and correct Miss Morgan’s work. The panel heard evidence that staff felt uncomfortable, and were reluctant, to work with Miss Morgan due to her dishonesty and family members were not confident in Miss Morgan’s ability to care for their relatives.

The panel bore in mind that the serious misconduct and lack of competence in this case was capable of being addressed. However, in the absence of evidence of insight or strengthened practice there was no evidence that the concerns had been remedied to date. The panel noted that it had no evidence before it of any action taken by Miss Morgan to acknowledge, address or remedy the concerns identified in relation to the matters in this hearing, or the attitudinal issues which appear to underpin them.

The panel is of the view that in the absence of insight, remorse and evidence that Miss Morgan had strengthened her practice, in the areas of concern identified by the panel, Miss Morgan was liable to repeat her actions in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that 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 was satisfied that, having regard to the nature of the misconduct and lack of competence in this case, *“the need to uphold proper professional standards and public confidence in the profession would be undermined”* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if Miss Morgan’s fitness to practise was not found to be impaired and therefore public confidence in the nursing profession would be undermined if Miss Morgan were allowed to practice unrestricted.

For all the above reasons the panel concluded that Miss Morgan’s fitness to practise is currently impaired by reason of misconduct and lack of competence on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Morgan off the register. The effect of this order is that the NMC register will show that Miss Morgan has been struck-off the register.

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

Submissions on sanction

Ms Taylor referred the panel to the NMC guidance entitled “Factors to consider before deciding on sanctions” (reference: SAN-1).

Ms Taylor reminded the panel that it had found that the charges found proved collectively amount to a serious departure from appropriate standards expected. She further reminded the panel that it had found that Miss Morgan’s practice is currently impaired by reason of lack of competence and misconduct on both public protection and public interest grounds.

Ms Taylor took the panel through the aggravating factors she considered to be engaged in this case. She referred the panel to the NMC guidance to assist in its consideration for what, if any, mitigating factors could be considered.

Ms Taylor submitted that taking no action, or imposing conditions of practice or a suspension period for the maximum period of time available would not reflect the seriousness of the conduct.

Ms Taylor submitted that the clinical concerns raised cannot be dealt with sufficiently by a conditions of practice order or a suspension order. She submitted that this is an attitudinal issue which are so serious that a strike off is the only proportionate sanction. She submitted that a strike off order is the only sufficient sanction that would protect the public from harm and maintain the necessary standards and confidence within the profession.

Ms Taylor invited the panel to impose a strike-off order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Miss Morgan abused her position of trust with her dishonesty;
- Miss Morgan had no insight into any of the concerns raised;
- Pattern of misconduct over a significant period of time, namely from 2007 to 2022;

- During the period of the concerns raised, Miss Morgan had her practice restricted by an interim condition of practice order. Miss Morgan failed to comply with this interim order;
- Miss Morgan's conduct put patients at risk of suffering harm;
- Miss Morgan's conduct had an adverse impact on colleagues. Miss Morgan intimidated colleagues who were trying to support her and keep patients safe from her.

After careful consideration, the panel could not find any mitigating features that would apply in this case.

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

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Morgan's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Morgan's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Miss Morgan's registration would be a sufficient and appropriate response.

The panel took into account the SG, and the indicative factors which may indicate that a conditions of practice order is suitable namely if there is no evidence of general incompetence. It bore in mind that Miss Morgan had been provided with

extensive support, over an extended period of time and across three employers to address the areas of concern. Additionally, Miss Morgan had an interim conditions of practice imposed which included an obligation to be supervised in medications management, inform the NMC of where she worked and of any complaints made against her. Despite this, she failed on numerous occasions to reach the standard expected of a band 5 nurse.

The panel considered that conditions of practice could have been formulated to address the areas raised regarding Miss Morgan's lack of competency. However, it also considered that conditions of practice would only be workable if Miss Morgan had shown remorse and insight, and there was an absence of evidence of those factors.

The panel also reminded itself of the seriousness of the misconduct, the lack of competence, the associated dishonesty which indicated attitudinal issues underpinning them. It was of the view that this was not something that can be addressed through retraining.

The panel is of the view that there are no practical or workable conditions that could be formulated to maintain patient safety given the nature of the charges. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Morgan's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered that the misconduct found was not a single instance as it had been repeated over a significant period of time.

The panel also considered the dishonesty in this case and took account of the NMC Guidance entitled "Considering sanctions for serious cases" (reference SAN-2). Under the sub-heading entitled "Cases involving dishonesty", it stated:

> *"… Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
> - *misuse of power*
> - *vulnerable victims*
> - *personal financial gain from a breach of trust*
> - *direct risk to people receiving care*
> - *premeditated, systematic or longstanding deception*

The panel was satisfied that all of the above were engaged in this case. It also considered Miss Morgan's dishonesty, in relation to false references and referees, constituted a deliberate systematic approach in misleading employers and the NMC. This demonstrated evidence of deep-seated attitudinal problems that pose a risk to both patient safety and public interest.

The panel also noted that the areas of concern in relation to lack of competence, identified by the panel, namely patient care, medications management, record keeping, and interpersonal communication demonstrated that these failings were repetitive in nature. It was satisfied that the clinical failings were pervasive despite numerous attempts from others to assist in strengthening Miss Morgan's practice. The panel found that Miss Morgan had demonstrated no insight into any of the concerns identified, nor recognised the amount of support offered by others to strengthen her practice.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Morgan's actions is fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Miss Morgan's misconduct, dishonesty and the attitudinal issues that underpinned them raised fundamental questions about her professionalism. It was clear to the panel she had demonstrated absolutely no insight into the concerns raised. It determined that, in light of Miss Morgan's behaviour and attitudinal issues, the public would expect Miss Morgan's name be removed from the NMC Register.

Miss Morgan’s actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Morgan’s actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Morgan’s actions in bringing the profession into disrepute by adversely affecting the public’s view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Miss Morgan in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Morgan’s own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Taylor. Given the panel’s findings in relation to sanction she submitted that only an interim suspension order

for a period of 18 months will be appropriate. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Miss Morgan is sent the decision of this hearing in writing.

That concludes this determination.