Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 July – Friday, 12 July 2024

Virtual Hearing

Name of Registrant:	**Catherine Jayne Stewart**
NMC PIN:	89J0253E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 30 November 1992
Relevant Location:	Derbyshire
Type of case:	Misconduct
Panel members:	Darren Shenton (Chair, Lay Member) Catherine McCarthy (Registrant Member) Lorraine Wilkinson (Lay Member)
Legal Assessor:	Michael Hosford-Tanner
Hearings Coordinator:	Angela Nkansa-Dwamena
Nursing and Midwifery Council:	Represented by Jemima Lovatt, Case Presenter
Miss Stewart:	Present and represented by Aparna Rao, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charge 4
Facts proved:	Charges 1c (with respect to sub-charge iv), 1e, 1f, 2a, 2b, 2c, 2d, 2e, 2f, 3a and 3c.
Facts not proved:	Charges 1a, 1b, 1c (with respect to sub-charges i, ii, iii and v), 1d, 3b and 5.
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18**

months)

Details of charge

That you, a Registered Nurse,

Case Reference 088644

Whilst employed as Deputy Manager at Branksome Nursing Home:

1. In respect of Resident A:

a) On 11 April 2022, failed to check in Resident A's medication, that you had received and signed for that same day.

b) Between 11-14 April 2022, failed to ensure the safe storage of A's medication.

c) On one or more dates between the 11–14 April 2022 failed to administer the following medication to Resident A:

i. Risperidone

ii. Codeine

iii. Amiloride

iv. Paracetamol

v. Sertraline

d) Did not administer Resident A's transdermal Reletrans patch due on the 11 April 2022 until 15 April 2022

e) Did not escalate the missing stock medication for Resident A until the 14 April 2022.

f) Provided inaccurate information to colleagues regarding the missing medication during the daily team flash meeting held on 14 April 22.

2. On the 14 April 2022:

a) signed for but failed to administer Losartan to Resident B.

b) signed for but failed to administer Lansoprazole and/ or Spironolactone to Resident C.

c) signed for but failed to administer Doxazosin to Resident D.

d) failed to administer Strivit to Resident E.

e) signed for but failed to administer Ramipril to Resident F.

f) administered a double dose of Simvastatin to Resident G.

Case Reference 090412

Whilst employed as a Staff Nurse at Haddon Hall Care Home,

3. In respect of Resident H:

a) On a date unknown in August 2022, did not obtain a blood sugar and / or contact 111 for advice on the management of their PEG feed, after they had returned from hospital;

b) On a date unknown in August 2022 set up a PEG feed while they were lying flat;

c) On 30 August 2022 failed to provide water flushes as prescribed.

4. On a date unknown between 6 June 2022 and 2 September 2022, failed to administer the controlled drug Gabapentin to Resident I.

5. Between 6 June and 2 September 2022 failed to give adequate handovers to staff on one or more occasions.

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

Decision and reasons on application to admit hearsay evidence

At the outset of the hearing, Ms Lovatt, on behalf of the Nursing and Midwifery Council (NMC), made an application for the witness statements and exhibits of Witness 6 to be admitted into evidence. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted that this case laid out the following factors to be considered in admitting hearsay evidence and she further stated that she would address each factor respectively:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Lovatt submitted that Witness 6's evidence goes to Charge 3 and Charge 5 and it is not the sole and decisive evidence for these charges as it is also supported by the documentary evidence of Witness 1. She further submitted that Witness 1 would be attending the hearing and there would be an opportunity for her evidence to be challenged and tested by the panel.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Lovatt submitted that this factor would be best addressed by Ms Rao, on your behalf.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Lovatt submitted that there was no suggestion that Witness 6 had any reason to fabricate the allegations made against you.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Lovatt submitted that the charges are serious and, should the NMC be successful, there would be an impact on your career through the eventual sanction, should that stage be reached.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Lovatt submitted that the reason for Witness 6's non-attendance was [PRIVATE]. She referred the panel to an email from Haddon Hall Care Home dated 24 June 2024 which confirmed this.

vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Lovatt submitted that in these circumstances, [PRIVATE].

vii. Whether the registrant had prior notice that the witness statement would be read:

Ms Lovatt submitted that notice of the NMC'S intention to rely upon hearsay evidence was sent to you and Ms Rao a week ago.

Ms Lovatt submitted that the case of *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) is also relevant for the panel's consideration, given the circumstances of Witness 6's non-attendance. She submitted that in this case, the panel considered the admissibility of hearsay evidence where the absence of a witness was as a result of [PRIVATE].

In conclusion, Ms Lovatt submitted that in these circumstances, hearsay evidence may be admissible if there is some way of assessing the reliability of that hearsay

evidence. She submitted that in this case, the panel can test the evidence as Witness 1 will be attending the hearing and there would be an opportunity for her evidence to be challenged and tested in cross examination.

Ms Rao submitted that in relation to the hearsay evidence of Witness 6, she did not oppose this application. She submitted that there is plainly a good reason as to why Witness 6 will not be able to attend this hearing and that she would make submissions on what weight should be attached to this evidence in due course.

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 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) 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.

In reaching its decision, the panel considered the case of *Thorneycroft*. The panel considered the evidence of Witness 6 and determined that whilst it was not sole and decisive evidence for Charges 3a, 3c and 5, it was the sole and decisive evidence for Charge 3b. It had regard to Witness 6's NMC witness statement in which it was alleged that you had set up a Percutaneous Endoscopic Gastrostomy (PEG) feed whilst Resident H was lying flat. The panel noted that this was supported by Witness 6's near-contemporaneous local statement written on 14 September 2022, reasonably close to the alleged incident.

However, the panel considered that there was no other supporting evidence for Charge 3b but, that it could take account of the near-contemporaneous local statement produced by Witness 6 and the panel could afford such weight to the evidence as it felt appropriate once all of the evidence in the case had been heard. The panel was of the view that there was no reason to believe that the contents of Witness 6's statements were fabricated. The panel considered that the allegations with respect to Haddon Hall were serious and would have an adverse impact on you if a finding were to be made.

The panel noted that in these circumstances, no steps could be taken to secure Witness 6's attendance and prior notice had been given to you and Ms Rao of the NMC's intention to admit Witness 6's evidence as hearsay evidence. The panel also noted that there were no objections raised by Ms Rao to the NMC's application to admit Witness 6's documentary evidence into evidence.

The panel found that Witness 6's documentary evidence was not the sole and decisive evidence for Charges 3a, 3c and 5. Although Witness 6's evidence is the sole and decisive evidence for Charge 3b, the panel took into account that it would have been admissible as relevant if Witness 6 attended the hearing to give her live evidence, had it not been [PRIVATE].

The panel decided to accede to the NMC's application to admit the witness statements and exhibits of Witness 6 into evidence. At the appropriate stage, upon receiving legal advice, the panel will consider the evidence before it and attach the appropriate weight to the hearsay evidence of Witness 6.

Decision and reasons on application to admit hearsay evidence

Ms Lovatt made a further application to admit the local statement of Ms 1 and the local interview notes of Ms 2 into evidence. She referred the panel again to the case of *Thorneycroft* and addressed each factor in turn:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Lovatt submitted that the statement of Ms 1 and interview notes of Ms 2 are not the sole and decisive evidence with respect to Charges 1a, 1b and 1c. She submitted that Ms 1's statement goes to Charges 1a and 1b which are supported by the documentary evidence of Witnesses 2, 3, 4 and 5. She further submitted that the allegations in Ms 2's interview notes were also supported by the documentary evidence of Witnesses 2, 3 and 4.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Lovatt submitted that this factor would be best addressed by Ms Rao in due course.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Lovatt submitted that there was no suggestion that the witnesses had any reason to fabricate their allegations made against you.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Lovatt submitted that the charges are serious and should the NMC be successful, there would be an adverse impact on your career through the eventual sanction, should that stage be reached.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Lovatt submitted that there was no good reason for the non-attendance of Ms 1 and Ms 2. She submitted that this was an oversight on the NMC's part as the witnesses were not requested to attend and witness statements were not obtained.

vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Lovatt submitted that as a result of the oversight, no steps were taken to secure the attendance of Ms 1 and Ms 2.

vii. Whether the registrant had prior notice that the witness statement would be read:

Ms Lovatt submitted that no prior notice was given to you or Ms Rao and you both had only been informed this morning.

Ms Rao accepted that the evidence of Ms 1 and Ms 2 are not the sole and decisive evidence for Charges 1a, 1b and 1c. However, she submitted that if the NMC was relying on their evidence, it should have obtained witness statements or secure their attendance, which could have easily been done.

Ms Rao referred to the factors of *Thorneycroft* and submitted that factors v and vi are the main factors of concern. She submitted that Ms 1 and Ms 2 are purporting to give evidence that is part of an overall picture in which you are alleged to have failed to do something that you deny. Ms Rao submitted that, in these circumstances, the evidence of these witnesses would need to be challenged. She further submitted that no steps have been taken by the NMC to secure their attendance as they were not previously identified as witnesses, and now was not the time to do this.

Ms Rao submitted that a number of things could have been done, including obtaining a signed witness statement with a declaration of truth attached. She submitted that Ms 2 is a registered nurse who has a professional obligation to engage in and attend the hearing if required. Ms Rao submitted that since the panel has no information on factors v and vi of *Thorneycroft*, it would not be proper or fair to you to rely on the evidence of Ms 1 and Ms 2.

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

The panel had regard to the statement of Ms 1 and interview notes of Ms 2 and it considered that both were relevant to the charges and were already available within the agreed exhibit bundle. The panel noted that their evidence was not the sole and decisive evidence for the charges, and you had been questioned during the local investigation about these matters. The panel was of the view that you have had an awareness of the matters to which Ms 1 and Ms 2 refer to and other witnesses who will attend the hearing can also be challenged with respect to these matters.

The panel determined that it would be fair and relevant to admit the evidence of Ms 1 and Ms 2 into evidence and at the correct time, it would attach the appropriate weight to these documents, considering each separately.

The panel considered that with regards to obtaining best evidence, the NMC should have obtained witness statements from Ms 1 and Ms 2. The panel was of the view that there was no good reason given by the NMC for the non-attendance of or the absence of their written witness statements. The panel considered that the matters in this case are serious, and steps to obtain the witness statements should have been made.

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

During panel questioning of Witness 1 on Day 2, the panel decided that it would be necessary to hold this part of the hearing in private as proper exploration of Witness 1's evidence may involve [PRIVATE]. This application was made pursuant to Rule 19 of the Rules and the panel heard submissions from Ms Rao and Ms Lovatt.

Ms Rao submitted that it would be appropriate to hold this part of the hearing in private due to the questions that may be asked, and the panel has the power and responsibility to hear such matters in private. She invited the panel to allow this application to apply to other parts of the hearing in which [PRIVATE].

Ms Lovatt submitted that she supported this application given the potential issues that the panel had alluded to being raised.

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

The panel decided that the hearing will be heard partly in private so that matters pertaining to [PRIVATE] would be heard in private.

Decision and reasons on application to withdraw your admission to Charge 1d

At the outset of the hearing, the panel heard from Ms Rao, who informed the panel that you made admissions to Charges 1d and 4.

During closing submissions, Ms Rao made an application to withdraw your admission to Charge 1d in light of the evidence heard during the course of these proceedings.

Ms Rao submitted that Charge 1d could not be found proved, as the evidence before the panel suggests that you did not have any clinical duties on 11 April 2022 as you had been undertaking your Deputy Manager duties in a supernumerary capacity. She submitted that after exploring Resident A's Medication Administration Record (MAR) charts with a number of witnesses, it is unclear whether Resident A's transdermal Reletrans patch was in fact due to be administered on 11 April 2022. Ms Rao further submitted that there was oral and documentary evidence to suggest that the transdermal patch was administered on 15 April 2022, however this had been carried out by Witness 5 and not by yourself.

Ms Rao submitted that in these circumstances, it would not be safe to accept your admission to Charge 1d and that the panel has the appropriate authority to make its own judgement on the facts in relation to this matter. She submitted that it is fair to you for the evidence to be considered by the panel and for your admission to be withdrawn.

Ms Lovatt submitted that the NMC objected to you being permitted to withdraw your admission to Charge 1d. Her submissions fell into two parts, namely the procedural issues and the factual circumstances of this case. She submitted that the NMC objected to the way this issue has been handled. She submitted that the correct procedure would have been to ask for written submissions from both sides for the panel to then consider whether the charge could be put to you again. Miss Lovatt referred the panel to the case of *Kojima v HSBC Bank PLC* [*2011*] EWHC 611 (Ch), in which the judge stated that once a party has admitted to a claim, the other party is in principle entitled to assume that, barring any appeal, that is the end of the matter.

Ms Lovatt submitted that as a result of this, she had not explored this charge with any of the witnesses and she invited the panel to consider the factors set out in paragraph seven of the Practice Direction to part 14 of the Civil Procedure Rules (CPR), which outline:

a. The grounds upon which the applicant seeks to withdraw the admission, including whether or not new evidence has come to light which was not available at the time the admission was made.
b. The conduct of the parties, including any conduct which led the party making admission to do so.
c. The prejudice that may be caused to any person if the admission is withdrawn.
d. The prejudice that may be caused to any person if the application is refused.
e. This stage in proceedings at which the application to withdraw is made, in particular in relation to the date or period that has been fixed for any trial, the prospects of success of the claim or part of the claim in relation to which the submission has been made.

Ms Lovatt submitted that the panel should in any event consider the evidence before it. She referred the panel to Resident A's MAR chart which shows the administration of Resident A's transdermal Reletrans patch. Ms Lovatt submitted that during his oral evidence, Witness 5's accepted that had been the one to administer Resident A's transdermal patch on 15 April 2022, which is supported by a signature he identified as his on Resident A's MAR Chart. Ms Lovatt further submitted that your signature does not feature for this medication and on that basis, Charge 1d should be found proved in any event. Ms Lovatt was also unable to articulate the 'mischief' in the actual charge as alleged, despite her raising this issue with the NMC itself.

In response, Ms Rao submitted that she understood the NMC's position that it would be reasonable for it to rely upon admissions and that the case of *Kojima* outlines that once a judgement is given there is an expectation of finality. She submitted that the CPR are of assistance, but not binding and the NMC has its own rules which gives panels the ability to be more flexible in the way that it manages proceedings.

Ms Rao submitted that although the panel has announced its finding in relation to Charge 1d being found proved by way of admission, this decision has not been written up yet and indeed, the panel has not come to its full decision with respect to the facts stage. She referred to Rule 24 of the Rules and submitted that until the panel has reached a final decision on the facts, the facts are still open for the panel to decide and that it can allow you to withdraw your admission.

Ms Rao submitted that the way Charge 1d has been drafted implies that you administered Resident A's transdermal Reletrans patch on 15 April 2022, when the evidence clearly shows that this was not the case, and this charge cannot be found proved on the basis of an admission. In relation to the NMC's inability to examine witnesses and cross examine you, Ms Rao submitted that Ms Lovatt could make submissions on what matters she would have liked to have explored and that the NMC has had the documentary evidence. She submitted that there would be no unfairness to the NMC as it is the party which drafts the charges and collects the evidence.

The panel heard from and accepted the advice of the legal assessor who referred to Rule 24 of the Rules and the case of *Kojima*.

The panel decided to accept your application to withdraw your admissions to Charge 1d. The panel considered that there was no prejudice to the NMC that could be identified or further evidence that it considered likely would have been adduced by the NMC had it known your admission was going to be withdrawn. The panel acknowledged that the evidence emerged fully during the course of hearing witness evidence with regards to whether you had a clinical duty to administer Resident A's transdermal patch on 11 April 2022 and the NMC had not identified with precision what the alleged failure was in relation to Charge 1d. The charge itself had not specifically alleged any failure, nor given any detail of any duty that fell upon you.

The panel recognised that it was not bound by the CPR, although it sets out a sensible basis for weighing prejudice, which the panel has done in this case. The panel acknowledged that it has an inquisitorial role, and it was satisfied that it has

been able to carry this out fully with respect to Charge 1d and was not hindered by your initial admission.

The panel concluded that on the balance of fairness, it would be more unfair to you than to the NMC to not allow you to withdraw your admission to Charge 1d and that the NMC is not disadvantaged as the evidence in relation to Charge 1d will be explored fully, with a careful examination of all relevant documents and the panel will consider all the evidence before it before making a finding on the facts of this case.

Background

On 27 April 2022, the NMC received a referral from Four Seasons Healthcare (Four Seasons), raising concerns about you. The charges arose whilst you were employed as the Deputy Manager of Branksome Nursing Home (Branksome).

It is reported that on several days between 11 and 14 April 2022, concerns were raised about your medication management and the safe storage of medications. It is also alleged that you provided inaccurate information to colleagues about missing medication. As well as working as Deputy Manager, you also worked nursing shifts ‘on the floor’.

On 5 September 2022, the NMC received another referral from Porthaven Care Homes (Porthaven), raising further concerns about you. At the time of the allegations, you were employed as a Staff Nurse at Haddon Hall Care Home (Haddon Hall).

After completing an intensive induction, it is alleged that you failed to properly manage Resident H’s PEG feed and set up the PEG feed whilst Resident H was lying flat despite you allegedly having had a full 'refresh' training on PEG administration a few weeks prior. It is further alleged that you failed to provide water flushes for the PEG tube as prescribed.

It is also reported that you allegedly failed to administer a controlled medication to Resident I as prescribed. It is also said that you gave poor quality handovers to

colleagues.

Decision and reasons on facts

At the outset of the hearing, the panel heard that you made an admission to Charge 4.

The panel therefore finds Charge 4 proved, by way of your admission.

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 Lovatt and Ms Rao.

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: Deputy Home Manager of Haddon Hall Care Home at the time of the alleged incidents.
- Witness 2: Quality Manager at Four Seasons Healthcare at the time of the alleged incidents.
- Witness 3: Managing Director at Four Seasons Healthcare at the time of the alleged incidents.

- Witness 4: Regional Support Manager at Four Seasons Healthcare at the time of the alleged incidents.

- Witness 5: Registered Nurse at Branksome Nursing Home at the time of the alleged incidents.

The panel also considered the written statement of:

- Witness 6: Registered Nurse at Haddon Hall Care Home at the time of the alleged incidents.

The panel also heard evidence from you under affirmation.

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

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

Charges 1a and 1b

1. In respect of Resident A:

a) On 11 April 2022, failed to check in Resident A's medication, that you had received and signed for that same day.

b) Between 11-14 April 2022, failed to ensure the safe storage of A's medication.

These charges are found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2, 3, 5 and Ms 1 and your oral evidence.

The panel noted that within his witness statement, Witness 5 had stated that there had been a medication delivery from Boots Pharmacy (Boots) around 14:00 hours on 11 April 2022:

> *'Later on in the day, on 11 April 2022, Boots delivered some medication, around 14:00pm during the fire drill training that day. I cannot recall if this was after the fire drill, nor who took the delivery from Boots. That delivery did not contain Resident A's out of stock medication.'*

During his oral evidence, Witness 5 stated that the medication that had been delivered did not contain Resident A's transdermal Reletrans patch as it did not arrive in the designated Boots controlled drugs (CD) bag. He further stated that there was another delivery later that day between 18:00 and 20:00 hours, but he was not aware of who had received the delivery, nor whether Resident A's medication was part of that delivery.

Witness 2 confirmed this within her witness statement in which she said:

> *'Boots informed me over the telephone that the medication had been delivered between 18:00 and 20:00 on 11 April.'*

The panel had regard to a Boots delivery note for 11 April 2022. It noted that there was no signature in the designated signature box at the bottom of the page. However, Witness 5 had stated that a signature would sometimes be placed next to the resident's order. He stated that the indecipherable 'squiggle' next to Resident A's

order under ‘No. of Tote Trays’ could have been your signature or his, but he was unsure.

You informed the panel that you did not receive a medication delivery on 11 April 2022 and that you thought that the signature under the ‘No. of Tote Trays’ column may have been a marking made by Boots.

The panel then went on to consider whether you had a duty to check in Resident A’s medication and to store it appropriately.

The panel had regard to the duty roster for the week commencing 11 April 2022. The panel noted that you were on a supernumerary 08:00 - 16:00 hours shift working in your Deputy Manager role. The panel heard from witnesses who confirmed that you would not have been the nurse responsible for medications on the day as you were not carrying out clinical duties. During your oral evidence, you told the panel that you did not receive the 14:00 hours Boots delivery which was confirmed to not have contained Resident A’s stock medication and that you had left Branksome at around 17:00 hours, prior to the second reported delivery, which is believed to have been delivered between 18:00 and 20:00 hours, according to Witness 2, who obtained that information when she telephoned Boots on 14 April 2022.

The panel considered the evidence of Witness 3, who conducted the local investigation at the time. During an interview with her, you accepted that the signature was similar to yours and it was clear that following this, the management at Branksome considered that it was in fact you who had received the CD, and subsequently had not followed policy in respect of its receipt and storage. In her evidence to the panel, Witness 3 raised her concerns that throughout your interviews you seemed ready to accept any allegations that were put to you, and she told the panel that she was worried about your over preparedness to do this.
Accordingly, the panel placed little weight on the admissions you had signed for the CD you made during your local investigation.

The panel considered the above and decided to accept your evidence. The panel noted that there was no clear evidence on the Boots delivery note to decipher who

had accepted the delivery on 11 April 2022. The panel also noted that Ms 1 had sought to locate Resident A's medications after the 14:00 hours delivery and had been unsuccessful. In light of this, the panel concluded that it was likely that Resident A's medication had been delivered between 18:00 and 20:00 hours, at a time when you were not on the premises and on a day where you did not have any clinical duties. The panel therefore determined that you did not fail to check in Resident A's medication as it was unlikely that you were the one to receive or sign for it.

In light of the above, the panel considered Charge 1b and whether you had failed to ensure the safe storage of Resident A's medication.

The panel noted that there was a lack of clarity as to whether this charge relates to all of Resident A's medication, which was out of stock, or only the CD (the transdermal Reletrans patch). The panel considered that the NMC's case must relate to Resident A's CD and your alleged associated failure.

The panel considered Witness 3's witness statement and oral evidence in which she stated that Resident A's transdermal Reletrans patch had been found on 12 April 2022 and had been booked in and appropriately stored by two agency nurses at 17:40 hours, which is supported by the CD book. The panel also had regard to Four Seasons' *'How to store medicines'* policy. The panel considered that the NMC's case relates to Resident A's transdermal patch and your alleged subsequent failure to store Resident A's transdermal patch, a CD, in accordance with the medication storage policy. The panel determined that you had not been the person to receive the Boots medication delivery and the medication storage policy demonstrated that the responsibility of storage rested with the person who received the medication. The panel considered whether in your role as the Deputy Manager, you had an overarching duty to ensure the safe storage of Resident A's medication between 11 and 14 April 2022. The panel determined that there was no evidence before it to suggest that you had a duty to ensure safe storage of these medications.

Accordingly, the panel found Charges 1a and 1b not proved.

Charge 1c (sub-charges i, ii, iii, iv and v)

1. In respect of Resident A:

c) On one or more dates between the 11–14 April 2022 failed to administer the following medication to Resident A:

i. Risperidone

ii. Codeine

iii. Amiloride

iv. Paracetamol

v. Sertraline

This charge is found NOT proved with respect to Charge 1c, sub-charges i, ii, iii and v.

This charge is found proved with respect to Charge 1c, sub-charges iv.

The panel had regard to the NMC's closing submissions, with respect to Charge 1c, sub-charges i, ii, iii and v. The panel considered that there was no evidence to support the fact that you had failed to administer those specific medications on or between 11 and 14 April 2022 for the reasons set out in relation to sub-charge iv. In its own judgement following the assessment of the evidence presented to it during the hearing, the panel determined that there was no evidence to sustain these charges.

Accordingly, the panel found Charge 1c, with respect to sub-charges i, ii, iii and v, not proved.

In reaching its decision on Charge 1c, part iv, the panel took into account the documentary evidence of Witness 2 and 3 and your oral evidence.

The panel noted that within her witness statement, Witness 2 had stated:

'…I checked Resident A's MAR chart, and found that Resident A had not had the following medicines since the start of their new cycle, i.e. 11 April 2022:

- *…*
- *…*
- *Paracetamol;*
- *…*
- *…'*

This was supported by the witness statement of Witness 3.

The panel went on to consider whether you had a duty to administer Paracetamol to Resident A between 11 and 14 April 2022. The panel had regard to the duty rota for the week commencing 11 April 2022. It noted that you worked a long day shift (08:00- 20:00 hours) on 14 April. This was the only day between 11 and 14 April that you had worked with responsibility for clinical duties and undertaking the medication round. The panel also had regard to Resident A's MAR chart which confirmed that you had a direct clinical duty, and you were the one responsible for administering medication to Resident A on 14 April 2022. The panel noted that you had administered the other medications to Resident A on that day.

With respect to Paracetamol, you told the panel that you had administered Resident A's noon dose but had not signed for the teatime dose. You stated that this may have been due to the fact that Paracetamol can only be administered at a minimum every four hours, and this time may not have elapsed by the time the teatime dose was due, but you accepted that you should have recorded that reason on the back of the MAR chart.

The panel considered the above evidence and determined that you had failed to administer Paracetamol to Resident A. The panel noted that on Resident A's MAR chart, the code 'G' had been written for the morning dose, as a reason for non-administration of the drug, and you had signed for and administered the noon dose.

However, the space for the teatime dose had been left blank and indicated that this dose had been missed. The panel considered your explanation and determined that if this had been the case, it would be expected that you would document this using a code and would explain the reason for non-administration on the back of the MAR chart.

In light of this, the panel was satisfied that you had not administered Paracetamol to Resident A on 14 April 2022.

Accordingly, the panel found Charge 1c, with respect to sub-charge iv, proved.

Charge 1d

1. In respect of Resident A:

    d) Did not administer Resident A's transdermal Reletrans patch due on the 11 April 2022 until 15 April 2022

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 5, the documentary evidence provided by Witness 3 and your oral evidence.

During his oral evidence, Witness 5 had stated that he had administered Resident A's transdermal Reletrans patch on 15 April 2022. This was consistent with Resident A's MAR chart and the CD book entries for Resident A.

The panel had regard to the duty rota and noted that it was not your duty to administer Resident A's patch, as you were not the nurse responsible for clinical duties on 11 or 12 April 2022 and you were not shown on the rota for 13 April 2022. The panel also noted that it was unclear from evidence that Resident A's previous MAR chart whether the patch was due to be administered on 11 April 2022, because it was due to be administered weekly and the recent dates when it had previously

been administered were unclear from the markings on the MAR chart and the information contained within the CD book.

The panel heard evidence from Witness 5 that he had been the one to administer Resident A's patch on 15 April 2022 and this was clear upon examination of Resident A's MAR chart and CD medication book. The panel considered that the wording of the charge did not ascribe a failure on your part, even if that might be implied, and the evidence did not support that you were the one with clinical responsibility to administer the patch on 11 April 2022, with some continuing duty to do so. The documentary evidence demonstrated that you were also supernumerary on 12 April and were not on duty at all on 13 April 2022. The documentary evidence showed in the CD medication book that the Reletrans patch had been checked in at 17:40 hours on 12 April 2022 by two agency nurses, and there was no explanation as to why it was not administered on 12 or 13 April 2022, when it would not have been your duty to do so in any event. The panel took into account that it the patch was administered by Witness 5 on 15 April 2022 and that the evidence did not establish that it was due to be administered before that date.

Accordingly, the panel found Charge 1d not proved.

Charge 1e

1. In respect of Resident A:

    e) Did not escalate the missing stock medication for Resident A until the 14 April 2022.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2, your oral evidence and the documentary evidence provided by Witness 3.

The panel had regard to Branksome's communication diary and the duty rota. The panel noted that you were on duty on 11, 12 and 14 April 2022, even though supernumerary on 11 and 12 April, and you had been aware of Resident A's missing stock medication on 11 April. This was recorded in the diary, in which you had acknowledged that Resident A had missing medication, and you had written that a RADAR Incident Form had been completed with respect to this, on the 11 April by Witness 5. The panel also noted that on 13 April 2022, you had made an entry in relation to Sertraline 100mg.

You told the panel that although you were not on duty on 13 April, you may have written the note on 12 April for staff to chase the following day. You further stated that you had not escalated the matter to senior management as you wanted to conduct further enquires to find out why the medication was missing and that you had contacted the GP and Boots. You stated that you thought that the managers were already aware as a RADAR form had been completed on 11 April 2022 and, as this was a computerised system, you assumed that management would have picked up this information.

The panel heard from Witness 2 that she had overheard a conversation in the office between you and Boots, in relation to Resident A's missing medication, on 14 April 2022. This was consistent with her written statement:

> *'On 14 April 2022, I was in the nurses' office, around lunch time when I overheard a telephone conversation between Miss Stewart and Boots Pharmacy ("Boots")…Miss Stewart was also chasing Resident A's out of stock medicines, but informed Boots that they had not looked for more stock in the treatment room…I enquired about Resident A's medication…'*

The panel considered the above evidence. It noted that you had knowledge that Resident A had missing medication since 11 April 2022. The panel further noted that you had not raised this as a concern to the senior management team (SMT), who were always present within Branksome, and it was by chance that Witness 2 had overheard your conversation with Boots and had become aware of Resident A's missing medication. Whilst the panel saw evidence of your attempts to reconcile the

missing stock medication by contacting Boots and the GP, it had no evidence before it to suggest that you had appropriately escalated this potentially serious matter to the SMT who were on site between 11 and 14 April 2022.

Accordingly, the panel found Charge 1e proved.

Charge 1f

1. In respect of Resident A:

    f) Provided inaccurate information to colleagues regarding the missing medication during the daily team flash meeting held on 14 April 22.

This charge is found proved.

In reaching this decision, the panel took into account your oral evidence and the documentary evidence of Witness 3.

The panel noted that within her witness statement, Witness 3 outlined the purpose of flash meetings:

> *'Flash meetings are daily meetings conducted to raise anything in the Home that requires escalating, such as out of stock medication… If Miss Stewart had raised [her] belief that Resident A's medication was still missing earlier, the medication would have been found and administered to Resident A sooner.'*

Witness 3 further stated that you had not raised Resident A's missing medication as an issue during the meeting:

> *'…despite still believing it to be missing on 14 April 2022 Miss Stewart did not raise Resident A's out of stock medication as an issue during the daily flash meeting on 14 April 2022.'*

The panel had regard to the *'Daily Flash Meeting'* notes for 14 April. It noted that you were in attendance and in the section entitled *'Medication Concerns/ Outstanding Pharmacy orders'* the only matter discussed was the order for the new cycle to be completed on that Sunday.

You told the panel that you were concerned about the missing medication, and you wanted to conduct further enquires to establish the reason for Resident A's medication being missing before alerting members of the SMT. You also stated that you thought that the managers were already aware as a RADAR form had been completed on 11 April 2022.

The panel considered the above evidence. It noted that the topic of medication concerns was a regular agenda item within the daily flash meetings and you had been aware since 11 April 2022 that Resident A had missing stock medication. The panel further considered that on 14 April 2022, you knew that Resident A's medication was still missing and as the Deputy Manager and nurse responsible for clinical duties on that day, you would have been expected to escalate this concern during the flash meeting. The panel was of the view that the purpose of the daily flash meeting was to highlight areas of concern and identify critical issues, especially at a time where Branksome was subject to scrutiny and intervention from the Care Quality Commission (CQC). It would have been expected that the issue of Resident A's missing medication to have been brought up at this time. There were also agenda items for *'Medication Concerns/ Outstanding Pharmacy orders'* and *'Any other business/outstanding items'* where you would have reasonably been expected to mention the missing medication at that time. The panel acknowledged that you had sought to find out why Resident A's medication was missing via the GP and Boots, but this should not have excluded you from informing the SMT during the daily flash meeting. The panel determined that by not escalating the matter during the meeting, you did not provide accurate information as members of the SMT were led to believe that there were no medication concerns.

In light of this, the panel found Charge 1f proved.

Charges 2a, 2b, 2c, 2d, 2e and 2f

2. On the 14 April 2022:

a) signed for but failed to administer Losartan to Resident B.

b) signed for but failed to administer Lansoprazole and/ or Spironolactone to Resident C.

c) signed for but failed to administer Doxazosin to Resident D.

d) failed to administer Strivit to Resident E.

e) signed for but failed to administer Ramipril to Resident F.

f) administered a double dose of Simvastatin to Resident G.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4, your oral evidence and the MAR charts of the respective residents referenced below.

The panel first established that you were working a long day shift on 14 April 2022 and you had been the nurse responsible for administering medications to residents. The panel concluded that it was incumbent upon you as a registered nurse to ensure that medications had been administered as prescribed. The panel applied this finding to its consideration to the whole of Charge 2.

The panel had regard to Witness 4's investigation summary dated 15 April 2022, which outlined the missed medications of multiple residents on 14 April 2022. During her oral evidence, Witness 4 confirmed that she had counted the medications in the presence of another nurse and confirmed that the running totals of medication were correct on 15 April 2022 following the administration of medications for the relevant residents. Witness 4 clarified that the pharmacy had a responsibility to ensure all medication counts were correct at the time of dispensing, which the panel accepted.

You told the panel that if you had signed for a medication, it meant that you had administered it. You further stated that despite wearing a red tabard, which indicated that you were not to be interrupted during your medication round, you would often get interrupted by staff, members of the SMT and residents.

The panel was assisted by the investigation summary provided as an exhibit by Witness 4, and on checking the MAR charts the panel established that this summary was accurate. If the running totals were inaccurate prior to administration by you on 14 April 2022, the panel considered that you would have noticed that when doing your count, as you claimed to have done, and that you would have made a note of the medications error.

The panel made the following findings:

Charge 2a- Resident B (Losartan)

The panel had regard to Resident B's MAR chart and noted that Losartan 50mg had been signed for and the total running balance was consistent, which implied that it has been administered. However, for Losartan 12.5mg, you had signed the box indicating that the medication had been administered but the running balance for the tablets was inconsistent as outlined by Witness 4's investigation summary:

> *'Resident B medication-Losartan*
> *Count States:*
> *13th = 25*
> *14th no count but signed*
> *15th = 24'*

The panel considered the above evidence and determined that although you had signed to suggest that you had administered Resident B's Losartan 12.5mg, the running balance was inconsistent with this being done. The panel concluded that it was more likely that the medication had not been administered given the inconsistency in the count balance for the tablets.

Accordingly, the panel found Charge 2a proved.

Charge 2b- Resident C (Lansoprazole and/or Spironolactone)

The panel had regard to Resident C's MAR chart and noted that Spironolactone 25mg and Lansoprazole 15mg, had been signed for by you, suggesting that you had administered them. However, the running balance for both medications were inconsistent as outlined by Witness 4's investigation summary:

> *'Resident C Medication Lansoprazole & Spironolactone*
> *Lansoprazole Count States:*
> *11th = 27*
> *12th = no count (26)*
> *13th = 25*
> *14th = signed but no count*
> *15th = 24*
>
> *Spironolactone count states:*
>
> *11th = 27*
> *12th = No count (26)*
> *13th = 25*
> *14th = signed but no count*
> *15th= 24'*

The panel considered the above evidence and determined that although you had signed to suggest that you had administered Resident C's medications, the running balances were inconsistent with this being done. The panel concluded that it was more likely that the medications had not been administered given the inconsistency in the count balance for the tablets.

Accordingly, the panel found Charge 2b proved.

Charge 2c- Resident D (Doxazosin)

The panel had regard to Resident D's MAR chart and noted that Doxazosin 4mg, had been signed for by you, suggesting that you had administered it. However, the running balance for this medication was inconsistent as outlined by Witness 4's investigation summary:

'Resident D medication Doxazosin
count states:
11th = 27
12th = No count
13th = 25
14th = 24
15th = 24'

The panel considered the above evidence and determined that although you had signed to suggest that you had administered Resident D's Doxazosin, the running balances were inconsistent with this being done. The panel concluded that it was more likely that this medication had not been administered given the inconsistency in the count balance for the tablets.

Accordingly, the panel found Charge 2c proved.

Charge 2d- Resident E (Strivit)

In your oral evidence, you referred the panel to the problem of interruptions and appeared to accept, upon examination of the evidence, that you had not given the Strivit that day. Upon further reflection, you asserted that Resident E did not like taking Strivit and that you would have tried to get her to take it as prescribed. You said that it was possible that you went back to Resident E later to try to get her to take it.

The panel had regard to Resident E's MAR chart and noted that Strivit-D3 800unit capsules, had not been signed for at all and there was no running balance for the

tablet, suggesting that it had not been administered. This was summarised by Witness 4's investigation summary:

'Resident E - Strivit
14th Not signed or given'

The panel considered the above evidence. It noted that the running balance on 13 April was 27 capsules and the running balance on 15 April was 26 capsules. The panel concluded that this was consistent with Witness 4's finding that Strivit had not been administered by you on 14 April. In addition, the absence of a signature also indicated that it was likely that you had not administered Strivit to Resident E on 14 April as you had stated in your oral evidence that you would have signed if you had administered the medication.

In light of the above evidence, the panel concluded that it was more likely than not that you had not administered Resident E's Strivit capsule on 14 April 2022.

Accordingly, the panel found Charge 2d proved.

Charge 2e- Resident F (Ramipril)

The panel had regard to Resident F's MAR chart and noted that Ramipril 10mg, had been signed for by you, suggesting that you had administered it on 14 April 2022. However, the running balance for this medication was inconsistent as outlined by Witness 4's investigation summary:

'Resident F - Ramipril
Count states:
11th = 27
12th = No count (26)
13th = 25
14th = signed no count
15th 24'

The panel considered the above evidence and determined that although you had signed to suggest that you had administered Resident F's Ramipril, the running balance for this medication was inconsistent with this being done. The panel concluded that it was more likely that this medication had not been administered by you on 14 April 2022, given the inconsistency in the count balance for the tablets.

Accordingly, the panel found Charge 2e proved.

Charge 2f- Resident G (Simvastatin)

The panel had regard to Resident G's MAR chart and noted that Simvastatin 40mg, had been signed for by you, suggesting that you had administered one tablet as prescribed. However, the panel noted that the running balance for this medication was inconsistent as outlined by Witness 4's investigation summary:

> *'Resident G - medication Simvastatin x1 only*
> *11th = 27*
> *12th = 26*
> *13th = 25*
> *14th = 23*
> *15th = 22'*

The panel considered the above evidence and determined that although you had signed to suggest that you had administered the correct dose of one tablet of Resident G's Simvastatin, the running balances were in fact consistent with you having administered two tablets.

The panel heard from you and you had stated that it was possible a tablet could have been dropped on the floor or into the medication packet by you or another member of staff.

The panel heard from Witness 4 who had stated that this could have been a possibility but, had this been the case, any inconsistencies in the count should have been picked up by you, documented and reported as an incident on the RADAR

system. Witness 4 confirmed that there had been no evidence of this being done. She also gave evidence that she had conducted a search of the immediate area for any missing medication, which she did not find.

In the absence of any evidence to support the fact that two medications had not been administered, or evidence to account for a missing dose in the patient records or MAR chart, the panel concluded that it was more likely than not that you had administered a double dose of Simvastatin to Resident G on 14 April 2022, given the inconsistency in the count balance for the tablets and the fact that you had reported that you would often get interrupted during a medication round.

Accordingly, the panel found Charge 2f proved.

Charge 3a

Whilst employed as a Staff Nurse at Haddon Hall Care Home,

3. In respect of Resident H:

a) On a date unknown in August 2022, did not obtain a blood sugar and / or contact 111 for advice on the management of their PEG feed, after they had returned from hospital;

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, the hearsay evidence of Witness 6 and your oral evidence.

During her oral evidence, Witness 1 stated that on the unknown August 2022 date in question, you had called her to ask for advice in relation to the management of Resident H after she had arrived back at Haddon Hall from the hospital. She stated that she had asked you to obtain a blood glucose reading and to call 111 as you were unsure whether Resident H had been given an insulin dose prior to being transferred to Haddon Hall. This was consistent with her witness statement:

'Earlier on in the day, Miss Stewart had called me, at time I cannot recall, to ask me for advice on how to manage Resident H's PEG feed following their return from hospital.

Resident H is a diabetic, and required two doses of insulin via subcutaneous injection…This injection needs to be given before the resident can be administered food via their PEG feed. I asked Miss Stewart if they checked Resident H's blood glucose as their blood glucose reading would indicate whether miss Stewart should administer the resident their insulin, and feed… '

Witness 1 went on to detail that she had advised that if you were still unsure, you should contact 111 as they could gain access to Resident H's hospital notes via SystemOne. Witness 1 stated that she had received a telephone call from Witness 6, the night nurse, and had learnt that you had failed to call 111 or obtain a blood glucose reading for Resident H. Around 21:00/22:00 hours, Witness 6 had called Witness 1 to inform her that this had been completed by her and Resident H's regimen had to be adjusted as a result of 111's advice.

You accepted that you had called Witness 1 and had been advised to obtain a blood glucose reading and call 111 for Resident H. However, you stated at the time that you did not feel competent to undertake blood glucose monitoring at Haddon Hall or work with PEG feeds, despite your previous experience and training. You said that you were not confident with using the blood glucose machine. You further stated that Resident H was cared for and was the responsibility of the agency nurse you had been working with.

The panel considered the above evidence and noted that Witness 1 had stated that she had called Haddon Hall a number of times to receive an update from you about Resident H, which you could not recall. The panel acknowledged that although there were inconsistencies with respect to how many phone calls were had and that there was no contemporaneous evidence to support this, it found Witness 1's evidence to be reliable and consistent with respect to the material issues for this charge. The panel had heard evidence from Witness 1 that she had personally demonstrated how

to use the blood glucose machines at Haddon Hall and you had indicated that you knew how to operate them. Witness 1 also stated that you had recently undertaken specialist training, along with other nurses at Haddon Hall to undertake PEG feeds to facilitate Resident H's needs. The panel also heard that you would have had the responsibility to oversee Resident H's care, and to take the steps advised by Witness 1, even if you were not directly caring for her.

The panel considered that there was no evidence to show that you had obtained a blood glucose reading for Resident H or called 111 as advised by Witness 1 and you did not assert that you had done so. The panel concluded that given your stated previous extensive experience as a palliative care nurse and your recent training, there was no reasonable explanation as to why you could not have undertaken a blood glucose test, referred to as a basic nursing task by Witness 1. The panel accepted the evidence of Witness 1 that a blood glucose test would have provided useful information and that phoning 111 would also have been a sensible step and something you should have done, even if you also chose to try and speak to the hospital directly.

The panel determined that the mere fact that Witness 6 had been advised by 111 to adjust Resident H's feeding and insulin regimen based on Resident H's blood glucose reading, made it more likely than not that you did not contact 111 or obtain Resident H's blood glucose reading at the time Witness 1 had asked and this had been carried out by Witness 6 instead. Although Witness 6's evidence is hearsay, the panel considered it could attach weight to her evidence in this matter where there was supporting evidence from Witness 1 as to the background of the need to carry out a blood glucose test and to phone 111 promptly. The panel concluded that you had a duty to ensure this was carried out and you had failed in this.

Accordingly, the panel found Charge 3a proved.

Charge 3b

Whilst employed as a Staff Nurse at Haddon Hall Care Home,

3. In respect of Resident H:

b) On a date unknown in August 2022 set up a PEG feed while they were lying flat;

This charge is found NOT proved.

In reaching this decision, the panel took into account the hearsay evidence of Witness 6 and your oral evidence.

In her written statement, Witness 6 outlined an incident where she had started her night shift and had found that Resident H was lying flat during a PEG feed. She outlined that this was dangerous as it could have put Resident H at risk of vomiting and choking on her own vomit and asphyxiating. She stated that she had asked you and an agency nurse why Resident H was lying flat as opposed to a 45-degree angle. She reported that you had admitted that you had left Resident H on her back during the PEG feed.

You told the panel that although you did not feel competent to undertake PEG feeds at Haddon Hall, your previous experience in a hospital made you aware that lying a PEG patient flat during a feed was dangerous and you would never do this. You told the panel that the agency nurse had been responsible for caring for Resident H. You indicated that Witness 6 seemed to have an issue with you, especially in relation to handovers.

The panel considered the above evidence and decided to accept your evidence. The panel considered the local handwritten statement of Witness 6, dated 14 September 2022 and her NMC written statement in March 2023. It noted that there was no other supporting documentation such as Resident H's records or a subsequent incident form which should have been completed at the time of the incident, given the serious nature of the allegation outlined by Witness 6. The panel further considered the legal advice with respect to hearsay evidence and the principles of *Thorneycroft*. Whilst it had no reason to disbelieve the account of Witness 6, it found itself unable to test

her evidence with respect to reliability, as it was the sole and decisive evidence for this charge.

In particular the witness statement contained an allegation that you had admitted being the nurse who had set up the PEG feed, which you deny, and in her local handwritten statement, close to the date of the incident, Witness 6 simply said that you gave no response when questioned, and made no reference to the presence of an agency nurse. These are matters which would have been explored in cross-examination if there had been live evidence, and it has not been possible to test the reliability of the witness statement. Further the panel was unable to conclude that it is demonstrably reliable, when the local statement was brief, and it does not appear that any incident report or nursing notes were made at the time.

In light of the above, the panel concluded that the NMC had not discharged its burden of proof in this regard.

Accordingly, the panel found Charge 3b not proved.

Charge 3c

Whilst employed as a Staff Nurse at Haddon Hall Care Home,

3. In respect of Resident H:

c) On 30 August 2022 failed to provide water flushes as prescribed.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1 and Witness 6 and your oral evidence.

In her witness statement, Witness 1 stated that:

'When administering food/drink via a PEG feed, it is vital to flush the PEG feed tube after food or medication, and there are specific amounts of water prescribed to flush the resident's PEG feed tube after the administration of food and/or medication. This is essential to clear the tube for the next scheduled feed.'

During her oral evidence, Witness 1 emphasised the importance of flushing a PEG feed tube as the PEG food was thick and if not flushed it would *'set like cement'* resulting in a subsequent hospital admission for the resident.

Witness 1 stated in her witness statement that:

'On 30 August 2022, Miss Stewart failed to flush Resident H's PEG feed, despite being provided with extensive PEG feed training on 19 August 2022…I asked Miss Stewart "you did flush the tube when you took down the feed didn't' you?" to which Miss Stewart looked at me vacantly and replied no. I reminded Miss Stewart that they had just completed PEG feed training on 19 August 2022, where it was stressed to all members of staff that flushing a PEG feed tube at the end of a feed is vital…'

This was supported by Witness 1's local handwritten note which she confirmed during oral evidence was written soon after the incident.

You told the panel that you did not feel competent to undertake PEG feeds as you were under the impression that you needed to be observed ten times before being signed off as competent. However, you accepted that due to your previous hospital experience, you knew the importance of flushing a PEG feed tube after a feed or medication and you would have done this. You told the panel that you were not the one caring for Resident H, an agency nurse was responsible for this. You informed the panel that you may have appeared 'blank' as you were not 100% what was happening.

The panel considered the above evidence and preferred the evidence of Witness 1. The panel found her evidence to be consistent and reliable and it found that your

evidence was at times inconsistent. It noted that despite stating that you did not feel you were competent to undertake PEG feeds, you had extensive experience whilst working in a hospital setting and you had informed Witness 1 of this, to which she had encouraged you to view the PEG training as a ‘refresher’ given your previous experience. The panel recognised that within her local statement, Witness 6 had also made reference to a similar incident involving PEG feed flushes. The panel noted that there was no evidence before it to suggest that an agency nurse was responsible for the care of Resident H and considering your experience, the panel would have expected you to have been more proactive in overseeing the care of Resident H. The panel found that you were responsible for flushing Resident H’s PEG tube and that you had failed to carry this out.

Accordingly, the panel found Charge 3c proved.

Charge 5

> 5. Between 6 June and 2 September 2022 failed to give adequate handovers to staff on one or more occasions.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, the hearsay evidence of Witness 6, in her witness statement and her short handwritten local statement, and your oral evidence.

Within her witness statement, Witness 6 had outlined that she had received insufficient handovers from you, as they often lacked important information. She stated that she would have to ask follow-up questions and prompt you to give definitive answers, but Witness 6 did not give any specific examples in either statement.

Witness 1 had stated during her oral evidence that Witness 6 had raised these concerns with her and as a result, she had stayed behind on a shift to observe a

handover by you. She informed the panel that she also had concerns about that handover, but she did not provide specific examples of where the handover was inadequate.

The panel had regard to your supervision record dated 4 July 2022, where concerns about your handovers had been raised, but did not contain specific details. You told the panel that you often felt like you could never please Witness 6 and that your handovers were never good enough for her. You stated that she would often interrupt your handovers when you were giving important information, by asking what you felt were irrelevant questions at the time.

The panel considered the above evidence. It noted that it had no independent information before it on what your handovers were expected to contain and no handover proforma existed. The panel recognised that Witness 6 and Witness 1 had both raised their concerns and these had been addressed with you during your supervisions. However, there were no specifics or details provided on what your handovers were lacking or how you could improve your performance and the charge simply alleged a failure to give an adequate handover on one or more occasions over a three-month period.

In the absence of this evidence, the panel determined that the NMC had not discharged its burden of proof.

Accordingly, the panel found Charge 5 not proved.

Fitness to practise

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

The panel, in reaching its decision, 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 therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Lovatt submitted that at this stage, the panel must determine whether the charges found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired as a result of that misconduct. She reminded the panel that its statutory duty is to protect the public and maintain public confidence in the profession. Ms Lovatt further submitted that at this stage, there is no standard or burden of proof, so in reaching its decision, the panel should exercise its own professional judgement.

Ms Lovatt referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* She submitted that in this case, Lord Clyde went on to identify the standard of propriety may often be found by reference to the rules and standard ordinarily required to be followed by a practitioner in the particular circumstances.

Ms Lovatt submitted that *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2018) (the Code) sets out the rules and standards that nurses are required to follow. She submitted that a nurse must prioritise people, preserve safety and promote professionalism and that you have breached the Code as outlined within the misconduct matrix she had provided:

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Charge	***Relevant NMC Rule(s)***
1c(iv) *In respect of Resident A, on one or more dates between 11-14 April 2022 failed to administer the following medication to Resident A: Paracetamol.*	*Rule 1.2: make sure you deliver the fundamentals of care effectively.* *Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 18: Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.*
1e *In respect of Resident A, did not escalate the missing stock medication for Resident A until 14 April 2022.*	*Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 16: Act without delay if you believe that there is a risk to patient safety or public protection.*
	Rule 1.4: make sure that any treatment,

1f *In respect of Resident A, provided inaccurate information to colleagues regarding the missing medication during the daily team flash meeting held on 14 April 2022.*	*assistance or care for which you are responsible is delivered without undue delay.* *Rule 16: Act without delay if you believe that there is a risk to patient safety or public protection.*
2 *On the 14 April 2-22:* *a) signed for but failed to administer Losartan to Resident B.* *b) signed for but failed to administer Lansoprazole and/ or Spironolactone to Resident C.* *c) signed for but failed to administer Doxazosin to Resident D.* *d) failed to administer Strivit to Resident E.* *e) signed for but failed to administer Ramipril to Resident F.* *f) administered a double dose of Simvastatin to Resident G.*	*Rule 1.2: make sure you deliver the fundamentals of care effectively.* *Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 10: keep clear and accurate records relevant to you practice.* *Rule 18: Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.*

3a *In respect of Resident H: on a date unknown in August 2022, did not obtain a blood sugar and / or contact 111 for advice on the management of their PEG feed, after they had returned from hospital.*	*Rule 1.2: make sure you deliver the fundamentals of care effectively.* *Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 18: Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.*
3c *In respect of Resident H: on 30 August 2022 failed to provide water flushes as prescribed.*	*Rule 1.2: make sure you deliver the fundamentals of care effectively.* *Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 18: Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.*

4 *On a date unknown between 6 June 2022 and 2 September 2022, failed to administer the controlled drug Gabapentin to Resident I.*	*Rule 1.2: make sure you deliver the fundamentals of care effectively.* *Rule 1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.* *Rule 18: Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.*

In relation to all of the above charges the following failures to follow the NMC Code have been identified:

Rule 6.2: maintain the knowledge and skills you need for safe and effective practice.

Rule 13: recognise and work within the limits of your competence
Rule 13.3: ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.
Rule 13.4: take account of your own personal safety as well as the safety of people in your care

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

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.

Rule 20: Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code.'

The panel had regard to the written submissions of Ms Rao. She referred to the cases of *Roylance, Howd v. Bar Standards Board* [2017] EWHC 210 (Admin), *Khan v. Bar Standards Board* [2018] EWHC 2184 (Admin), *Hindmarch v. Nursing and Midwifery Council* [2016] EWHC 2233 (Admin) and *Johnson and Maggs v. Nursing and Midwifery Council (No. 2)* [2013] EWHC 2140 (Admin).

'9. The Registrant faces the following remaining charges which she has admitted or which the Panel has found proved. As a general observation, the failure of many of the NMC's charges, including those relating to the initial receipt and checking in of drugs, sets the scene for considering the scope of misconduct committed by the Registrant.

10. The failure of charges 1(a) and 1(b) in particular shows that the internal investigation was flawed and that several erroneous conclusions were acted upon (especially as to the contents, timing, and documentation of Boots deliveries). It might be thought that, had the errors not been wrongly attributed to the Registrant, her position at Branksome may not have been terminated. This investigation and action at Branksome also overshadowed the Registrant's subsequent work at Haddon Hall and forms an important part of the background to any misconduct that occurred there.

Charge 1(c) and Charge 2

11. In relation to charge 1(c) paracetamol and charge 2, all of which concern medications on 14/4/22, these properly fall within the category of a temporary lapse (Khan). It is obvious that this specific day was very stressful for the Registrant. She made a number of errors and has acknowledged that her record-keeping was not adequate. The Registrant has always accepted this

was poor practice and has reflected on this. Registrant also repeats the submissions made at paragraphs 16-18 of her submissions at the factual stage. It is submitted that this conduct while undesirable and disappointing is confined to a single day's shift and does not constitute serious misconduct according to the high threshold set out in Roylance.

Charges 1(e) and 1(f)

12. Charges 1(e) and 1(f) relate to the escalation of the missing medications before 14/4/22 and during the flash meeting. The Registrant accepts that the Panel has determined she did not deal with the escalation adequately and should also have raised it in the flash meeting. There was no malicious or dishonest motive behind these failures but rather an error of judgment. The RADAR and patient notes show efforts made by the Registrant and others to obtain the medications in circumstances where the Home had an acknowledged problem with the pharmacy, medication ordering, and storage that was not of the Registrant's making. Indeed the error in receiving and not checking in the medication on 11/4/24 was not the Registrant's. Having learned that the medication had apparently not arrived by 12/4 when she returned to work, the Registrant should have done more and she accepts this. But her error needs to be seen in the context of the Home's wider inadequacies which made it possible for the situation to arise and to persist. It is respectfully submitted that while 1(e) and 1(f) may constitute some misconduct they do not meet the threshold for serious misconduct as set out in the case law above.

Charges 3(a) and 3(c)

13. These errors are explained by the Registrant's lack of confidence and feeling of being undertrained and underprepared at Haddon Hall. Again, there is no suggestion that her mistakes were due to anything other than inattention and confusion. They are confined to a period of at most a few weeks in August 2022. As the Panel has observed, the lapse in standards is at odds with the experience of the Registrant. They are unfortunate errors that may be

'simple negligence' but are not 'gross professional negligence' (Johnson and Maggs). The fact that there were or may have been serious consequences from conduct does not transform it into serious misconduct or gross negligence (Hindmarch).

Charge 4

14. The Registrant plainly and understandably had difficulty with the electronic medication system at the Home and sought additional training to help her with this problem. She had not noticed the alert relating to Gabapentin when it was due. She did not realise what must have occurred on the computer system until it was brought to her attention when she immediately acknowledged the error.

15. It is noted that there are no supporting documents to prove that she committed this error such as MAR charts or a log of activity on the electronic system (see [Witness 1's] statement, w/s p40 para 34, para 36). Nonetheless the Registrant has admitted her error and is willing to accept the consequences. This is a single error of the temporary lapse variety and does not constitute misconduct.'

Ms Rao further submitted that the matters found proved do not individually or cumulatively constitute sufficiently serious misconduct such that the panel needs to move onto the next stage. She submitted that at this stage, it was important to delineate misconduct from impairment as one may have a generalised view that misconduct automatically means someone is impaired. She submitted that misconduct is not merely something a nurse should not be doing, but it is something that is considered deplorable, grossly negligent or grossly poor behaviour or conduct and the matters found proved do not fall into these categories. She further submitted that whilst the panel may consider that your practice is impaired, the panel must still consider whether the misconduct was sufficiently serious to amount to professional misconduct.

Ms Rao submitted that the misunderstanding of the events that occurred on 11 April 2022, led you to be accused of things you had not done. She submitted that the errors on 14 April 2022 were in isolation and in the context of a home where there were numerous mediation problems that NMC witnesses had been frank about. Ms Rao further submitted that you went to a different care home after your confidence had been knocked and this is an important factor to consider when determining misconduct.

Ms Rao outlined the three incidents found proved in relation to Haddon Hall (failing to obtain a blood glucose reading and call 111, failing to flush a PEG tube after a feed and failing to administer medication) and submitted that whilst some of these incidents might be misconduct, they are not sufficient to constitute a finding of serious misconduct. Ms Rao submitted that a mere breach of the Code does not mean that the misconduct is serious.

Submissions on impairment

Ms Lovatt moved on to the issue of impairment and submitted that impairment of your fitness to practise needs to be considered as of today's date and whether you can practice kindly, safely and professionally.

Ms Lovatt outlined the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that limbs a, b and c of Dame Janet Smith's 'test' are engaged in this case. Ms Lovatt submitted that limb d is not engaged in this case as you did not act dishonestly. She submitted that your behaviour had put Resident's A, B, C, D, E, F and G at risk of harm due to the non-administration of medication. In addition, Resident H was placed at risk of harm as you did not undertake a blood glucose test or contact 111 for advice on how to manage their PEG feed, as instructed by Witness 1 and you did not provide water flushes as prescribed.

Ms Lovatt submitted that your actions had brought the nursing profession into disrepute, and you had breached the fundamental tenets of the nursing profession demonstrated by the breaches of the Code exhibited within the misconduct matrix.

Ms Lovatt addressed whether you are liable to repeat your conduct in the future. She submitted that there was an element of repetition of your conduct across two employers. However, she submitted that you have shown some insight and you have taken some steps to remediate the concerns by way of undertaking training courses. She referred the panel to your training certificates and submitted that you are not working as a nurse at the moment. She submitted that it is not clear how you would approach things differently in the future. Ms Lovatt submitted that as a result, there is a risk of repetition.

With regards to insight and remediation, Ms Lovatt referred to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and submitted that the panel should consider the following:

1. Can the conduct be remediated?
2. Whether the concern has been addressed
3. Whether it is highly unlikely that the conduct will be repeated

Ms Lovatt referred to NMC guidance *(reference FTP-14a)* and submitted that your conduct is capable of remediation. She referred the panel to NMC guidance (*reference FTP-14b*) and submitted that although you have demonstrated some insight, you are currently not working as a nurse and have not provided significant evidence of remediation and you have not made it clear how you would approach things differently in the future. Ms Lovatt invited the panel to consider *FTP-14c* and submitted that in light of the concerns raised by two employers, there is a risk of repetition.

Ms Lovatt invited the panel to find that the charges found proved amount to misconduct and that your fitness to practise is impaired as of today's date.

The panel had regard to Ms Rao's written submissions with regards to impairment:

*'**Impairment***

16. In the event that serious misconduct is found, the Registrant submits that there is no current impairment to her ability to practise as a nurse.

17. The Panel has been provided with a bundle containing references, training documents, and a reflection. The reflection has already addressed the medication errors and record keeping errors. Her insight into her own conduct and willingness to accept responsibility is evident in documentation and in her behaviour during the hearing.

18. It is submitted that these, taken with the Registrant's oral testimony to the panel, demonstrate professional knowledge, skill, expertise, and care for patients.

19. The Panel is respectfully invited to find that in the circumstances of this case there is no serious misconduct and no impairment.'

Ms Rao further submitted that you have been subject to an interim conditions of practice order since the matters were referred to the NMC and as a consequence of the effect these proceedings and the allegations have had on you, you have not worked as a registered nurse since the investigation commenced.

Ms Rao informed the panel that you have been working as a manager of a hotel and you have been looking for options to return to work as a nurse depending on the panel's decision. She submitted that you have also been completing a counselling course and this is something you are interested in continuing. Ms Rao referred to your training certificates and submitted that you have been undertaking online training courses, but it is accepted that these are not a substitute for daily practical management of medications in a supervised context.

Ms Rao submitted that, unusually and contrary to her written submissions, if the panel were to find misconduct, you are of the view that your practice would need some form of supervision and assistance before you would be confident enough to practice independently as a nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance, Grant, Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin), *Schodlok v GMC* [2015] EWCA Civ 769, *Rimmer v GDC* [2011] EWHC 3438 (Admin) and *Johnson and Maggs v NMC* [2013] EWHC 2140 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code, including:

> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> ***…***
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***…***
>
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***…***
>
> ***8 Work cooperatively***
>
> *To achieve this, you must:*
>
> ***…***
>
> ***8.2** maintain effective communication with colleagues*
>
> ***…***

8.6 *share information to identify and reduce risk*

…

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.

…

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

To achieve this, you must:

16.1 *raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices*

…

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

To achieve this, you must:

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

…

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved did amount to serious misconduct. The panel considered that individually, the stock medication errors may not amount to serious misconduct. However, the panel considered that whilst these errors took place within a single shift, they occurred throughout the day and across different medication rounds, not only was medication not administered, but the MAR had been signed to indicate that it had, thereby leaving a false impression to any other medical professional regarding the medication, namely that it had been administered to each of the five patients. It considered that the cumulative effect of these similar medication errors was serious misconduct.

It also determined that particularly in your role as the Deputy Manager of Branksome, your failure to escalate concerns about Resident A's missing stock medication over a number of days and providing inaccurate information at the daily flash meeting in this respect was cumulatively misconduct.

The panel considered that concerns were raised about your practice by two different employers and involved vulnerable patients. The panel was also of the view that your failure to obtain a blood glucose reading, call 111 and administer water flushes as prescribed, despite clear instructions from Witness 1, had put Resident H, another vulnerable patient, at an unwarranted risk of harm, again was cumulatively misconduct.

The panel determined that as your failures related to fundamental aspects of a registered nurse's role, including practising effectively and preserving safety, your actions did fall seriously short of the conduct and standards expected of a nurse. Accordingly, they amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library (*reference DMA-1*), updated on 27 February 2024, 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. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) *…'*

The panel concluded that limbs a, b and c of the *Grant* test are engaged in this case. The panel found that vulnerable residents were put at a risk of unwarranted harm as a result of your misconduct. The panel was also of the view that your misconduct had breached the fundamental tenets of the nursing profession, as demonstrated by your breaches of the Code, and had therefore brought its reputation into disrepute. The panel was aware that this is a forward-looking exercise, and accordingly it went on to consider whether your misconduct was remediable and whether you had strengthened your practice.

The panel had regard to the case of *Cohen* as referred to in the case of *Grant* and NMC guidance (*references FTP-14 a, b and c*). The panel considered whether the misconduct identified was capable of remediation. The panel was of the view that your misconduct was capable of remediation as it largely related to clinical failures and could be addressed through training and supervision. The panel then went on to consider whether you had already remedied the concerns in this case. It had regard to your bundle which contained your reflective pieces dated 26 June 2024, your training certificates and testimonials. The panel noted that the majority of the relevant training certificates, including medication administration, had been undertaken whilst you were working at Branksome and had been completed prior to the incidents that were found proved. Whilst the panel noted you had completed an

online *'Safe Handling and Administration of Medication'* course on 8 June 2023, you have not worked as a registered nurse since 2022 and therefore you have not been able to demonstrate strengthened practice or apply your training in a practical sense. The panel also noted that the testimonials you provided were not from colleagues who had worked with you recently except from a junior member of staff at Branksome. You have not produced any testimonials from people who could comment on your current performance in a work environment.

Regarding insight, the panel considered your reflective pieces. It noted that you were remorseful and had reflected on the impact of your actions on the residents and your employers. However, the panel was of the view that you had showed limited insight into the incidents, and you had failed to demonstrate an understanding of what had caused your repeated failures over an extended period of time across two nursing homes or to fully appreciate the seriousness of your actions. The panel noted that in your reflective piece, you had not reflected on the impact your actions may have had on your colleagues, the public and the wider reputation of the nursing profession. The panel also considered that you had not addressed how you would manage [PRIVATE] differently should they arise again, in order to ensure that this conduct is not repeated.

In light of this, the panel concluded that there was a risk to the public and there was a likelihood of this conduct being repeated. The panel was of the view that your limited insight into how your actions, could put patients at a risk of harm. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required as public confidence in the profession would be undermined if a finding of

impairment were not made in this case. The panel was also of the view that a finding of impairment would be necessary to uphold the standards of the nursing profession, maintain trust and confidence in the profession and the NMC as its regulator. Therefore, the panel found your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order. There will be a review of this order near the end of the 18-month period.

In reaching this decision, the panel 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 Lovatt submitted that an aggravating feature in this case is that there were repeated medication errors which spanned across two employers. She submitted that mitigating features are:

- Some insight has been shown, a reflective statement has been provided and you have expressed remorse.
- There have been no previous concerns in the 30 years of your nursing practise prior to this.
- Contextual factors such as working in a home that was under scrutiny from the CQC.

Ms Lovatt invited the panel to impose a conditions of practice order. She referred to the SG (*reference SAN-3c*) and outlined the factors for the panel's consideration. She submitted that taking into account the factors and the insight you have shown, an 18-month conditions of practice order would be an appropriate sanction in this case.

Ms Lovatt submitted that a caution order would not meet the seriousness of this case, or adequately protect the public. She further submitted that a suspension order would be disproportionate given the factors identified, and it would not address the areas of concern identified.

Ms Lovatt submitted that both she and Ms Rao are in agreement that the terms of your current interim conditions of practice order would be sensible to continue. She submitted that it may be helpful to add a condition to address the need for retraining and supervision to monitor your improvement in the areas of concern in your clinical practice, such as a requirement to undertake a course in medicines management, administration and to provide a certificate of this to your NMC case officer. Ms Lovatt further submitted that a review of the order should be undertaken before its completion.

Ms Rao submitted that although there has been an agreement for the terms of the interim conditions of practice order to be adopted, this is ultimately a decision for the panel. She submitted that these conditions would adequately address the concerns identified.

Ms Rao submitted that Condition 1 which relates to restricting your nursing practice to one substantive employer which is not an agency would make the other conditions easier and more realistic to follow. She submitted that the second condition is the most important one as it would enable you to have effective practical training 'on the job' by way of supervision whilst administering and managing medication for a considerable period of time in a work environment. She submitted that any academic or theoretical study and certificate would be repetitive and of limited value and would prove to be administratively difficult. Ms Rao submitted that she was not aware any other course that you could undertake that would assist you. She submitted that in

your oral evidence and written reflective piece, you have expressed that you are keen to go back to nursing practice.

Ms Rao submitted that Condition 3 is accepted, and Condition 4 would mean that there would be somebody in a supervisory management position who is able to provide a report as well as monitor your progress, which would be helpful to you and the profession and will help determine whether Condition 2 has been complied with. She further submitted that Conditions 5-9 are standard condition that you are happy to comply with.

Ms Rao submitted that you have been undertaking a counselling course and you wish to continue with this as a possible career option going forward. She submitted that there does not seem to be an overlap as that profession is regulated in a different way, but you would inform them of these conditions if they were imposed. She submitted that the conditions would not apply to your work as a counsellor as the panel's concerns are specifically about medication management and administration and not about you as a person, your interactions with patients or your propriety.

Ms Rao submitted that she was neutral on the length of the order.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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:

- Repeated medication errors
- Episodes of misconduct at two separate nursing homes
- Conduct which put vulnerable patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Some evidence of insight and steps taken to address the concerns.
- Remorse
- [PRIVATE], change of working environment from a hospital setting into a care home setting that was subject to considerable scrutiny from the CQC.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG (*reference SAN-3c*), in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

- *The nurse or midwife has insight into any personal and health issues;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel also considered that a conditions of practice order would adequately address the public protection concerns and would meet the public interest considerations in this case. The panel had regard to the fact that other than these incidents, you have had an unblemished career of over 30 years as a nurse and that you would be willing to comply with a conditions of practice order. The panel concluded that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case as the matters found proved are of a clinical nature that can be addressed through training and supervision.

Having regard to the matters it identified, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse. The panel noted that as part of her submissions, Ms Rao referred the panel to the interim conditions of practice order you have been subject to and invited the panel to confirm this order as the substantive sanction. Ms Rao, on your behalf, had already informed the panel at the impairment stage that you feel that you need supervision and assistance in order to return safely to practice as a registered nurse.

The panel has exercised its own independent judgement and determined that the following conditions, which are broadly in line with the interim conditions of practice order, are appropriate and proportionate in this case:

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

1. You must restrict your nursing practice to a single substantive employer. You must not engage in agency work.

2. You must ensure that you are supervised any time you are working. Your supervision must consist of:

- Being directly observed by another registered nurse whilst administering and managing medication.
- At any other time, working at all times on the same shift as, but not always directly observed by, another registered nurse.

3. You must not be the nurse in charge of any shift.

4. You must meet with your line manager or supervisor fortnightly to discuss your performance in the following areas of concern:

- Medication administration and management
- Abiding by policies and protocols relating to all medications
- Documentation
- Communication with colleagues, including the appropriate delegation of tasks

- Responding to emergencies and concerns from colleagues

You must submit a report from your line manager or supervisor on your progress in these areas before each NMC review of your case.

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

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

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

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

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

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

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

a) Any organisation or person you work for.
b) Any employers you apply to for work (at the time of application).
c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

a) Any clinical incident you are involved in.
b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

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

a) Any current or future employer.
b) Any educational establishment.
c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 18 months.

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

You may apply for an early review of these conditions at any stage should there be evidence that effective steps have been taken to address the regulatory concerns.

Any future panel reviewing this case would be assisted by:

- Evidence of your understanding as to how the actions found proved affect the reputation of the nursing profession.
- Evidence of competence in the role of safe practice of medicines administration.
- [PRIVATE].
- Your continued engagement with these regulatory proceedings.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Lovatt. She invited the panel to impose an interim conditions of practice order for a period of 18 months on the grounds of public protection and otherwise in the public interest. She submitted that as the substantive conditions of practice order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

Ms Rao submitted that she did not oppose this application.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The panel therefore decided to impose an interim conditions of practice order for a period of 18 months to allow for the possibility of an appeal to be made and determined. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

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

That concludes this determination.