Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Tuesday, 28 – Friday, 31 May 2024
Wednesday, 5 – Wednesday, 12 June 2024

Virtual Hearing

Name of Registrant:	Angel Brown
NMC PIN	19F0024W
Part(s) of the register:	Registered Adult Nurse (15 August 2019)
Relevant Location:	Newport
Type of case:	Lack of competence and Misconduct
Panel members:	Janet Fisher (Chair, lay member) Rosalyn Mloyi (Registrant member) Nicola Strother Smith (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter (28 May – 7 June 2024) James Edenborough, Case Presenter (7 - 12 June 2024)
Mrs Brown:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b, 2a(i), 2a(ii), 2b, 2c, 3a, 3b, 3c, 4a, 4b, 4c, 4d, 5a(i), 5a(ii), 5a(iii), 5a(iv), 6a, 6b, 7a, 7b, 8a(i), 8a(ii), 8b, 8c, 9, 10a(i), 10a(ii), 10b(i), 10b(ii), 10c, 11, 12a, 12b, 12c, 13a, 13b(i), 13b(ii), 13b(iii), 13c, 13d, 14, 16a, 16b, 16c(i),16c(ii), 16c(iii), 16d,17, 18a, 18b, 19, 20a, 20b, 21, 22a and 22b
Facts not proved:	Charge 15

Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Brown was not in attendance and that the Notice of Hearing letter had been sent to Mrs Brown's registered email address by secure email on 22 April 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Brown

The panel next considered whether it should proceed in the absence of Mrs Brown. It had regard to Rule 21 and heard the submissions of Mr Brahimi who invited the panel to continue in the absence of Mrs Brown. He submitted that Mrs Brown had voluntarily absented herself.

Mr Brahimi submitted that there had been no engagement by Mrs Brown with the NMC in relation to her attendance at these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future

occasion. He submitted that the case deals with matters of competence and misconduct which makes it a serious case and that there is a need for the case to be heard expeditiously.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Brown. In reaching this decision, the panel has considered the submissions of Mr Brahimi, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Brown;
- Mrs Brown has not engaged with the NMC about attending this hearing and has not responded to any of the correspondence sent to her;
- There is no reason to suppose that adjourning would secure Mrs Brown's attendance at some future date;
- A number of witnesses are due to attend during the course of this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2020 and 2023;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Brahimi, on behalf of the NMC, to amend the wording of charge 5.

The proposed amendment was to amend the date recorded in the charge. It was submitted by Mr Brahimi that the proposed amendment would more accurately reflect the evidence. He submitted that there is no injustice for the amendment of this charge as the amendment is based on material that Mrs Brown would have been in receipt of, not new material. He submitted that if Mrs Brown was in attendance at the hearing, it would be unlikely that she would oppose the application as the evidence before the panel clearly to refers to 29 June 2020.

<u>Original wording of Charge 5</u>

“5) On 23 June 2020;

a) Did not know;

i) How to set up a transducer;

ii) What landmark the transducer should be placed on;.

b) How a nasal high flow machine worked;

c) The local nasogastric feeding protocol.”

Proposed wording of Charge 5

“5) On ~~23 June 2020~~ ***29 June 2020****;*

a) Did not know;

i) How to set up a transducer;

ii) What landmark the transducer should be placed on;.

b) How a nasal high flow machine worked;

c) The local nasogastric feeding protocol.”

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Details of charge (AS AMENDED)

That you a registered nurse, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5 nurse, in that you;

Whilst working at The Royal Gwent Hospital/Grange University Hospital;

1) On 4 March 2020;

a) Were unable to explain the difference in oxygen delivery between a facemask and nasal cannula.

b) Did not administer one or more doses of Terlipressin to Patient A, as prescribed.

2) On 7 March 2020 after Patient B's insulin infusion was stopped/gliclazide had been administered;

a) Did not check/record Patient B's blood glucose level;

i) On one or more occasion at 2 hours intervals.

ii) Between 10:11 and 19:00.

b) Administered gliclazide at 18:00 to Patient B, without checking/recording Patient B's blood glucose level;

c) Failed to recognise Patient B's deterioration/hypoglycemia.

3) On 15 June 2020;

a) Left the bedside area of an unknown patient who was desaturating/when their alarm was going off, to obtain some gauze/syringes.

b) Did not set an alarm limit for the unknown patient.

c) Did not adequately assess the unknown patient's condition/monitor before walking away.

4) On 17 June 2020;

a) Inappropriately silenced a desaturating patient's monitor alarm.

b) Did not assess the desaturating patient.

c) Did not check the patient's equipment.

d) Did not set an alarm limit for the desaturating patient.

5) On 29 June 2020;

a) Did not know;

i) How to set up a transducer;

ii) What landmark the transducer should be placed on;.

b) How a nasal high flow machine worked;

c) The local nasogastric feeding protocol.

6) On 24 June 2020;

a) Selected the wrong bag of NG feed for an unknown patient.

b) Were unable to demonstrate an understanding of how to return nasogastric aspirate.

7) On 25 June 2020 were unable to demonstrate an understanding of;

a) Knowing when a patient needs an Arterial Blood Gas analysis.

b) A cuff leaks link to low ETC02.

8) On 1 July 2020;

a) Failed to treat an unknown patient's low means arterial pressure in that you;

i) Did not consider adjusting the noradrenaline rate.

ii) Did not escalate the low pressure to the nurse in charge.

b) Incorrectly recorded that an unknown patient's breathing mode was on a mandatory set rate.

c) Failed to escalate an unknown patient's Acute Respiratory Distress Syndrome.

9) On 2 July 2020 on one or more occasion failed to conduct patient observations for an unknown patient.

10) On 8 July 2020;

a) Failed to demonstrate an understanding of;

i) Ventilator alarms.

ii) Subglottic suction.

b) On one or more occasion copied from previous shifts recordings for;

i) WAASP

ii) Waterlow

c) Disturbed an unknown patient from sleeping on one or more occasion.

11) On 13 July 2020, were unaware of what equipment was needed for extubation.

12) On 10 August 2020;

a) Administered Patient C's hydrocortisone later than prescribed.

b) Incorrectly administered hydrocortisone to Patient C orally/via NG without ensuring the necessary changes had been made on the prescription/drug chart.

c) Failed to order Patient C's hydrocortisone from the pharmacy.

13) On 10 September 2020 during your Objective Structured Clinical Examination;

a) Did not complete one or more safety checks.

b) After being informed that Patient D's Clonidine infusion had been changed;

i) Did not check the pump adequately.

ii) Did not recalculate the dose of Clonidine.

iii) Incorrectly documented the same dose of Clonidine prior to the changed infusion rate.

c) Failed to demonstrate an understanding of anaphylaxis.

d) On one or more occasion did not check Patient D's pump on an hourly basis/regularly

14) On one or more occasion were unable to calculate the correct rate of administration of a fluid bolus/Hartmans.

15) Failed to complete an Informal Capability Process which commenced on 15 June 2020.

16) On 12 November 2020;

a) Attempted to place Patient E on a sedation hold when it was inappropriate to do so/prior to going on your break.

b) Attempted to stop Patient E's Propofol when it was inappropriate to do so.

c) Extubated Patient E when it was inappropriate to do so, in that you;

i) Did not restart the propofol as advised;

ii) Did not bring over the emergency airway trolley.

iii) Did not titrate sedation, as advised.

d) Inaccurately informed one or more colleague/s that Patient E was for extubation.

17) On 26 November 2020 failed your calculations test.

18) Around 30 December 2020 were unable to;

a) Carry out a correct furosemide calculation.

b) Provide correct information to an operator when asked to put of a cardiac arrest call.

19) Failed to complete a Formal Capability Process which commenced on 9 November 2020.

20) On unknown dates;

a) On one or more occasion attempted to replace/clean a tracheostomy device alone.

b) inappropriately requested an X-ray for one patient, whilst another patient in the next bed required a tracheostomy procedure.

21) Around July 2021 were unable to adequately complete your probation period at Spire Healthcare.

And in light of the above, your fitness to practise is impaired due to your lack of competence.

That you a registered nurse;

22) Breached/attempted to breach Undertaking 5 which took effect on 14 September 2022, in that you between 30 August 2023 and 4 September 2023

a) Applied for a role as a nurse in a hospital through an agency MPS Healthcare

b) Interviewed for a role as a nurse in a hospital through an agency at MPS Healthcare

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

Background

Lack of competence charges

Mrs Brown was referred to the NMC in February of 2021 by Aneurin Bevan University Health Board (the Health Board), her former employer. Mrs Brown started working as a nurse in the Critical Care Unit (CCU) at the Royal Gwent Hospital (the Hospital) in August 2019 as a newly qualified nurse.

During Mrs Brown's employment, she had been responsible for several medication management omissions and errors. As a result of these issues, Mrs Brown was given further training and was placed on informal and formal capability processes. However, she resigned from the Health Board without completing the formal capability process.

The errors that Mrs Brown was responsible for included the following:

• on 4 March 2020, Mrs Brown had been unable to explain the differences in oxygen delivery between a facemask and a nasal cannula.

• on 4 March 2020, Mrs Brown failed to administer two doses of Terlipressin to Patient A.

• on 7 March 2020, Mrs Brown failed to properly monitor the blood glucose of Patient B for a nine-hour period, after the patient's insulin infusion had been stopped, despite having been told to do so every two hours. The patient subsequently suffered a hypoglycaemic episode.

As a result of these concerns, on 18 March 2020, Mrs Brown was told to stop administering medication, until an investigation had been completed. The investigation concluded that Mrs Brown had made two serious medicines administration errors, so she was asked to undertake a medicines management competency assessment.

Directed learning objectives were produced for Mrs Brown, which she accepted, and an informal capability process was started. However, despite this measure, concerns continued in respect of Mrs Brown's performance:

- On 15 June 2020, Mrs Brown failed to recognise and respond appropriately to a patient with a tracheostomy, when the patient had a significant desaturation. Mrs Brown had not set or assessed the patient's alarm limits.
- On 17 June 2020, Mrs Brown failed to recognise and act appropriately to a significant patient desaturation while repositioning a patient. Once again, Mrs Brown had not assessed the patient's alarm limits.

Despite some apparent progress, concerns once again continued in Mrs Brown's practice:

- On 10 August 2020, Mrs Brown administered hydrocortisone to Patient C via the wrong route, without first having the patient's drug chart changed from intravenous to nasogastric as the means of administration. Mrs Brown's colleague asked her get the drug chart changed several times, but she did not do this. Mrs Brown was given further medicines management training but shortly after, she failed her medicines management assessment. She did not recalculate a clonidine dose for Patient D on an IV drip.

- on 26 September 2020, Mrs Brown was unable to calculate the rate of administration of a fluid bolus on two occasions.

On 13 October 2020, Mrs Brown was informed that she would be progressed to a formal capability process. Mrs Brown was told that she would be relocated to the Grange Hospital and given three months' supernumerary to support her in completing the process.

On 12 November 2020, Mrs Brown extubated a patient when it was inappropriate to do so, having been told to commence a sedation hold and not to extubate. The patient experienced extreme agitation at the time and had to be reintubated later that day.

After this incident, Mrs Brown attended her IV study day. However, only a week later the Mrs Brown was unable to calculate a simple equation despite this further training.

On 07 January 2021, Mrs Brown submitted her resignation. Mrs Brown was informed that she had not completed her objectives and that a referral would have to be made to the NMC if she left the employment of the Health Board without achieving them. Mrs Brown initially withdrew her resignation but later decided to continue with her resignation.

On 10 February 2021, Mrs Brown began working for Spire Cardiff Hospital. However concerns were raised about her attitude, behaviour and the safety of her practice. As a result, Mrs Brown failed her probation at Spire Cardiff.

On 21 September 2021, Mrs Brown commenced employment as a recovery nurse with The Nuffield Health, Cardiff and Vale Hospital (Nuffield Health). Mrs Brown successfully completed her medication administration and theatre competencies with them and submitted a number of training certificates in the areas of:

- Reducing medication errors;
- How to perform calculations for the safe administration of IV infusions and medicines;
- How to perform drug calculations for the safe administration of medications; and
- Maintaining best practice in record-keeping and documentation.

Misconduct charge

Mrs Brown accepted undertakings in September 2022 as proposed by the NMC case examiners. Mrs Brown's undertaking required her to restrict her practice to a single employer and restricted her from working as an agency nurse. Following Mrs Brown's resignation from her position at Nuffield Health in July 2023, she attempted to apply for an agency role with MPS Healthcare in September 2023 which put her in breach of her undertakings.

Decision and reasons on application to amend the charge

The panel invited Mr Brahimi to make submissions to amend the format of charge 5.

The proposed amendment was to amend the format of the sub charges in charge 5. Mr Brahimi submitted that the proposed amendment is a typographical error which would allow the sub charges to flow from the stem of the charge. He submitted that there is no injustice in relation to amending this typographical error.

Original wording of Charge 5

"5) On 29 June 2020;

a) Did not know;

i) How to set up a transducer;

ii) What landmark the transducer should be placed on;

b) How a nasal high flow machine worked;

c) The local nasogastric feeding protocol."

Proposed wording of Charge 5

"5) On 29 June 2020;

a) Did not know;

i) How to set up a transducer;

ii) What landmark the transducer should be placed on;

*~~b)~~ **iii)** How a nasal high flow machine worked;*

*~~c)~~ **iv)** The local nasogastric feeding protocol.”*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Brown.

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: Practice Educator for Critical Care employed by the Health Board.

- Witness 2: Deputy Sister in the Critical Care Unit (CCU) employed by the Health Board.
- Witness 3: Deputy Sister in the Intensive Care Unit (ICU) employed by the Health Board.
- Witness 4: Staff Nurse in in the Critical Care Unit (CCU) employed by the Health Board.
- Witness 5: Practice Educator for Critical Care employed by the Health Board.
- Witness 6: Deputy Sister in the Intensive Care Unit (ICU) employed by the Health Board.
- Witness 7: Candidate Care Manager employed by MPS Healthcare.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel considered the witness and documentary evidence before it.

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

Charges 1a and 1b

> "That you a registered nurse, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5 nurse, in that you;

Whilst working at The Royal Gwent Hospital/Grange University Hospital;
1) On 4 March 2020;
a) Were unable to explain the difference in oxygen delivery between a facemask and nasal cannula.
b) Did not administer one or more doses of Terlipressin to Patient A, as prescribed."

These charges are found PROVED.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, Witness 4, Witness 2 and Mrs Brown's reflective statement.

The panel considered the evidence of Witness 1. She stated that *"In August 2019 Angel came to CCU at the Royal Gwent Hospital as a newly qualified nurse."* It noted that Mrs Brown detailed in her CV that she was a Band 5 nurse and outlined her duties, responsibilities and training/educational background. Further, the panel noted Witness 1 stated *"Angel did not want to move hospital but all staff were moving to the Grange anyway and this had been imminent since the start of Angel's employment, something which Angel had been made aware of."* The panel was satisfied that Mrs Brown was employed as a Band 5 nurse and worked at The Royal Gwent Hospital and Grange University Hospital.

In Witness 1's NMC witness statement she stated

> *"On 09 March 2020 I was informed of three medication errors apparently made by Angel within the previous seven days. On 04 March 2020 it was alleged that Angel had been unable to explain the differences in oxygen delivery between a facemask and a nasal cannula, having documented and handed over incorrect values. Angel was spoken to informally and no further action was deemed necessary."*

The panel had regard to an email from Ms 19 dated 7 March 2020, which states

"*Whilst on ward round, i noticed that she had documented on her chart that the patient was receiving 3l o2 via fm, however the patient was on an inspiron o2 circuit which does not deliver 3l. I asked her to explain to me how she had worked out the o2 concentration, and explained the delivery system to her, however she could not give me a straight answer. She was mumbling incomprehensible words and appeared to not understand what i was saying to her. I then asked her to change o2 delivery from facemask to nasal cannula. An hour or so later i saw that the patient was still on fm o2 (with elephant tubing) and neb in situ. I asked her if the patient had been changed to nasal cannula, she told me " yes on 30% o2" . I asked her how she was delivering 30% o2 via nasal cannula, she again started mumbling and acting confused and then told me she had not put her patient on nasal cannula, she was on 30%02 via fm. I again explained to Angel that the inspiron circuit would either deliver 28% or 35% o2 and not 30%. She gave no explanation of how she had acheived this and put patient onto nasal canula as I requested. Whilst on shift today, [Ms 18] approached me re ?omission of Terlipressin by Angel on the same patient above, on the same day. This was a gastro patient who had had multiple G.I. bleeds. On the ward round [Ms 20] had specifically instructed that the Terlipressing was to continue for a total of 72hrs as recommended previously in the medical notes. She then highlighted this on the drug chart. Angel was present during this discussion."*

The panel noted that the email from Ms 19 was written close to the date of the incident. The panel noted that Ms 19 was under a duty to report on Mrs Brown's professional conduct accurately to support with her learning and the safety of patients. The panel accepted that this email from Ms 19 was a reliable account.

The panel had regard to the evidence of Witness 4. She stated in her NMC witness statement

"On 05 March 2020 I was working the day shift from 0655h to 1935h. I was tasked to look after a patient I will call Patient A. During individual handover from the night shift nurse [Ms 21], I noted that Patient A's Terlipressin prescription chart showed four empty boxes and had not been signed since 0600h on 04 March… [Ms 21] told me that Angel had handed over to her the previous day that Patient A's Terlipressin had been stopped. The chart clearly showed that the doctors had drawn a noticeable line for when they wanted the medication stopped, but that was after the 04 March and the boxes remained empty. I also checked Patient A's clinical notes, which told me the Terlipressin was to be stopped on 05 March."

The panel had regard to Witness 4's local statement which stated

"Received handover on the 5th March 2020 from [Ms 21] in the morning of my day shift. We were going through the medication charts in handover and [Ms 21] noticed that she did not give the prescribed nebuliser to the patient during the night, so we let [Ms 10] know regarding missing the nebuliser. We continued to go through the medication chart and I spotted that Terlipressin had not been given for four prescribed doses since 6am the day before, we noticed this as the boxes were empty. [Ms 21] explained to me that Angel had handed over to her that the doctors had stopped the Terlipressin, however the doctors had put a noticeable line for when they wanted the Terlipressin to be stopped but the doses weren't give and the boxes remained empty. I also checked Patient A's clinical notes, which told me the Terlipressin was to be stopped on 05 March. [Ms 21] and I spoke with our supervisors and deputy sister [Witness 2] marked the empty boxes with a '6' as an acknowledgement that the medication hadn't been given in error."

The panel noted that this was written by Witness 4 on 16 March 2020.

The panel took into consideration the oral evidence of Witness 4. She said that it would be in Patient A's care plan as to who was responsible for administering the medication to Patient A.

The panel noted that Witness 2 said in her oral evidence that she wrote the 6's into the Terlipressin boxes the day after, on 5 March 2020. She explained that code '6' was written in the administration section of the MAR chart, which meant that the medication had not been administered, then the reason why the medication was not given was written at the back of the chart. Witness 2 in her oral evidence said that Mrs Brown was responsible for two of the doses of Terlipressin for Patient A during the day shift as the bedtime dose was normally administered at midnight.

The panel had regard to the MAR chart for Patient A dated March 2020. It noted that there were 6's entered on the MAR chart for Terlipressin administration boxes for 4 March 2020. The panel did not have sight of the back of the MAR chart.

The panel considered Mrs Brown's reflective statement in relation to this incident on 4 March 2020. She stated

> *"Vertical lines can be seen on the 2nd, 3rd and 4th of March, which in my understanding, not to be given during my shift, but on the 5th of March instead as its last doses. At the top of that page, where Terlipressin was originally prescribed on the 2nd of March, codes of 6 were already written 3 times for the midday, evening and bedtime. I never wrote those codes or omit the drug."*

The panel considered the evidence before it. In respect of charge 1a, the panel concluded that on 4 March 2020 Mrs Brown was unable to explain the difference in oxygen delivery between a facemask and nasal cannula. The panel therefore found charge 1a proved.

In respect of charge 1b, the panel accepted the witness evidence and Mrs Brown's account in her reflective statement that she had not given the two doses of Terlipressin, for which she was responsible. The panel also accepted the evidence of Witness 2 in respect of the MAR chart and what was recorded on it on 4 March and then subsequently on 5 March. The panel noted that Mrs Brown was not on shift at bedtime when the third

dose was omitted. However, Mrs Brown was responsible for administering two doses of Terlipressin to Patient A, namely the morning and afternoon dose. The panel concluded that on 4 March 2020, Mrs Brown did not administer one or more doses of Terlipressin to Patient A, as prescribed. The panel therefore found charge 1b proved.

Charge 2a(i), 2a(ii), 2b and 2c

> "2) On 7 March 2020 after Patient B's insulin infusion was stopped/gliclazide had been administered;
> a) Did not check/record Patient B's blood glucose level;
> i) On one or more occasion at 2 hours intervals.
> ii) Between 10:11 and 19:00.
> b) Administered gliclazide at 18:00 to Patient B, without checking/recording Patient B's blood glucose level;
> c) Failed to recognise Patient B's deterioration/hypoglycemia."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1 and Mrs Brown's reflective statement.

The panel considered the evidence of Witness 1. In her NMC witness statement she stated

> *"On 07 March 2020 it was alleged that Angel had failed to properly monitor the blood glucose of Patient 'B' after the patient's insulin infusion had been stopped at 10:00hrs and the oral anti-diabetes medication gliclazide had been administered in its place… Angel checked Patient B's blood sugar level at 10:11hrs, and again at 19:00hrs, at which point it measured 3.8 mmol/L, indicating that Patient B was suffering a hypoglycaemic episode. Angel had not checked Patient B's blood sugar level during the intervening 9 hour period, despite being told to do*

so every two hours… This tallies with the patient's Point of Contact (POCT) printout… The POCT records all electronic testing done by the individual nurse. If Angel had conducted further checks between 10:11hrs and 19:00hrs they would have been recorded electronically, even if Angel had neglected to mark up the chart. Angel had administered more gliclazide at 18:00hrs without first checking the patient's glucose level. Patient B subsequently went into hypoglycaemia, which was successfully managed by Angel's colleagues."

The panel had regard to Patient B's Chart dated 7 March 2020. It noted that the chart recorded Patient B's airway and breathing and specifically, blood glucose. It noted that there was an entry at 10am of '8.6' and then the next entry is at 19:00 of '3.8'.

The panel had regard to Mrs Brown's reflective statement on this incident of 7 March 2020. She stated

"On the 7th of March… During the morning ward round, the sliding scale (VRII) has been stopped, so I monitored her BM level in 2 hourly basis as advised by the nurse-in-charge. The patient has been prescribed with Gliclazide twice daily (morning and evening), which I have administered and was taken orally with consent by the patient. Around 18.45pm, the patient has asked me why so many people coming into the ward, and I explained to her that they were the night staff. Then, she started to get out of bed, insisting to go home. Despite telling her that she can't go home yet as per doctor's advice, still she kept her two legs out of the bed to get out. One staff nurse came to help and contacted the patient's daughter via mobile phone to have a word with the patient about going home. The doctor came and was aware of the patient's behaviour and told me to check her blood sugar level again. So, I've done the blood gas (ABG's) at around 7pm, which showed a hypoglycaemic result of 3.8mmol/L The doctor was informed of the BM result, including the night staff who was waiting for the handover. The night staff gave a bottle of Glucose shot juice to the patient to improve her blood sugar level and the patient drank all of it. Then, we proceed with the handover.…I felt guilty for

not checking the blood sugar level of the patient at 6pm prior to administering the evening dose of Gliclazide and for not seeking expert's advice whether it was ok to give Gliclazide without checking the blood sugar level when the patient is eating and drinking". She further states in her reflection *"I have administered the evening dose of Gliclazide without checking the patient's blood sugar level at 6pm prior to administration."*

The panel had regard to the meeting minutes dated 11 March 2020 with Witness 1, Witness 5 and Mrs Brown. It states

"2. v. Angel states that [Ms 18] was on shift and [Ms 17] was in charge. She states that she asked if she should monitor the blood sugar hourly and was directed by [Ms 17] that she should monitor it 2 hourly.
2.viii. Angel states that she did the blood glucose measurement at 19:00 hours not [Witness 4] and Angel used her own barcode. She states that she did monitor the blood glucose during the shit[sic] *about 12 noon but used the Glucometer.".*

In respect of charges 2a(i) and 2a(ii), the panel preferred Witness 1's evidence to Mrs Brown's explanation. The panel bore in mind Witness 1's evidence that if Mrs Brown had completed the glucometer readings (electronic readings) these would be automatically uploaded to the system however the panel did not have any evidence of these readings before it and was of the view that this suggests that the reading was not completed by Mrs Brown. The panel concluded that on 7 March 2020 after Patient B's insulin infusion was stopped/gliclazide had been administered, Mrs Brown did not check/record Patient B's blood glucose level on one or more occasion at 2 hours intervals. The panel therefore found charges 2a(i) and 2a(ii) proved.

In respect of charge 2b, the panel accepted Mrs Brown's admission that *'I felt guilty for not checking the blood sugar level of the patient at 6pm prior to administering the evening dose of Gliclazide*'. The panel concluded that on 7 March 2020 after Patient B's insulin

infusion was stopped/gliclazide had been administered, Mrs Brown administered gliclazide at 18:00 to Patient B, without checking/recording Patient B's blood glucose level. The panel therefore found charge 2b proved.

In respect of charge 2c, the panel considered Mrs Brown's account that Patient B had asked why so many people were coming onto the ward and expressed wanting to go home. The panel was of the view that Mrs Brown was not aware of the patient's deterioration/hypoglycemia having not monitored Patient A's readings as directed or identified the patient's behaviour as potentially related to her blood glucose levels. The panel concluded that on 7 March 2020 after Patient B's insulin infusion was stopped/gliclazide had been administered Mrs Brown failed to recognise Patient B's deterioration/hypoglycemia. The panel therefore found charge 2c proved.

Charges 3a, 3b and 3c

> "3) On 15 June 2020;
> a) Left the bedside area of an unknown patient who was desaturating/when their alarm was going off, to obtain some gauze/syringes.
> b) Did not set an alarm limit for the unknown patient.
> c) Did not adequately assess the unknown patient's condition/monitor before walking away."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 3 and the documentary evidence of Witness 1.

The panel considered the evidence of Witness 3. In her NMC witness statement she stated

"On 15 June 2020… Angel had been assigned to a level three patient with a tracheostomy… At about 12.30hrs I was on the opposite side of the ward to Angel's patient but I had full sight of all patients. I heard Angel's patient's alarm ringing. It didn't matter where you were in the unit, you could always hear the alarms going off… I looked over to see which alarm was sounding and could see Angel's patient's oxygen level had depleted to 80%. Normal oxygen levels are 100%... I had assumed Angel had gone to get additional suction catheters to help with the removal of secretions, but she returned to the bed carrying items to stock her bed area up – syringes and gauzes".

The panel had regard to a local statement made by Witness 3 which was written close to the date of the incident. In the statement she stated

"During a day shift on the 15.6.20 at aprox. 12.30pm, I was in charge on ICU. I saw bed 4 monitor alarming and patient's oxygen levels were 80%. As I was heading toward the bed space I saw Angel which was the nursing looking after this patient, leave the best space and saw [Ms 16] doing deep suctioning on the patient. I immediately put the patients oxygen up to 95% via her trachy face mask. I assumed Angel went to get more suction catheters. I continued to help [Ms 16] improve the patients oxygenation. It took a lot of suctioning but the patients oxygen saturations did eventually start to increase slowly. Angel then returned to the bed space with syringes and gauzes… I explained to Angel that she is looking after very sick patients on the ITU and that they must be watched at all times for signs of deterioration and the reason for doing bed checks and setting alarm limits at the start of every shift was that you are alerted to the fact that something is wrong with your patient. Angel admitted that she had not looked at the monitor at all before leaving her bed space."

The panel considered Witness 3's oral evidence. She told the panel that setting of alarms was a fundamental aspect of nursing care in the critical care unit and all nurses would receive training in this area. She explained that the alarms when they are sounding are

loud and that she could hear it from across the room. She stated that on hearing the alarm her reaction was to run to the patient. She stated that it would not be acceptable to leave a patient with a speech and language therapist whilst they were desaturating/their alarm was going off, as they would not know how to deal with the patient or the equipment.

The panel considered Witness 3's evidence to be consistent across all the accounts she provided.

The panel considered the local witness statement of Ms 16 which was reported on the date of the incident. She stated

> *"At approximately 12pm Midday on the 15.6.20, physios were applying a speaking valve to the patient in bed 4. The patient's heart rate decreased and became hypertensive up to 230 systolic. I asked Angel if everything was okay and she replied yes and not looking at the monitor and comprehend the patient was deteriorating. The patient then began to de-saturate down to 80%. I then entered the bed space to help and began to deep suction the patient. She then began to further deteriorate and her sats were continuing to drop. At this point Angel left the beds space without telling me and [Witness 3] entered. Angel returned a few minutes later with a stock of syringes and gauzes…At 18.30pm on the 15.6.20 Angel asked me to watch her patient as she got a bag of feed. When I looked at her monitor and her patient had stats of 87%. I then had to explain to her before she walked off that her stats were 87% and she needed to act on it."*

The panel took into account that Witness 3 and Ms 16's evidence corroborated each other's accounts.

The panel had regard to Mrs Brown's reflective statement in relation to this incident. She stated

"Later, around 4pm after coming back from my lunch break, the Nurse-in-charge approached me and raised her concerns about what has happened; she told me that I shouldn't leave my patient without looking the monitor and ignoring the alarms. I told her that I didn't hear any alarms before I left the bedside area, no intention of ignoring the alarms and the patient, and that I felt sorry and guilty of what has happened I also told her that I appreciate her help and the rest of the team."

The panel considered the document titled "Meeting to address informal Capability 22th June 2020". It noted that these were minutes of a meeting at which Mrs Brown was in attendance. It stated

"The first incident occurred on Monday 15th June at around 12:30. Statements indicated the patient was desaturating and AB walked away from the bed area and came back with gauze and syringes. AB said she was asked by the Speech and Language Therapist to get gauze to clean the tracheostomy site, which is why she left the bed area. She suggested that she would not walk away from the bed area if the alarms were sounding. AB was asked had she set her alarm limits and she replied 'no'. AB was asked if she assessed the patient or looked at the monitor before she walked away, she replied 'no'. AB was reminded that the Speech and Language Therapists are not ultimately responsible for the patient and the responsibility for patient safety lies with the nurse at the bedside, it is imperative to ensure the patient is safe before leaving the bed area. AB acknowledged this."

The panel considered the evidence before it. The panel took into consideration that Witness 3 and Ms 16 were under a duty to report this incident accurately for Mrs Brown's professional development and to uphold patient safety. It was of the view that these witnesses took this responsibility seriously. The panel decided that it preferred the account of Witness 3 and Ms 16, to that of Mrs Brown. The panel concluded that on 15 June 2020 Mrs Brown left the bedside area of an unknown patient who was desaturating/when their alarm was going off, to obtain some gauze/syringes, she did not set an alarm limit for the

unknown patient, and she did not adequately assess the unknown patient's condition/monitor before walking away. The panel therefore found charges 3a, 3b and 3c proved.

Charges 4a, 4b, 4c and 4d

"4) On 17 June 2020;
a) Inappropriately silenced a desaturating patient's monitor alarm.
b) Did not assess the desaturating patient.
c) Did not check the patient's equipment.
d) Did not set an alarm limit for the desaturating patient."

This charge is found PROVED.

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

The panel considered the local witness statement from Ms 13 dated 18 June 2020. Ms 13 states

> *"At approximately 05:00 S/N A Brown, with the assistance of S/N [Ms 14], was repositioning the patient. I was in bed area 5, preparing to help reposition this patient. I glanced over at the monitor in bed 6 and noted that his SpO2 was 60%. The alarm had been silenced and the patient was quiet. He was lying flat in the bed… I subsequently spoke to SN A Brown and asked her why she had not called for help, and explained that as a critical care nurse this was expected of her. She tried to explain how she had believed that the SpO2 reading of 60% was inaccurate and therefore she had silenced the alarm."*

The panel considered the document titled “Meeting to address informal Capability 22th June 2020”. It noted that these were minutes of a meeting at which Mrs Brown was in attendance. It stated

> *“AB stated that the patient had been admitted earlier that night and was known to desaturate. She was asked had she assessed the patient at that point and stopped when she noticed the patient’s oxygen saturations. She replied ‘she did not look at the monitor’. AB was asked ‘had she set alarm limits on the monitor’, for which she replied ‘no’.”*

The panel considered the evidence before it and noted that Mrs Brown assumed that the equipment was inaccurate rather than conducting any checks to ensure that it was working properly. As a result, Mrs Brown did not assess the patient and act accordingly. The panel concluded that on 17 June 2020, Mrs Brown inappropriately silenced a desaturating patient’s monitor alarm, did not assess the desaturating patient, did not check the patient’s equipment and did not set an alarm limit for the desaturating patient. The panel therefore found charges 4a, 4b, 4c and 4d proved.

Charges 5a (i), (ii), (iii) and (iv)

> “5) On 29 June 2020;
> a) Did not know;
> i) How to set up a transducer;
> ii) What landmark the transducer should be placed on;
> iii) How a nasal high flow machine worked;
> iv) The local nasogastric feeding protocol.”

These charges are found PROVED.

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

The panel had regard to a document titled ‘Feedback AB’ completed by Ms 12. Ms 12 states in this document

> *“Throughout the shift I found myself having to switch from an observing role to a teaching role. AB did not know how to set up a transducer or what landmark the transducer should be placed. After talking through the process of setting up a transducer, we both agreed more practice is needed to help build AB’s confidence.”*

Ms 12 also stated

> *“I found that her knowledge of the nasal high flow machine was extremely limited and did not know that we record humidification temperature or recognise an alarm for tube blockage. The machine was alarming to show a blockage of the nasal prongs, but AB did not recognise the flow was limited and recorded the altered flow on the observation chart. She also did not know how to troubleshoot the restricted flow by simply adjusting the nasal prongs, when questioned AB thought the issue was due to secretions.*
>
> *AB seemed unfamiliar with our local NG feeding protocol. She seemed confused when I asked what feed was required or what rate the patients target was. I asked if AB remembered this information from the shift change handover but prompted her to look for the protocol to ensure the correct type and rate was commenced. There was also confusion of safety checks of the NG tube, the length and where to record it, what pH aspirate is required and what to do if it is not in this range.”*

The panel took into consideration that Ms 12 was approached by Witness 1, who explained *“[Ms 12] would be observing AB over a number of shifts during a 4 week*

supernumerary period." Ms 12 stated that *"Feedback forms were completed and discussed with AB at the ed* [sic] *of every shift."*

The panel took into consideration that Mrs Brown signed the 'FEEDBACK FORM FOR DIRECTED LEARNING' dated 29 June 2020 which identified the following areas for development:

> *"- Transducer – landmark and setting up confidently*
> *- NG Protocol and placement – identifying rate of feed and change of type, length of NG recorded and importance of why*
> *- NHF troubleshooting – why flow was restricted, recognising and correcting"*

The panel noted that Mrs Brown did not provide an alternative explanation for her actions.

The panel considered the evidence before it. The panel was of the view that Ms 12 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care. Ms 12's observations were made at the material time and she had discussed them with Mrs Brown. The panel concluded that on 29 June 2020, Mrs Brown did not know how to set up a transducer, what landmark the transducer should be placed on, how a nasal high flow machine worked or the local nasogastric feeding protocol. The panel therefore found charges 5a (i), (ii), (iii) and (iv) proved.

Charges 6a and 6b

> "6) On 24 June 2020;
> a) Selected the wrong bag of NG feed for an unknown patient.
> b) Were unable to demonstrate an understanding of how to return nasogastric aspirate."

These charges are found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document *"Encouraged Angel to always follow the NG feeding protocol, NG feed had run out and she selected the wrong bag of feed I intervened before feed changed, she was also unsure what to do with NG aspirate and was going to discard the NG asp and not return it."* The panel was of the view that Ms 11 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care.

The panel considered the evidence before it and noted that it had no alternative explanation for the actions outlined in the charges. The panel concluded that on 24 June 2020, Mrs Brown selected the wrong bag of NG feed for an unknown patient and she was unable to demonstrate an understanding of how to return nasogastric aspirate. The panel therefore found charges 6a and 6b proved.

Charges 7a and 7b

> "7) On 25 June 2020 were unable to demonstrate an understanding of;
> a) Knowing when a patient needs an Arterial Blood Gas analysis.
> b) A cuff leaks link to low ETC02."

These charges are found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

"Patient had an audible cuff leak and a low ETC02, although I was alerted about the alarm for low ETC02 Angel did not link them together and only when I said the patient had a cuff leak and the need for her to check the cuff pressure did she do this. Knowing when the patient needs an ABG and not just doing one with no clinical need, explained that if the patient is stable and there has been no changes more than a couple of hours is ok."

The panel was of the view that Ms 11 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care.

The panel also considered a document titled 'FEEDBACK FORM FOR DIRECTED LEARNING' dated 26 June 2020. Mrs Brown indicates 'areas of learning' being *"knowing when to do an ABG and not just doing one with no clinical need"* and *"Cuff leak management and connection to low ETC02"*. The panel noted that this was completed and signed by Mrs Brown the day following the incident, on 26 June 2020.

The panel considered the evidence before it and noted that it had no alternative explanation for the actions outlined in the charges. The panel concluded that on 25 June 2020, Mrs Brown was unable to demonstrate an understanding of knowing when a patient needs an Arterial Blood Gas analysis and a cuff leaks link to low ETC02. The panel therefore found charges 7a and 7b proved.

Charges 8a(i) and 8a(ii)

"8) On 1 July 2020;
a) Failed to treat an unknown patient's low means arterial pressure in that you;
i) Did not consider adjusting the noradrenaline rate.
ii) Did not escalate the low pressure to the nurse in charge."

These charges are found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

> *"AB set the patients alarm limits safely within tight parameters but when there was an audible alarm for low MAP, AB felt she needed to change the alarm limit without thinking of treating the issue and adjusting the noradrenaline rate or letting the nurse in charge know."*

The panel also considered a document titled 'FEEDBACK FORM FOR DIRECTED LEARNING' dated 1 July 2020, signed by Mrs Brown. The document stated *"Alarm limits – set within safe parameters, but when MAP alarms was sounding for low alarm, Angel felt she needed to change the limit … so it wasn't alarming without thinking about changing the Norad or letting the NIC know."*

The panel considered the evidence before it. The panel concluded that on 1 July 2020, Mrs Brown failed to treat an unknown patient's low means arterial pressure in that she did not consider adjusting the noradrenaline rate and did not escalate the low pressure to the nurse in charge. The panel therefore found charges 8a (i) and 8a(ii) proved.

Charges 8b

> "8) On 1 July 2020;
> b) Incorrectly recorded that an unknown patient's breathing mode was on a mandatory set rate."

This charge is found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

> *"The patient was trialled on a spontaneous breathing mode but AB's documentation of observations stated that the patient was on a mandatory set rate. When questioned what elements on the ventilator screen indicate the patient is spontaneously breathing AB could not answer this."*

The panel was of the view that Ms 11 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care. It noted that this statement was made close to the incident and for this reason considered it an accurate account.

The panel considered the evidence before it. The panel concluded that on 1 July 2020, Mrs Brown incorrectly recorded that an unknown patient's breathing mode was on a mandatory set rate. The panel therefore found charge 8b proved.

Charges 8c

> "8) On 1 July 2020;
> c) Failed to escalate an unknown patient's Acute Respiratory Distress Syndrome."

This charge is found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

> *"AB felt she had to seek reassurance and advice from myself about ABG results. AB relies on the upper and lower range on the ABG slip rather than patient specific targets. The patients PF ratio was less than 20, AB understood that this meant the patient had signs of ARDS but did not feel she should let the nurse in charge know or make the doctors aware."*

The panel also considered a document titled 'FEEDBACK FORM FOR DIRECTED LEARNING' dated 1 July 2020, signed by Mrs Brown. The document stated *"ABG's – P.F ration aware 17 is low and <20 is ARDs picture, unaware that she should let the doctors and NIC know, she felt she should increase the FiO2* [sic] *but unaware why we prone and when".*

The panel considered the evidence before it and concluded that on 1 July 2020, Mrs Brown failed to escalate an unknown patient's Acute Respiratory Distress Syndrome. The panel therefore found charge 8c proved.

Charge 9

> "9) On 2 July 2020 on one or more occasion failed to conduct patient observations for an unknown patient."

This charge is found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

> *"During as insertion of a tracheostomy, AB was very interested in observing the procedure but while doing so forgot to observe the patients observations and ensuring stability of the patient, therefore I had to step in and provide this role for the doctors. I explained to AB that if she is unfamiliar with the procedures and wishes to observe, then she needs to make another nurse aware as someone is needed to monitor the patient's observations."*

The panel was of the view that Ms 11 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care.

The panel considered the evidence before it and concluded that on 2 July 2020 on one or more occasion, Mrs Brown failed to conduct patient observations for an unknown patient. The panel therefore found charge 9 proved.

Charges 10a(i), 10a(ii), 10b(i), 10b(ii) and 10c

"10) On 8 July 2020;
a) Failed to demonstrate an understanding of;
i) Ventilator alarms.
ii) Subglottic suction.
b) On one or more occasion copied from previous shifts recordings for;
i) WAASP
ii) Waterlow
c) Disturbed an unknown patient from sleeping on one or more occasion."

These charges are found PROVED.

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

The panel had regard to a document titled ‘Feedback for shifts worked with A.B’ completed by Ms 11. Ms 11 states in this document

> *“On 8th July we worked a nightshift… On checking the alarm limits of the ventilator, they had not been set. AB lacks understanding on what the alarms are for and therefore does not know what alarm limits are safe, even though in previous shifts I have explained this. Throughout the shift I found myself checking AB’s paperwork, the assessment documentation is now more thorough than previous shifts, but there is still some issues. The tracheostomy care bundle you to check subglottic suction, AB had ticked to say yes for this every 2 hours. When I questioned AB how she had done this, she was hesitant and then explained that she ‘had checked the in-line suction tubing was connected.’ This patient’s tracheostomy did not have a subglottic suction port and therefore AB would not have been able to complete any subglottic suction. I have to explain this to AB 4-5 times before she understood. There were also issues with her assessment scoring of CPOT, Waterlow and WAASP having been copied from the previous shift. I then asked her to repeat her Waterlow score to find that she struggled to record accurately due to lack of understanding of terminology… During the shift I felt I had to remind AB it was a night shift and to try not to disturb the patient when she was asleep. The patient did get annoyed on a few occasions when AB had attempted suction without warning.”*

The panel also considered a document titled ‘FEEDBACK FORM FOR DIRECTED LEARNING’ dated 9 July 2020, signed by Mrs Brown. It states under ‘areas for improvement’:

> “*2. understanding of ventilator alarm limits – meaning of and safe settings*
> *3. Accurate documentation – including waterlow score, WASSP etc.*”

The panel considered the evidence before it. It concluded that on 8 July 2020, Mrs Brown failed to demonstrate an understanding of ventilator alarms and subglottic suction. It also concluded that Mrs Brown on one or more occasion copied from previous shifts recordings for WAASP and Waterlow. It also determined that Mrs Brown disturbed an unknown patient from sleeping on one or more occasion. The panel therefore found charges 10a(i), 10a(ii), 10b(i), 10b(ii) and 10c proved.

Charge 11

> "11) On 13 July 2020, were unaware of what equipment was needed for extubation."

This charge is found PROVED.

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

The panel had regard to a document titled 'Feedback for shifts worked with A.B' completed by Ms 11. Ms 11 states in this document

> *"Prompted to take an ABG 30 minutes after extubation and explained the importance of taking it. Unaware of what equipment needed for extubation, explained that when a level 3 is having a sedation hold and is possibly for extubation to get aquapak, tubing and mask ready. Having a challenging patient was very difficult as Angel wanted to complete all of the ward paperwork, however the patient wanted to self-discharge."*

The panel considered the evidence before it. It concluded that on 13 July 2020, Mrs Brown was unaware of what equipment was needed for extubation. The panel therefore found charge 11 proved.

Charges 12a, 12b and 12c

"12) On 10 August 2020;
a) Administered Patient C's hydrocortisone later than prescribed.
b) Incorrectly administered hydrocortisone to Patient C orally/via NG without ensuring the necessary changes had been made on the prescription/drug chart.
c) Failed to order Patient C's hydrocortisone from the pharmacy."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 5.

In Witness 5's NMC witness statement she stated

> *"I had already examined the prescription chart of the patient under Angel's care on 10 August 2020. I will call the patient 'Patient C' and I exhibit their prescription chart... At the bottom of page one of the chart it can be seen that 25mg hydrocortisone was to be administered intravenously (IV) at 10:00hrs and 22:00hrs daily. The prescription had been signed by the prescriber. At the top left of the page it clearly says: "use one route only for each entry". This indicates that in this instance the only way this medication should have been given to this patient was by IV. Angel appeared to have been late in giving Patient C their morning hydrocortisone, at 13:00hrs, and had given it orally instead of by IV, and on the chart this was marked up as an error."*

The panel had regard to the Medication Charts of Patient C, dated for the period between 8 and 10 August 2020. The panel noted that the hydrocortisone was administered at 1pm which was later than the prescribed time of 10am.

The panel took into consideration the oral evidence of Witness 5. She told the panel that the oral/NG hydrocortisone was not available on the ward at the prescribed time and that Mrs Brown administered it at 1pm, an hour after it arrived on the ward at midday.

The panel considered the local statement of Ms 15, dated 13 August 2020. She stated

> *"Firstly I asked the nurse to order the medication from pharmacy, this did not happen so I did this for her. Once the medication was received I checked the oral medication was correct drug. I then asked the nurse to get the prescription changed to NG before administering the medication. I noticed that this still had not been done so I prompted the nurse to get the prescription changed again & again before administering."*

In a reflective statement completed by Mrs Brown, dated 17 August 2020, she states

> *"The floater nurse volunteered to order it from the pharmacy. The stock arrived in the ward around midday and I was waiting for the floater nurse to come back in my bed space to supervise me with my medicines administration…The Nurse next to my bed space has checked and countersign all my midday due medications, including the hydrocortisone 20mg oral. She agreed to administer the hydrocortisone 20mg NG based on the written instructions on the drug chat. So I gave it with her supervision… On my next LD shift, I was being told that I made a medication error in administering the hydrocortisone 20 mg via NG route without prescription. This was surprising because the two nurses who supervised me giving medications never told me that if I will administer the oral 20mg dose of hydrocortisone, I will be trouble for medication error. It was my first time to encounter a prescribed medication with changes of doses plus a special written instructions, which I thought can still be administered as part of the prescription chart. I only learned it was an error when the Band 7 informed me that I had administered it wrongly."*

The panel considered the evidence before it. The panel concluded that on 10 August 2020 Mrs Brown administered Patient C's hydrocortisone later than prescribed, she incorrectly administered hydrocortisone to Patient C orally/via NG without ensuring the necessary changes had been made on the prescription/drug chart and failed to order Patient C's hydrocortisone from the pharmacy. The panel therefore found charges 12a, 12b and 12c proved.

Charges 13a, 13b(i), 13b(ii), 13b(iii), 13c and 13d

> "13) On 10 September 2020 during your Objective Structured Clinical Examination;
> a) Did not complete one or more safety checks.
> b) After being informed that Patient D's Clonidine infusion had been changed;
> i) Did not check the pump adequately.
> ii) Did not recalculate the dose of Clonidine.
> iii) Incorrectly documented the same dose of Clonidine prior to the changed infusion rate.
> c) Failed to demonstrate an understanding of anaphylaxis.
> d) On one or more occasion did not check Patient D's pump on an hourly basis/regularly"

These charges are found PROVED.

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

The panel considered the document titled 'Registrant's OSCE Assessment and Patient D's Chart 10 September 2020'. It noted the OSCE (Objective Structured Clinical Examination)/ Assessment Criteria at number three stated *"Perform safe practice and technique throughout the whole procedure and provide support and care to the patient and carer"*

and the options were either ‘Pass’ or ‘Refer’, in this case ‘Refer’ was ticked. It noted that this document was signed by Mrs Brown and her supervisor.

In the same document, the panel took into account a handwritten note, signed by Mrs Brown and her supervisor, which states:

> *“1. IV Clonidine: referred on assessment due to error in reconstitution – over diluted. Angel did recognise this and dispose of the medication to start again 2. IV clonidine: referred on assessment due to error in calculation monitoring on observation chart documented as 2 MCG/KG/HR. However current infusion was 1.6 MCG/KG/HR Angel had not recalculated – Nurse in charge had made the alternation and notified Angel.”*

Further, the document states:

> *“With questioning Angel displayed insufficient knowledge of anaphylaxis recognition and treatment. Asked to complete ESR training module. Discussed the resus council anaphylaxis algorithm today with Angel.”*

The panel took into account the document ‘Meeting to address informal Capability Review 14th September 2020’. It states *“Angel was asked if she checked the pumps hourly and she responded ‘no only at the start of the shift and when she changed it.’”*

The panel considered the evidence before it. The panel concluded on 10 September 2020 during Mrs Brown’s Objective Structured Clinical Examination she did not complete one or more safety checks and after being informed that Patient D’s Clonidine infusion had been changed, she did not check the pump adequately, she did not recalculate the dose of Clonidine and incorrectly documented the same dose of Clonidine prior to the changed infusion rate. The panel also determined that Mrs Brown failed to demonstrate an understanding of anaphylaxis and on one or more occasions did not check Patient D’s

pump on an hourly basis/regularly. The panel therefore found charges 13a, 13b(i), 13b(ii), 13b(iii), 13c and 13d proved.

Charge 14

> "14) On one or more occasion were unable to calculate the correct rate of administration of a fluid bolus/Hartmans."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 6 including her documentary exhibits.

The panel had regard to Witness 6's evidence. In her NMC statement she stated

> *"On 26 September 2020 I received an email from Deputy Sister [Ms 10], describing a medicines management near miss involving Angel. Angel had been unable to calculate the rate of administration of a fluid bolus twice in one shift... This was significant as an inability to calculate the rate of infusion could lead to a patient being given too much medication, which could harm the patient. Angel did not appear to be able to manage simple calculations of basic rates, which did not bode well for her ability to do more complex calculations on a daily basis."*

The panel also had regard to an email sent from Ms 10 to Witness 1, Witness 5 and others dated 26 September 2020. The email states

> *"I was the PSN on ICU on Saturday and I was required to support Angel with her medication giving. At the beginning of the shift she had to give a stat bolus of 250mls Hartmans, she asked me to supervise her, she put in the volume to give as 250mls but was unable to work out the rate, I told her to think about it, I told her it was to be given quickly, she was going to give it at 250mls hour, then 30mls, she*

still needed me to assist her that it was to run as fast as the pump would go. Later in the shift she had to give 250mls of a drug over 2 hours, again she put the 250 volume in but couldnt work out the rate, she first said 250mls, then 500mls until I tried to explain that both those would be too quick, so again I showed her how to work it out, and the correct rate would be 125mls/hr."

The panel considered the evidence before it. The panel was of the view that Ms 10 is a reliable and credible source of information as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care. It noted that it did not have any alternative explanation from Mrs Brown. The panel concluded that on one or more occasion Mrs Brown was unable to calculate the correct rate of administration of a fluid bolus/Hartmans. The panel therefore found charge 14 proved.

Charge 15

"15) Failed to complete an Informal Capability Process which commenced on 15 June 2020."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

When considering this charge, the panel considered the phrase 'failed to complete' as meaning chose not to see the process through to the end, rather than did not pass it or did not successfully complete it.

In Witness 1's NMC witness she stated

"A further meeting with Angel was held on 13 October 2020, during which Angel was informed that despite some evidence of improvement in practice, it was felt

that with the number of events that had occurred over the last few months and in the interests of patient safety and that of Angel, the Divisional Nurse was being contacted with a view to formalising Angel's capability process. Angel was being given time to arrange representation if she wished to do so."

Witness 1 said in her oral evidence that the informal capability process rolled into the formal capability process. She explained that these two processes did not run in parallel, nor did they overlap. The panel noted that Witness 1 said that only the objectives of the capability process overlapped.

The panel took into account that the document 'Meeting to address informal Capability Review 13th October 2020' detailed that Mrs Brown now had to follow the 'Formal Capability Pathway'.

The panel considered the evidence before it and noted that it was her employer's decision to move Mrs Brown from the informal capability process to the formal capability process. As a result, Mrs Brown did not have the opportunity to complete the informal capability process. The panel accordingly concluded that it would not be accurate to say that Mrs Brown failed to complete the informal capability process which commenced on 15 June 2020. The panel therefore found charge 15 not proved.

Charges 16a, 16b, 16c(i), 16c(ii), 16c(iii) and 16d

"16) On 12 November 2020;
a) Attempted to place Patient E on a sedation hold when it was inappropriate to do so/prior to going on your break.
b) Attempted to stop Patient E's Propofol when it was inappropriate to do so.
c) Extubated Patient E when it was inappropriate to do so, in that you;
i) Did not restart the propofol as advised;
ii) Did not bring over the emergency airway trolley.
iii) Did not titrate sedation, as advised.

d) Inaccurately informed one or more colleague/s that Patient E was for extubation."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 6.

The panel had regard to Witness 6's NMC statement. She stated

> *"On 12 November an ICU ward round saw a discussion about Patient E led by an ICU consultant and registrar. Patient E was Angel's patient on a one-to-one basis due to intubation; consequently Patient E was sedated. Angel was present during the round, as was I. One point of discussion was to consider placing Patient E sedation on hold, to see how they reacted and to assess the viability of a later extubation… Angel asked me whether she should carry out the sedation hold immediately. I advised Angel not to do so as she was planning on taking her break imminently… Angel was there with another staff nurse but Angel had not restarted the propofol as she had been advised and Patient E was plainly in great distress. Angel had not brought over the emergency airway trolley, which has all the equipment for any airway emergency scenario and was readily available in the ICU; it was standard procedure to have this to hand when extubating."*

In Witness 6's local statement she stated

> *"This statement is directly related to an incident that took place on Thursday 12 November 2020… SN Brown asked if the sedation hold should be carried out immediately; I advised not as she was planning on leaving for her break imminently and it would not be safe to stop sedation now. I explained she could not perform a sedation hold and leave her colleague to supervise as she already had a level 3 patient. SN Brown was already attempting to stop the propofol infusion at this time and I had to ask her to restart this to maintain Patient E's safety during SN Browns*

break…. After completion of this task I was confronted by another member of staff, asking if SN Brown's patient should have been extubated onto nasal high flow; my response was this patient was for a sedation hold, not to be extubated now…Furthermore SN Browns instruction to the two other staff nurses that came to help her, was to extubate, not titrate sedation in order to make an appropriate assessment of Patient E."

The panel had regard to Witness 6's oral evidence. Witness 6 was asked whose decision it would be for a patient to be extubated, she was clear that someone with Mrs Brown's experience, namely a Band 5 registered nurse, should seek assistance from a senior nurse or a doctor and should not attempt this procedure on their own. Witness 6 stated that Mrs Brown was too junior to make that decision or to do this procedure on her own. She stated that there were doctors available on the ICU to provide assistance in relation to this procedure. Furthermore, she stated that the emergency airway trolley should be brought to the bedside before extubation as it had all the emergency equipment on it.

The panel had regard to a reflection completed by Mrs Brown dated 12 November 2020. She states *"That time when the patient was fighting with the ET tube I was not thinking of turning back the propofol as the NIC have told me. That time when she opened her eyes and squeezed my hand and fighting with the tube, I thought it was appropriate to extubate as planned."*

The panel considered the evidence before it. It concluded that on 12 November 2020 Mrs Brown attempted to place Patient E on a sedation hold when it was inappropriate to do so/prior to going on her break and attempted to stop Patient E's Propofol when it was inappropriate to do so. It also determined that Mrs Brown extubated Patient E when it was inappropriate to do so, in that she did not restart the propofol as advised, did not bring over the emergency airway trolley and did not titrate sedation, as advised. The panel also determined that Mrs Brown inaccurately informed one or more colleague/s that Patient E was for extubation. The panel therefore found charges 16a, 16b, 16c(i), 16c(ii), 16c(iii) and 16d proved.

Charge 17

"17) On 26 November 2020 failed your calculations test."

This charge is found PROVED.

In reaching this decision, the panel took into account evidence of Witness 6.

In Witness 6's NMC statement she stated *"I checked Angel's answers for the calculations test and knowledge for practice paper she had completed on 26 November 2020 after her IV study day. I could see that Angel had not passed her calculations test…, as she had got one question wrong and needed 100% to pass."*

The panel took into account an email from Ms 9 to Mrs Brown dated 15 January 2021. The email stated *"I have assessed the documents you sent in November, and unfortunately I am unable to issue a certificate to you at this time. There are some errors in both the answers you have given in the Knowledge for Practice section, and you did not have 100% in your calculations test."*

The panel had regard to Mrs Brown's Calculation Test, dated 26 November 2020. The panel noted that Mrs Brown answered question 22 of the test incorrectly.

The panel considered the evidence before it and concluded that on 26 November 2020 Mrs Brown failed her calculations test. The panel therefore found charge 17 proved.

Charges 18a and 18b

"18) Around 30 December 2020 were unable to;
a) Carry out a correct furosemide calculation.

b) Provide correct information to an operator when asked to put of a cardiac arrest call."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence from Witness 6, including her exhibits.

The panel considered the evidence of Witness 6. In her NMC witness statement she stated *"Sister [Ms 8] told me that Angel had been unable to calculate a simple equation involving a dose of furosemide, despite having only attended the IV study day on 26 November 2020. Angel was still making basic medicines mistakes despite her additional training."*

The panel had regard to a document titled 'Review meeting with Ward manager C4' dated 30 December 2020. The panel noted that Mrs Brown was invited to this meeting but did not attend. The document states:

> *"There were a couple of concerns highlighted that raised concern*
> *1. Medicines management - Angel was still unable carryout a simple calculation (give 40mg of frusemide*[sic] *from a 50mg vial). Angel had completed the IV study day the previous week.*
> *2. Angel was not able to give the correct information to the operator when asked to put out a cardiac arrest call."*

The panel was satisfied that the events discussed and documented in the 'Review meeting with Ward manager C4' occurred shortly before the meeting. The panel was of the view that the information contained in this formal document could be relied upon.

The panel considered the evidence before it. The panel noted that it had no information about these charges from Mrs Brown. The panel concluded that around 30 December

2020, Mrs Brown was unable to carry out a correct furosemide calculation and provide correct information to an operator when asked to put of a cardiac arrest call.

Charge 19

> "19) Failed to complete a Formal Capability Process which commenced on 9 November 2020."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 6.

The panel bore in mind that Mrs Brown was informed that she would be placed on a 'formal capability process' as detailed in the document 'Meeting to address informal Capability Review 13th October 2020'. The panel had regard to a document titled 'Hearing notes First Formal Capability 9th November 2020'. It noted Mrs Brown was present at this meeting, the first formal capability meeting.

The panel considered the letter of resignation from Mrs Brown to the Health Board dated 7 January 2021.

The panel took into account the document titled '20/01/21 Record of meeting between Ms 8 and RN Angel Brown'. The panel noted that the document noted the options available to Mrs Brown, if she were to resign and these were discussed at length. At the end of this meeting, Mrs Brown *"decided to retract her resignation".*

The panel considered the evidence of Witness 1. In her NMC statement she stated *"On 20 January 2021 we held a formal capability review meeting to discuss Angel's progress… Angel was advised to complete her capability process within our health board, before moving elsewhere. Angel told us she would consider this and speak to Sister [Ms 8] about it before giving us her answer… At the end of that meeting Angel retracted her*

resignation, however, the following day Angel confirmed her intention to resign from our health board."

The panel considered the evidence before it. It took into account that as Mrs Brown had decided to resign from the Health Board she subsequently failed to complete the Formal Capability Process which commenced on 9 November 2020. The panel therefore found charge 19 proved.

Charge 20a

"20) On unknown dates;
a) On one or more occasion attempted to replace/clean a tracheostomy device alone."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 6.

In Witness 6's NMC witness statement she stated

"Previously I had witnessed Angel attempting to change and clean a tracheostomy device which had a Velcro tie around it to prevent it from becoming dislodged from the patient. This was a job for two people but Angel was trying to do it alone. I explained to Angel that the safety implications of her actions were that the patient may cough out the airway and that in that instance Angel would not be able to handle the consequences on her own. Angel appeared to listen but was a little dismissive of my concern. Several weeks later I saw Angel do this again so I advised her again and told her I'd escalate it further if I saw her do it again. Angel appeared to take on board what she was told but did not seem able to translate that into practice."

In her oral evidence, Witness 6 was consistent with her NMC statement. The panel noted that it had the opportunity to challenge Witness 6's evidence. The panel determined that Witness 6 was a reliable and credible witness as these observations were made for the purpose of Mrs Brown's training and to ensure patient safety under Mrs Brown's care.

The panel considered the evidence before it and concluded that on an unknown date, on one or more occasion, Mrs Brown attempted to replace/clean a tracheostomy device alone. The panel therefore found charge 20a proved.

Charge 20b

> "20) On unknown dates;
> b) inappropriately requested an X-ray for one patient, whilst another patient in the next bed required a tracheostomy procedure."

This charge is found PROVED.

In reaching this decision, the panel took into account Witness 6's evidence.

In Witness 6's NMC witness statement she stated

> *"On another occasion Angel requested an x-ray for her patient at the same time as the patient in the adjacent bed space needed a tracheostomy procedure. When doing an x-ray the adjacent beds need to be moved to avoid the radiation; we were doing a time critical procedure so couldn't move the bed, but at no point did Angel tell me she was doing the x-ray."*

In her oral evidence, Witness 6 was consistent with her NMC statement. She added that, she did not find out about the x-ray until the radiographer was on the ward about to take

an x-ray and asking staff to move from the adjacent bed space. The x-ray team is generally responsive to requests from the ICU and respond in about 30 minutes.

The panel considered the evidence before it and concluded that on an unknown date Mrs Brown inappropriately requested an X-ray for one patient, whilst another patient in the next bed required a time sensitive tracheostomy procedure. The panel therefore found charge 20b proved.

Charge 21

> "21) Around July 2021 were unable to adequately complete your probation period at Spire Healthcare."

This charge is found PROVED.

In reaching this decision, the panel took into account a letter from Spire Healthcare Limited to Mrs Brown and an email from Spire Healthcare Limited to the NMC.

The panel took into consideration a letter dated 12 July 2021 from Spire Healthcare Limited to Mrs Brown. The letter states *"Following the probation review meetings that have taken place during your probation period, this is to confirm that as we discussed we are terminating your employment with effect from 12 July 2021. We appreciate the effort you have made during your time in your role; however you have not achieved the standard of performance in role which we needed to see."*

The panel also had regard to an email dated 16 July 2021 from Spire Healthcare Limited to the NMC. The email states:

> *"We have also given …reasons for failing AB's probation for background information.*

Reasons for failing probation

We had received negative feedback from staff regarding documentation of pain levels and not escalating pain control issues to a senior nurse.

Negative feedback had also been received from ancillary staff about how she had spoken to patients and linen had not been changed despite patients asking.

Concern had also been raised about her method of removing a drain post-operatively and she required training for this. She was subsequently able to carry out this task appropriately.

Care of deteriorating patient was appropriate and she escalated concerns however a senior member of staff reported that a patient in her care was not administered oxygen on return to ward following surgery under a spinal diamorphine anaesthetic (this was observed quickly and the patient was not compromised).”

The panel considered the evidence before it and concluded that around July 2021, Mrs Brown was unable to adequately complete her probation period at Spire Healthcare Limited. The panel therefore found charge 21 proved.

Charges 22a and 22b

“22) Breached/attempted to breach Undertaking 5 which took effect on 14 September 2022, in that you between 30 August 2023 and 4 September 2023

a) Applied for a role as a nurse in a hospital through an agency MPS Healthcare

b) Interviewed for a role as a nurse in a hospital through an agency at MPS Healthcare”

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 7 and a letter from the NMC to Mrs Brown dated, 14 September 2022.

The panel had regard to Witness 7's evidence. In her NMC statement she said *"On 30 August 2023, Angel contacted our onboarding team regarding roles as a registered nurse in a hospital… Angel arrived for the for the interview as scheduled on 4 September."*
In Witness 7's oral evidence she explained that MPS Healthcare was not a recruitment agency for full time nursing roles but rather for temporary agency nursing roles. Witness 7 clarified that Mrs Brown attended a virtual interview with her. During the interview Mrs Brown said to Witness 7 that the undertakings, as seen on the NMC website at the material time, have stopped as she has since left her former role and the undertakings have now expired. Witness 7 said that the interview process came to an end as it is a policy at the agency not to proceed with candidates facing an NMC investigation.

The panel had regard to the letter sent to Mrs Brown by email on 14 September 2022 which stated *"Thank you for agreeing to the undertakings the case examiners recommended".* The panel noted that within the letter, Undertaking 5 stated *"You will limit your nursing practice to your current employer. You must not work for an agency."*

The panel considered the evidence before it. It took into consideration that Mrs Brown had not been successful in her application and interview process in securing work in another hospital via the Agency. It concluded that Mrs Brown had attempted to breach Undertaking 5 which took effect on 14 September 2022, in that between 30 August 2023 and 4 September 2023 she applied for a role as a nurse in a hospital through the Agency. It also found that Mrs Brown had interviewed for a role as a nurse in a hospital through the Agency. The panel therefore found charges 22a and 22b proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and/ or

misconduct and, if so, whether Mrs Brown's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to lack of competence and/or misconduct. Secondly, only if the facts found proved amount to lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, Mrs Brown's fitness to practise is currently impaired as a result.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practise.'*

Mr Edenborough provided the panel with written submissions. Within his written submissions, he submitted that Mrs Brown's failings took place over a period of 16 months and that she failed to demonstrate the competences in her practise. He submitted that training and guidance was provided to Mrs Brown however, she gave up on her efforts and resigned from the Health Board, demonstrating an attitudinal concern. He submitted Mrs Brown has placed doubt on the capability support offered by the Health Board and whether this is an effective measure. He referred the panel to relevant NMC guidance as well as 'The Code: Professional standards of practice and behaviour for nurses and

midwives (2015)' ("the Code") in making its decision. He identified the specific, relevant standards where Mrs Brown's actions amounted to a lack of competence.

Mr Edenborough invited the panel to take the view that the facts found proved in charges 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20 and 21 amount to a lack of competence and that Mrs Brown failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in a number of areas.

Submissions on misconduct

Mr Edenborough 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.'*

Mr Edenborough provided the panel with written submissions. He invited the panel to take the view that the facts found proved in charge 22 amount to misconduct. He referred the panel to the Code and identified the specific, relevant standards where Mrs Brown's actions amounted to misconduct. He submitted that Mrs Brown's actions as found proved fall far short of what would be expected of a registered nurse and it may make the public consider that the NMC has been ineffective in using undertakings to address the concerns identified in Mrs Brown's nursing practice.

Submissions on impairment

Mr Edenborough provided the panel with written submissions. He moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included application of the principles outlined in the case of *Council*

for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin). He referred the panel to the relevant NMC guidance.

Mr Edenborough submitted that Mrs Brown's conduct demonstrated a serious departure from the standards expected of a nurse. He submitted that a finding of impairment should be made on the grounds of public protection and is otherwise in the public interest. In respect of public protection, he submitted that Mrs Brown poses a real risk of harm with her lack of competence in key areas of practice and that despite ample training she was unable to show sufficient progress. He submitted her conduct demonstrated a real risk of repetition. He also noted that Mrs Brown was unable to pass the informal and formal capability processes.

Further, he submitted Mrs Brown sought to ignore her undertakings which were designed to prevent a risk of harm. In respect of public interest, he submitted that a member of the public would feel unsafe and would lose confidence in the nursing profession where a nurse has failed to address a number of areas, despite multiple opportunities to address them. He submitted that a member of the public may lose confidence in the NMC if undertakings fail to regulate the behaviour of nurses and are an ineffective means of addressing misconduct. He submitted that, as a result of Mrs Brown's lack of competence and/or misconduct, confidence and integrity of the nursing profession has been challenged and put into disrepute, therefore the panel should make a finding of impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on lack of competence and misconduct

When determining whether the facts found proved amount to a lack of competence and/or misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Brown's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Brown's actions amounted to breaches of the Code. Specifically:

'***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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

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

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

The panel bore in mind, when reaching its decision, that Mrs Brown should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard. The panel considered each of the charges in turn as to whether Mrs Brown's nursing practice met the standards of the reasonable average Band 5 registered nurse.

In relation to charge 1a, the panel was of the view that it is reasonable for a Band 5 nurse in ICU to know the difference in oxygen delivery between a facemask and nasal cannula. The panel bore in mind the potential for harm in not knowing the difference between the two methods to ensure patients are appropriately supported with breathing in different circumstances. The panel was satisfied that Mrs Brown's lack of knowledge in this area amounted to a lack of competence.

The panel considered charge 1b. The panel noted the potential for serious harm to Patient A in not receiving their prescribed doses of Terlipressin. The panel noted that Mrs Brown did not provide a reason as to why she did not administer this medication to the patient. The panel was of the view that it was reasonable for a Band 5 nurse to understand a medication chart or to seek guidance before deciding whether to administer prescribed

medication to a patient. The panel was satisfied that Mrs Brown's failure to administer this medication amounted to a lack of competence.

The panel next considered charge 2. It noted significant and potential harm to Patient B as a result of Mrs Brown's conduct found proved in the charge. Actual harm was caused to the patient in that they experienced a hypoglycaemic episode and the panel was of the view that the level of harm was only mitigated by the doctor's interventions. However, it considered that it was reasonable for a Band 5 nurse to check and record the patient's blood glucose level, before administering gliclazide and to recognise when a patient has deteriorated or is hypoglycaemic. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel had regard to charge 3. It noted the potential for serious harm to the patient. It considered that it is reasonable for a Band 5 nurse to attend to a patient who is desaturating when their alarm is going off rather than leave a patient's bed space to obtain non urgent supplies, in this case gauzes or syringes. The panel heard that setting of alarm limits for patients in ICU is a fundamental part of nursing care. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

Regarding charge 4, the panel considered that the patient was at a very serious risk of harm. The panel noted that the patient's oxygen level was very low at 60%. It noted that Mrs Brown was only caring for one patient at the material time. The panel noted that the supervisor had intervened, and so no actual harm was caused to the patient. The panel was of the view that it is reasonable for a Band 5 nurse to respond to an alarm of a desaturating patient's monitor rather than silencing it and to ensure that the patient's equipment is checked. The setting of appropriate alarm limits is a fundamental part of nursing care particularly for a patient who was known to desaturate. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

In respect of charge 5, the panel was of the view that these were areas which were fundamental to the care in the ICU. The panel considered that Mrs Brown was working in

the ICU at the material time and that in this environment she would not be expected to work with this equipment without some training or instruction. The panel noted the supernumerary periods Mrs Brown worked under and determined that it was more likely than not, that these were areas that she should have known about. The panel considered the risk of potential harm to the patient which was mitigated by the response of Mrs Brown's supervisor. The panel considered the that it was reasonable for a Band 5 nurse in ICU to know how to set up a transducer, what landmark the transducer should be placed on, how a nasal high flow machine works and to know the local nasogastric feeding protocol. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel took into account its findings at charge 6. The panel bore in mind the potential risk of harm of Mrs Brown's actions in this charge. The panel considered that it was reasonable for a Band 5 nurse in ICU to know the appropriate NG feed to provide to a patient and to demonstrate an understanding of what to do with nasogastric aspirate. The panel was of the view that this is fundamental to the care in the ICU. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel considered its findings of charge 7. It noted that it was observed that Mrs Brown did not know why she was conducting ABGs and it appeared that she did not understand the equipment to identify a cuff leak. The panel noted the risk of harm to patients was lower in this charge. The panel was of the view that it is reasonable for a Band 5 nurse to demonstrate an understanding of when a patient needs an Arterial Blood Gas analysis and to establish a cuff leak link to low ETC02. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel had regard to its findings of charge 8a and the potential risk of harm to the patient. It noted the risk of harm to a patient if a low mean arterial pressure is not treated. The panel noted that there were a number of ways in which Mrs Brown could have escalated this situation due to the presence of the doctors, nurse in charge and floating nurse on the ward. The panel was of the view that it is reasonable for a Band 5 nurse to

treat a patient's low mean arterial pressure by considering adjusting the noradrenaline rate and escalate it to the nurse in charge. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

In relation to charge 8b, the panel bore in mind the potential harm to the patient if a nurse is not able to read the breathing equipment correctly. The panel was of the view that it is reasonable for a Band 5 nurse in ICU to correctly record a patient's breathing mode. It was of the view that this is fundamental to the care in the ICU. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

In respect of charge 8c the panel took into consideration the potential for serious harm to the patient. The panel was of the view that it is reasonable for a Band 5 nurse in ICU to be able to appropriately escalate a patient who is displaying Acute Respiratory Distress Syndrome. It was of the view that this is fundamental to the care in the ICU. The panel noted that there were a number of ways in which Mrs Brown could have escalated this situation due to the presence of the doctors, nurse in charge and floating nurse on the ward. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel next considered its finding in relation to charge 9. In this particular instance, the panel bore in mind that Mrs Brown was distracted by observing a procedure for the patient she was to monitor observations for. The panel considered the risk of harm and noted that the risk was limited in these circumstances, as there were other medical professionals with the patient and Mrs Brown's supervisor stepped in to assist with the observations. The panel was of the view that it is reasonable for a Band 5 to monitor patient observations and Mrs Brown was not acting appropriately as a member of the multi-disciplinary team because the other staff would not know the patient's status. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel took into account its findings of charge 10. The panel took into consideration the very serious risk of harm outlined by the conduct in these charges.

In respect of charge 10a, the panel was of the view that it is reasonable for a Band 5 to demonstrate an understanding of ventilator alarms. It was also of the view that it is reasonable for a Band 5 in ICU to demonstrate an understanding of subglottic suction. The panel bore in mind that subglottic suction is fundamental to care in the ICU.

In relation to charge 10b, the panel was of the view that it is reasonable for a Band 5 to be able to accurately record WAASP and Waterlow risk assessments in the patient's notes. The panel was of the view that accurately recording risk assessments is fundamental to nursing care. By copying recordings from previous shifts Mrs Brown has prevented herself and colleagues from determining if any intervention is required for the patients involved.

The panel was of the view that Mrs Brown's actions in this charge demonstrated an attitudinal concern as she sought to cover up her lack of knowledge and understanding in these areas.

Regarding charge 10c, the panel was of the view that it was reasonable for a Band 5 nurse to demonstrate basic care toward patients by informing the patient of any procedures that they may have to undertake for the patient's care, particularly whilst they are asleep.

The panel was satisfied that Mrs Brown's actions in charge 10 amounted to a lack of competence.

The panel next considered its finding in relation to charge 11 and the potential risk of harm to patients. The panel was of the view that it is reasonable for a Band 5 nurse to be aware that emergency equipment should be nearby while attempting extubation. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel had regard to its findings of charge 12. In respect of charge 12a, the panel was of the view that Mrs Brown's conduct in this charge demonstrated a low risk of potential harm to the patient and that the delay in administering the hydrocortisone to the patient

was understandable in the circumstances. The panel found that this did not amount to a lack of competence.

In relation to charge 12b, the panel noted that Mrs Brown did not follow the right medication administration protocol despite being told what to do by her supervising nurse. The panel was of the view that this is fundamental to nursing care. The panel was of view that it is reasonable for a Band 5 nurse to ensure that the necessary changes are made on the prescription/drug chart when there is a change in the route for the delivery of medication. The panel noted that in these circumstances the risk of harm to the patient was low however this failing could carry a high risk of harm in other instances.

Regarding charge 12c, the panel was of the view that it is reasonable for a Band 5 nurse to order medication from the pharmacy. It noted that Mrs Brown was requested to order the hydrocortisone by her supervisor. The panel noted that the risk of harm in this instance was low as Mrs Brown's supervisor ordered the medication from the pharmacy.

The panel considered that Mrs Brown has demonstrated an attitudinal concern in respect of this charge, in that she did not act on instructions from her supervisor. The panel was satisfied that Mrs Brown's actions in charge 12b and 12c amount to a lack of competence.

In respect of charge 13a, it noted that the OSCE is a fundamental, formal, important exam for nursing practice. The panel noted the context of formal assessment of Mrs Brown's skills and the potential risk of harm by failing to complete one of the safety checks. The panel was of the view that it is reasonable for a Band 5 nurse to complete all safety checks as required during their OSCE.

In relation to charge 13b, the panel had regard to its findings and the risk of serious harm to the patient. The panel was of the view that it is reasonable for a Band 5 nurse after being informed that a patient's clonidine infusion had been changed to check the pump, recalculate the dose of clonidine and record the revised dose of clonidine.

Regarding charge 13c, the panel bore in mind the risk of potential harm to the patient. It was of the view that it is reasonable for a Band 5 nurse to demonstrate an understanding of anaphylaxis.

The panel took into consideration to its findings at charge 13d. It took into consideration Mrs Brown's apparent lack of understanding of the need to check the equipment. The panel had regard to the potential risk of harm of not checking the patient's equipment. The panel was of the view that it is reasonable for a Band 5 nurse to check the patient's pump as directed (in this instance, on an hourly basis / regularly).

The panel was satisfied that Mrs Brown's actions in charge 13 amounted to a lack of competence.

The panel considered its findings at charge 14 and the real risk of serious harm which arises from this charge. The panel bore in mind that Mrs Brown was trained on undertaking calculations. The panel was of the view that it is reasonable for a Band 5 nurse to calculate the correct rate of administration of a fluid bolus/Hartmans. The panel was of the view that this is a fundamental nursing skill. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel took into account its findings of charge 16 and that there was actual harm caused to the patient. The panel bore in mind that Mrs Brown ignored instructions provided to her and failed to take the necessary precautions and put her colleagues at risk by giving them inaccurate information. The panel was of the view that it is reasonable for a Band 5 nurse to know when it is appropriate to place a patient on sedation hold, when to stop a patient's propofol, when to extubate a patient (specifically following advice, ensuring the emergency airway trolley is available and titrating the sedation as advised) and accurately informing colleagues when a patient is ready for extubation. The panel considered that Mrs Brown has demonstrated an attitudinal concern in respect of this charge in that she did not act on instructions from her supervisor. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

The panel considered its findings at charge 17. The panel bore in mind the potential risk of serious harm which arises from this charge in failing to calculate medicine doses correctly and not being able to perform this skill in practice. The panel was of the view that it is reasonable for a Band 5 nurse who has received appropriate training and support to pass their calculations test. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

Regarding charge 18a, the panel was of the view that is reasonable for a Band 5 nurse to carry out a correct furosemide calculation as this is a fundamental nursing skill. The panel noted that there is a risk of harm to patients if calculations are not completed correctly.

In respect of charge 18b, the panel considered its findings and that it did not have specific details in relation to this charge. However, the panel considered the potential for serious harm to the patient due to the emergency nature of cardiac arrest calls. The panel was of the view that it is reasonable for a Band 5 nurse to provide correct information to an operator when asked to put out a cardiac arrest call to ensure that the right support is in place for the patient.

The panel was satisfied that Mrs Brown's actions in charge 18 amounted to a lack of competence.

The panel had regard to its findings at charge 19. The panel bore in mind that it did not know all the reasons as to why Mrs Brown resigned from the Health Board however, it noted that Mrs Brown was informed that she would be referred to the NMC due to the Health Boards concerns regarding the potential risk of harm she posed to patients if she were to practise as a nurse unsupervised elsewhere. The panel was of the view that it is reasonable for a Band 5 nurse to complete their Formal Capability Process to ensure they have the required basic and fundamental skills for nursing. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.

In respect of charge 20a, the panel bore in mind that there was a high risk of harm to the patient and that it heard witness evidence which described these incidents as ‘potentially catastrophic’. The panel bore in mind that Mrs Brown received advice about the risk of replacing or cleaning a tracheostomy device alone from her supervisor and considered that Mrs Brown demonstrated an attitudinal concern by disregarding this advice. The panel was of the view that it is reasonable for a Band 5 nurse to understand that attempting to replace or clean a tracheostomy device must be done with another colleague. The panel was satisfied that Mrs Brown’s actions in this charge amounted to a lack of competence.

In relation to charge 20b, the panel was of the view that it was reasonable for a Band 5 nurse to understand the wider picture in assessing the needs of all patients on a ward and to provide the appropriate care. The panel was of the view that Mrs Brown’s actions in requesting an x-ray for her patient without consulting her colleagues was inconsiderate toward her colleagues and adjacent patients. The panel considered the risk of harm in this instance had been mitigated by the radiographer who had asked staff and surrounding patients to be moved. The panel was satisfied that Mrs Brown’s actions in this charge amounted to a lack of competence.

The panel took into consideration its findings of charge 21. It noted that Mrs Brown failed to meet the sufficient standard required to pass her probation period at Spire Healthcare. The panel was of the view that it is reasonable, having received appropriate training and support, for a Band 5 nurse to pass their probation period. The panel was satisfied that Mrs Brown’s actions in this charge amounted to a lack of competence.

The panel concluded that Mrs Brown’s practice was below the standard that one would expect of the average registered Band 5 nurse acting in Mrs Brown’s role. In all the circumstances, the panel determined that Mrs Brown’s performance demonstrated a lack of competence.

The panel also appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered Mrs Brown’s conduct in charge 22 and took into consideration that Mrs Brown subject to an undertaking from her professional

regulator to ensure that her nursing practice was monitored and safe. However, Mrs Brown attempted to breach those restrictions imposed by the undertaking. The panel therefore determined that Mrs Brown's conduct, as found proved in charge 22, was sufficiently serious to amount to misconduct.

The panel found that Mrs Brown's actions did fall seriously short of the standards expected of a nurse and that her conduct in charge 22 amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of Mrs Brown's lack of competence and misconduct, her fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) *...'*

The panel found limbs a, b and c of Dame Janet Smith's "test" engaged in this case.

The panel found that patients were put at a real risk of significant harm as a result of Mrs Brown's lack of competence and misconduct. Mrs Brown's lack of competence and

misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Brown has limited insight. It took into consideration the reflective statements Mrs Brown completed during her employment at the Health Board in relation to the lack of competency charges found proved. It noted that she was showed some remorse for her conduct. However, it bore in mind that Mrs Brown sought to blame others for some of her mistakes and did not reflect on the impact her actions had on her colleagues. Further, she did not reflect on how her actions impacted the reputation of the profession and members of the public. It noted that Mrs Brown demonstrated limited insight in her reflective statements however, she repeated her mistakes and so it did not appear that her reflections turned into positive changes in her practice.

The panel was satisfied that the lack of competence charges in this case could potentially be capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Brown has taken steps to strengthen her practice in relation to the lack of competence charges. The panel took into account the evidence of progress Mrs Brown supplied from her employment at Nuffield Health including two references, completing training in a number of relevant areas and obtaining positive feedback. However, the panel had received no recent evidence of her practice as the most recent documents were from February 2023. Therefore, the panel was not satisfied that Mrs Brown has demonstrated a consistent period of applying the knowledge from her training to her nursing practice without any concerns raised. The panel took into consideration that it had no information about Mrs Brown's current insight or nursing practice apart from her misconduct, found proved, in charge 22.

The panel was satisfied that the misconduct in this case is difficult to address. It noted that the misconduct underlying charge 22 was related to Mrs Brown's attitude and integrity, the panel did not accept that she had misunderstood the undertakings and therefore she had withheld information from a potential employer. Therefore, the panel carefully considered

the evidence before it in determining whether or not Mrs Brown has taken steps to strengthen her practice in relation to this charge. The panel took into account that it had no recent information from Mrs Brown regarding her insight, remorse or any evidence of strengthened practice in relation to her actions as outlined in the charge.

The panel concluded that there is a real risk of repetition as it could not be satisfied that Mrs Brown's behaviour, in both the lack of competence and misconduct charges, would not be repeated in the future.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. It considered that public confidence in the profession would be undermined, the reputation of the nursing profession and the NMC as a regulator would be damaged, given the requirement to declare and uphold proper standards, if a finding of impairment were not made in this case. The panel was of the view that an informed member of the public would be concerned to learn that a registered nurse with the findings found proved in this case was allowed to practise unrestricted. The panel therefore also finds Mrs Brown's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Brown's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Brown's registration has been suspended.

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

Submissions on sanction

Mr Edenborough provided the panel with written submissions. He invited the panel to impose a suspension order for a period of 12 months in light of the panel's findings that Mrs Brown's fitness to practise is currently impaired. He outlined the aggravating and mitigating features of the case. He submitted the appropriateness on the sanctions available to the panel in the circumstances. He referred the panel to the relevant NMC guidance.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Mrs Brown has demonstrated limited insight in relation to the lack of competence failings and no insight into the misconduct charge.

- Mrs Brown's lack of competence demonstrates a pattern of behaviour over a long period of time.
- Mrs Brown's failings caused actual harm to some patients and was otherwise a serious risk of harm to patients.
- Mrs Brown has demonstrated a lack of competence over a long period of time despite having supportive employers who invested significant time and resources into improving her practice.

The panel also took into account the following mitigating features:

- Mrs Brown has demonstrated some evidence of strengthening practice through her reflective statements, relevant training courses, the two character references she has provided and positive feedback from colleagues and patients.
- At the material time of the concerns identified, Mrs Brown was a newly qualified Band 5 nurse working in a specialist area of practice.

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 Mrs Brown's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Brown's misconduct and lack of competence failings were 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 Mrs Brown's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel bore in mind that it had no evidence before it that Mrs Brown was willing to respond positively to retraining as she had not engaged with this hearing. The panel was not satisfied, as a result of its findings at the impairment stage, that patients would not be put in danger either directly or indirectly, during the period that conditions were imposed on Mrs Brown's practice. The panel took into account that is has no evidence that Mrs Brown has demonstrated harmful deep-seated personality problems. However, the panel bore in mind that it has identified that Mrs Brown has demonstrated attitudinal concerns in her nursing practice, in that she did not adhere to instructions from her supervisors. The panel determined that there are identifiable areas Mrs Brown's practice which are in need of assessment and retraining and she had demonstrated a general lack of incompetence in her nursing practice. It noted that Mrs Brown was provided with supernumerary support and training from the Health Board and Spire Healthcare however this did not prevent the failings occurring in her practice.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the wide-ranging areas of Mrs Brown's lack of competence in this case and that any conditions of practice imposed would be tantamount to a suspension order. Furthermore, the panel concluded that the placing of conditions on Mrs Brown's registration would not adequately address the seriousness of the misconduct and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered that the following factors from the SG in relation to a suspension order that are apparent in the circumstances of this case:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*

- *No evidence of repetition of behaviour since the incident;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel bore in mind that it is has no evidence that Mrs Brown has demonstrated harmful deep-seated personality problems however it has identified that Mrs Brown has demonstrated attitudinal concerns in her nursing practice.

Whilst the panel has no evidence of repetition of the misconduct and lack of competence failings since the material incidents, the panel bore in mind that it has found that Mrs Brown has limited insight and there is a real risk of repetition.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation identified, the panel concluded that it would be disproportionate. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. It noted the seriousness of Mrs Brown's misconduct was suitable for a sanction of suspension, due to the issues with integrity identified, but was not serious enough to warrant a striking off order. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Brown's case to impose a striking-off order.

The panel bore in mind that this case largely relates to Mrs Brown's wide-ranging lack of competence and that the panel did not have the sanction of striking off available to it, in respect of those charges, on this occasion.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Brown. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and to provide Mrs Brown with the opportunity to address the lack of competence failings she has demonstrated in her practice.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Brown's attendance and engagement at any future hearing.
- Reflective statement which demonstrates:
    - Insight into her lack of competence and misconduct
    - How her lack of competence and misconduct has impacted her patients, colleagues, wider nursing profession and members of the public.
- Evidence of professional development including training in the relevant areas in which Mrs Brown demonstrated a lack of competence.
- Testimonials from a line manager or supervisor that detail your current work practices (whether in healthcare or elsewhere).

This will be confirmed to Mrs Brown in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Brown's own interests until the suspension 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 Mr Edenborough. He submitted that an interim suspension order was necessary on the grounds of public protection and public interest for a period of 18 months to cover any potential period of appeal.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential period of appeal.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Brown is sent the decision of this hearing in writing.

That concludes this determination.