Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday 6 June 2024 – Tuesday 11 June 2024

Virtual Meeting

Name of Registrant:	Gillian Buchanan
NMC PIN	86A0019S
Part(s) of the register:	Registered Nurse – (sub part 2) General Nurse – Level 2 – 19 October 1987
Relevant Location:	Peterborough
Type of case:	Misconduct
Panel members:	Bernard Herdan (Chair, Lay member) Kathryn Smith (Registrant member) Philippa Hardwick (Lay member)
Legal Assessor:	Guy Bowden
Hearings Coordinator:	Catherine Blake Shela Begum (10 June 2024)
Facts proved:	Charges 1a, 1b ii, 1b iii, 2 (in its entirety), 3, 5, 6, 10, 11 (in its entirety), 12 (in its entirety), 13b, 13c, 14c, 14d, 15, 16c, 17b, 17c, 17d, 17e, and 18a
Facts not proved:	Charges 1b i, 4, 7 (in its entirety), 8 (in its entirety), 9 (in its entirety), 13a, 14a, 14b, 16a, 16b, 17a, 18b, 18c, 19
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been posted to Ms Buchanan's last known address on 10 January 2024. The panel had regard to proof of posting using Royal Mail Delivery and Royal Mail tracking information that this was delivered and signed for on 18 April 2024. Additional papers were posted to Ms Buchanan on 17 May 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, and dates of the meeting, and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Ms Buchanan has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse

1. On the night shift of 18/19 January 2015 in relation to Patient A:
    a. Did not escalate to the registered medical officer when Patient A complained of palpitations.
    b. Did not complete the following assessments.
        i. A-E assessment
        ii. Bloods
        iii. ECG

2. On or before 28 March 2015 in relation to Patient B:
    a. Did not record blood transfusion observations correctly.
    b. Did not record the administration of codeine.
    c. Incorrectly recorded the administration of paracetamol.

3. On 12 June 2015 gave Patient C a discharge letter belonging to another patient.

4. On 4 April 2018 was rude and/or abrupt to Patient D.

5. On 24 April 2018 left Patient E naked whilst obtaining a gown.

6. On 21 November 2018 you did not administer Rivaroxaban to Patient G.

7. On 14 March 2019, in relation to Patient H:
    a. Did not administer and/or record administration of Inhixa.
    b. Did not administer and/or record administration of Metformin.
    c. Did not record administration of Paracetamol.

8. On 15 March 2019 in relation to Patient H:
    a. Did not record the administration of Inhixa.
    b. Did not record the administration of Metformin

9. On 14 March 2019 in relation to Patient J:
    a. Administered Enoxaparin that was not clinically prescribed.
    b. Did not record the administration of Enoxaparin.

10. On 18 March 2019 when Patient I asked for assistance in putting the back of their bed up said ‘do it yourself’ or words to that effect.

11. On 23 March 2019 in relation to Patient J:
    a. Administered Enoxaparin that was not clinically prescribed.
    b. Did not record the administration of Enoxaparin.

12. On 24 March 2019 in relation to Patient J:
    a. Administered Enoxaparin that was not clinically prescribed.
    b. Did not record the administration of Enoxaparin.

13. On 30 July 2019 in relation to Patient K:

a. Did not introduce yourself when collecting the patient from theatre.
b. Did not provide water when requested.
c. Did not provide pain relief when requested.

14. On 31 July 2019, when instructed to administer a blood transfusion:
    a. Did not obtain patient consent.
    b. Did not provide the patient with the information leaflet.
    c. Did not assess for transfusion associated circulatory overload.
    d. Did not record the baseline NEWS.

15. On 31 July 2019 did not record the administration of medication to Patient L without prompting by Colleague A.

16. On 3 October 2019 in relation to Patient M
    a. On being asked how they could get to the bathroom said ‘hop’ or words to that effect
    b. Did not assist Patient M to the bathroom.
    c. Did not secure Patient M’s gown.

17. On 4 November 2019
    a. Did not escalate the deterioration of Patient N.
    b. Did not provide Patient N with oxygen.
    c. Did not take observations of Patient N.
    d. Delegated observation tasks of Patient N to Colleague B.
    e. Did not review observations of Patient N conducted by Colleague B.

18. On 23 November 2019 in relation to Patient O:
    a. Incorrectly administered a 10 mg dose of Oxycodone.
    b. Incorrectly recorded the administration of Ondansetron.
    c. Administered Oxycodone earlier than the prescribed time.

19. On or around December 2019 did not show Patient P dignity.

Background

The charges arose whilst Ms Buchanan was employed as a registered nurse by Fitzwilliam and Boston West Hospitals ('the Hospital').

Ms Buchanan was referred to the NMC on 27 July 2020 with concerns in respect of record keeping, medication administration, failing to follow clinical nursing procedure and failing to follow the professional code of conduct.

The following is a summary of the allegations concerning these matters.

On the night shift of 18 January 2015, Ms Buchanan did not complete assessment observations on Patient A who was experiencing palpitations. When the concern was raised with Ms Buchanan by Ward Manager JS, Ms Buchanan admitted that she failed to escalate the patient to the Registered Medical Officer ('RMO'). A disciplinary hearing took place on 23 February 2015 where Ms Buchanan admitted that she had not carried out observations and failed to escalate the patient to the RMO.

As a result of this the Hospital requested weekly reviews of Ms Buchanan's patient observations to monitor her performance. The reviews showed that Ms Buchanan was making errors in respect of observations, medication administration and record keeping.

In July 2015, the Hospital implemented a performance improvement plan until October 2015 when the Hospital assessed that Ms Buchanan's practice had significantly improved.

In April 2018, the Hospital received two complaints relating to Ms Buchanan's attitude, and also a failure to treat a patient with dignity. Ms Buchanan apologised for her failings and no further action was taken.

In November 2018, Ms Buchanan failed to administer a patient's medication, as a result her medication practice was assessed in February 2019. Ms Buchanan failed the

assessment and was subsequently placed under supervision when completing patient medications. The reviews conducted showed further poor record keeping

In March 2019, Ms Buchanan made numerous errors in record keeping and medication administration. There were also further concerns raised about her attitude. A formal investigation led to further disciplinary action and in August 2019 Ms Buchanan was issued with a final written warning.

Ms Buchanan remained under supervision until September 2019 when she was assessed as competent in medication. Not long after this, the Hospital received further complaints regarding Ms Buchanan's attitude in that she was rude and abrupt with patients. Further medication and record keeping errors together with omissions of care were also identified which led to another investigation and disciplinary action.

On 4 November 2019, Ms Buchanan failed to escalate the deterioration of a patient and did not provide the patient with oxygen as required, nor complete the required observations.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Ward Manager at the Hospital at time of the incidents.

- Witness 2: Night Sister at the Hospital at the time of the incidents.
- Witness 3: Physiotherapy Manager at the Hospital at the time of the incidents.
- Witness 4: Ward Sister and Critical Care Lead at the time of the incidents.

The panel also had regard to extensive documentary evidence provided by the NMC. Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel received no representations from Ms Buchanan.

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

Charge 1a)

'That you, a registered nurse

1. *On the night shift of 18/19 January 2015 in relation to Patient A:*
    a. *Did not escalate to the registered medical officer when Patient A complained of palpitations.'*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1, Ward Manager, as well as notes from the disciplinary hearing dated 28 August 2019, and a record of a conversation with Ms Buchanan dated 19 January 2015.

The panel considered that, in the notes from the disciplinary hearing, Ms Buchanan appears to accept that she did not escalate Patient A:

'Once establishing the issue GB [Gillian Buchanan] instructed that she should call on the RMO, however the patient stressed that they did not want the RMO called…

she could not explain why she did not carry out any of the above other than that the patient had requested that she did not call the RMO'

The panel noted the contemporaneous note of the telephone call on the evening of 19 January 2015 between Ms Buchanan and Witness 1:

'Q – Did you escalate your concerns to the RMO?

A – No, the patient did not want me to.

Q – Are you the patient advocate?

A – Yes, I have cocked up.'

Accordingly, the panel found charge 1a proved.

Charge 1b)

'That you, a registered nurse

1. *On the night shift of 18/19 January 2015 in relation to Patient A:*
    b. *Did not complete the following assessments.*
        i. *A-E assessment*
        ii. *Bloods*
        iii. *ECG'*

This charge is found proved in respect of charges 1b ii) and 1b iii), and NOT proved in respect of 1b i)

In reaching this decision, the panel took into account the witness statement of Witness 1, as well as notes from the disciplinary hearing dated 28 August 2019, and a record of a conversation with Ms Buchanan dated 19 January 2015.

The panel noted that the evidence for all sub-charges in charge 1b is the same, and so decided to determine charge 1b holistically.

The panel regarded the notes from the disciplinary hearing, and noted that Ms Buchanan appears to accept that she did not complete the assessments in 1b ii) and iii):

'[Witness 1] asked GB had she completed any the[sic] following processes:

EWS, A-E Assessment, blood, did she document any of the information

GB replied that she had not done any of the above'

In respect of charge 1b i), the panel noted a discrepancy in the evidence. In the conversation record, in response to being asked whether an A-E assessment was completed, Ms Buchanan said *'yes, but she did not document it'*. However, in the disciplinary hearing notes, in response to being asked whether she had completed the A-E assessment, Ms Buchanan is recorded as saying that she had not (quoted above). On the basis of this discrepancy, and given no one seems to have witnessed what actually happened, the panel was not satisfied that NMC had proved that Ms Buchanan did not complete the A-E assessment, only that she failed to record it.

Accordingly, the panel found charges 1b ii) and 1b iii) proved. The panel found there was insufficient evidence to support charge 1b i), and found it not proved.

Charge 2a)

'That you, a registered nurse

2. On or before 28 March 2015 in relation to Patient B:

a. Did not record blood transfusion observations correctly.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1, as well as the review of patient notes dated 28 March 2015.

The panel took account of Witness 1's review notes, in particular:

'Blood Transfusion observations were not recorded on the Blood Transfusion Care Pathway, they were recorded on the EWS chart. Gill said this is what she was told at her past Blood Transfusion training day by AC. [Witness 1] explained that this was not Ramsay protocol, on audit her paperwork would not show when the unit started, what the obs were after 15 minutes and the end time, which is safe transfusion. In future Gill will record blood observations in the blood Transfusions Care Pathway which is Ramsay protocol.'

The panel noted this was a contemporaneous review.

The panel noted that Ms Buchanan said that she recorded the observations on the EWS chart as this was what she was taught at her last blood transfusion training day, however the panel did not have sight of any information about what was covered on the training day. The panel noted that it also did not have sight of the Ramsay protocol, nor Patient B's records in order to assess the detail and quality of the observations. However, the panel also took into account the comments of Witness 1 that it was not safe to record these observations in EWS.

The panel determined that, while Ms Buchanan did record the blood transfusion observations, she did not adhere to the correct protocol when doing so and therefore did not do so correctly. Accordingly, the panel found this charge proved.

Charge 2b

'That you, a registered nurse

2. On or before 28 March 2015 in relation to Patient B:

b. Did not record the administration of codeine.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1 and the statement of Ms Buchanan for the patient notes review.

The panel took account of Ms Buchanan's statement for patient notes review, in which she admits to not recording the administration of codeine:

> *'I was looking after patient B on the night of 27 March 2015. When doing my drug round I gave the patient two paracetamol (1g) and 60mg of codeine. I had documented the paracetamol that was given on the drug chart but omitted to write the time above my signature however I did not document the codeine that I gave. I acknowledge that this is erroneous and will ensure that I document all medications and the time given from now on.'*

Accordingly, the panel found charge 2b proved.

Charge 2c

'That you, a registered nurse

2. On or before 28 March 2015 in relation to Patient B:

c. Incorrectly recorded the administration of paracetamol.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1 and the review of patient notes dated 28 March 2015.

The panel considered the review of patient notes dated 28 March 2015:

> *'At 22:00hrs Gill had recorded the pts pain as 6/10 and given Paracetamol. I asked if this was enough and she said she had given Codeine, but not documented it. On the drug chart Gill had signed for Paracetamol for 22.00hrs and had actually given it at 22.30hrs, when she recorded the patients [sic] observations.'*

The panel noted that this is a contemporaneous account, and that Witness 1 is cogent and credible. The panel considered that recording the correct time is a fundamental aspect in the safe administration of medication such as paracetamol in order to protect against overdosing. The panel therefore determined, on the balance of probabilities, Ms Buchanan

incorrectly recorded the administration of paracetamol, and therefore charge 2c is found proved.

Charge 3

'That you, a registered nurse

3. On 12 June 2015 gave Patient C a discharge letter belonging to another patient.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1 and Ms Buchanan's local statement, as well as the email from Witness 1 dated 12 June 2015.

The panel noted the following from Witness 1's email:

'I spoke to Gill…and she admitted she had made another mistake'

The panel also noted the following from Ms Buchanan's local statement:

'…I had stapled the 2 blue sections of the TTO forms together, and put them in [Patient C's] bag along with dressings and all her other discharge paperwork.

The next patient to be discharged was [Patient X] …I went to get her TTO's and saw them sitting on the side but the blue section of the form was missing, it was then I realised what had happened, I had stapled the blue copy of [Patient X's] TTO's to the copy for Patient C.

…

I apologise unreservedly for this error and will ensure that it does not happen again.'

Accordingly, the panel determined this charge proved.

Charge 4

'That you, a registered nurse

4. On 4 April 2018 was rude and/or abrupt to Patient D.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the statement of Witness 1, and the incident investigation file note dated 4 April 2018.

The panel noted that, in the file note, Ms Buchanan says *'I do not recall this patient, however it was never my intention to come across as rude. I do accept that I can sometimes come across as abrupt…'*

The panel took into account the statement of Witness 1, which refers to a patient complaint. The panel do not have sight of this.

There is no further information before the panel.

Being that Ms Buchanan does not remember the alleged incident, the incident seems not to have been witnessed by any other staff member, and in the lack of any other information, the panel determined that there is insufficient evidence to support this charge. Accordingly, the panel have found this charge not proved.

Charge 5

'That you, a registered nurse

5. On 24 April 2018 left Patient E naked whilst obtaining a gown.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1, and the incident investigation file note dated 24 April 2018.

The panel noted the incident report, and that Ms Buchanan does recall the event specifically. It noted in this report that Ms Buchanan does not expressly accept or deny the charge, but said that she wouldn't knowingly leave a patient naked:

'… I agreed to change her bed top to bottom. Unfortunately her gown was also wet and I went to get a fresh one. I would not knowingly leave a patient naked for ½hr whilst doing this.'

The panel considered that Ms Buchanan implicitly accepts that she left the patient naked (for an undefined duration) while she went to get a gown.

The panel also considered there was consistency between Ms Buchanan's account of the incident in her feedback, and the original complaint.

The panel has considered, on the balance of probabilities, that it is more likely than not that Ms Buchanan left Patient E naked while she went to obtain a fresh gown. Accordingly, this charge is found proved.

Charge 6

'That you, a registered nurse

6. On 21 November 2018 you did not administer Rivaroxaban to Patient G.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1, Ms Buchanan's statement dated 25 November 2018, and Patient G's Medication Administration Record (MAR) dated 21 November 2018.

Having regard to the MAR chart, the panel noted there is signature for medication missing from Patient G's record. This is corroborated by the statement of Ms Buchanan:

'I was looking after [Patient G] and it had been handed over that the Rivaroxaban was on the front of the drug chart but I forgot that this had been handed over. When it came time to administer her meds, I looked on the inside of her chart and saw that the Rivaroxaban has been prescribed but that it had a cross through the post op night dose. I asked my colleague who was on shift that night to make sure I wasn't missing it and that it was to start the next night.

When I was told about the missed dose I realised that I had missed seeing it on the front of the kardex as it was written much smaller than the anaesthetic medications and also it had the anaesthetic meds above and below it.'

Accordingly, the panel found this charge proved.

Charges 7 and 8

'That you, a registered nurse

7. *On 14 March 2019, in relation to Patient H:*
    a. *Did not administer and/or record administration of Inhixa.*
    b. *Did not administer and/or record administration of Metformin.*
    c. *Did not record administration of Paracetamol.*
8. *On 15 March 2019 in relation to Patient H:*
    a. *Did not record the administration of Inhixa.*
    b. *Did not record the administration of Metformin.'*

These charges are found NOT proved.

In reaching this decision, the panel took into account the statements of Witness 1 and Witness 2, the night sister, as well as the drug chart of Patient H, an email from Witness 2 to Witness 1 dated 22 March 2019, and Ms Buchanan's statement dated 22 March 2019, and the investigation report dated 22 April 2019.

The panel noted that charges 7 and 8 concern the same patient and rely on the same evidence and so decided to determine charge 7 and 8 together in their entirety.

The panel considered that the evidence presented regarding these charges was inconsistent and lacked specificity. In particular, the drug charts and the incident reports do not refer to a specific nurse, and what is stated on the incident report does not match what is seen on the drug charts. The panel also did not have sight of the local statement referred to in Witness 2's statement.

The panel regarded Patient H's drug chart and noted that the Inhixa was not recorded as administered at 6:00am on 14 March 2019. The panel noted that this would have been during the night shift. However, the panel saw no evidence that Ms Buchanan was working on that shift, or that she was responsible for administering the medication to Patient H.

The panel acknowledged that on 15 March 2019 there do appear to be initials at 6:00am and 6:00pm on the drug chart. The panel were not clear as to how this evidence related to the charge as these did not appear to be Ms Buchanan's initials.

The incident report refers to ticks being recorded instead of signatures, but the panel found there is no evidence of ticks being used in the drug chart in place of initials. The panel saw that ticks were recorded on the drug chart in the time column, but considered that the use of ticks was not consistent and sometimes the time was circled. The panel saw no information as to how to interpret this. It considered that the quality of the drug chart was poor and was inadequate to support the allegations.

With regard to the investigation report, the panel noted that the onsite pharmacist identified two missing signatures for drugs that had been given at 18:00, however this did not match the information on the drug chart.

The panel determined that, in light of a lack of reliable evidence, charges 7 and 8 are found not proved in their entirety.

Charge 9

'That you, a registered nurse

9. On 14 March 2019 in relation to Patient J:

a. Administered Enoxaparin that was not clinically prescribed.

b. Did not record the administration of Enoxaparin.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the information in the bundle and considered that there is no evidence that concerns this matter and Patient J on this date.

Accordingly, the panel found this charge was not proved.

Charge 10

'That you, a registered nurse

10. On 18 March 2019 when Patient I asked for assistance in putting the back of their bed up said 'do it yourself' or words to that effect.'

This charge is found proved.

In reaching this decision, the panel took into account the statements of Witness 1 and Witness 2, as well as Ms Buchanan's statement dated 22 March 2019, and the Patient Questionnaire Form (PQF) dated 18 March 2019.

The panel first had regard to the PQF, which rated the care received as 'poor', and which provides a contemporaneous account of the incident:

'Asked a nurse at 2am if she could put my back of my bed up as [I] was feeling uncomfortable + was told to do it myself in the dark as the light above my bed was not working.'

The panel also noted Ms Buchanan's statement in which she accepts that she told Patient I to put the back of their bed up themselves, and that she always advises patients to do this:

'She then asked me to raise her bed head and I located the bed buttons + she could adjust the bed to her comfort, that way she would be more comfortable rather than me guessing what would be comfortable for her. I always tell my patients that I will give the buttons to them and they can then adjust the bed accordingly.

I am sorry if the patient thought I was being rude this was not my intention.'

On the basis of this information the panel determined that Ms Buchanan accepts that she told Patient I to put their bed back up themselves and she has explained why she did this. The panel found this charge proved.

Charges 11 and 12

'That you, a registered nurse

11. On 23 March 2019 in relation to Patient J:

a. Administered Enoxaparin that was not clinically prescribed.

b. Did not record the administration of Enoxaparin.

12. On 24 March 2019 in relation to Patient J:

a. Administered Enoxaparin that was not clinically prescribed.

b. Did not record the administration of Enoxaparin.'

These charges are found proved in their entirety.

In reaching this decision, the panel took into account the statements of Witness 1 and Witness 2, as well as the incident report for drug error dated 23 March 2019, patient records for Patient J, and Ms Buchanan's statement dated 26 March 2019.

Noting that charges 11 and 12 concern the same patient and rely on the same evidence, the panel determined charges 11 and 12 together in their entirety.

The panel considered the following from Witness 2's statement:

'Gill was the nurse on nightshift who had been administering Enoxparin in 40mg injection form, to Patient J instead, Patient J had been prescribed Rivaroxaban, 10mg in tablet form… Gill had given Patient J the injections on two consecutive nightshifts, so on more than one occasion.'

The panel next took into account Ms Buchanan's statement:

'It was brought to my attention that I had given the Patient in room 25 on the 23 +24/3/19 Enoxaparin instead of the Rivaroxaban 10mg given.

I cannot answer why I gave the incorrect drug. I can only assume that I thought I was reading Enoxaparin.'

It also took into account Ms Buchanan's notes in the incident report:

'I gave Enoxaparin 40mg given instead of Rivaroxaban 10mg.'

The panel determined that Ms Buchanan has accepted that she administered Enoxaparin that was not clinically prescribed, and so found charges 11a and 12a proved.

The panel noted that on Patient J's records, Ms Buchanan's initials signed for Rivaroxaban. However, there is no mention of Enoxaparin on the record, so there was no way for Ms Buchanan to have signed for it as it had not been prescribed. Having found charges 11a and 12a proved that Ms Buchanan did administer Enoxaparin, the panel determined charges 11b and 12b as proved on the basis that the administration was not recorded.

Accordingly, the panel determined that charges 11 and 12 are proved in their entirety.

Charge 13

'That you, a registered nurse

13. On 30 July 2019 in relation to Patient K:

a. Did not introduce yourself when collecting the patient from theatre.

b. Did not provide water when requested.

c. Did not provide pain relief when requested.'

This charge is found proved in respect of charge 13b) and 13c), and NOT proved in respect of charge 13a).

In reaching this decision, the panel took into account the witness statements of Witness 1 and Witness 2, as well as the investigation report dated 2 August 2019.

The panel noted that the evidence for all sub-charges in charge 13 is the same, and concerns the same patient, so decided to determine charge 13 holistically.

The panel took into account Ms Buchanan's written statement in the investigation report and that she states, 'I brought [Patient K] back from theatre'. From this, the panel were satisfied that Ms Buchanan and Patient K had met, however the panel was of the view that there was no specific evidence to say that Ms Buchanan did not introduce herself. The panel also considered Patient K's handwritten statement in the report in which she refers to Ms Buchanan as 'Nurse Gill', which implies that she knew her name. On the basis of this, the panel determined that charge 13a) is not proved.

Regarding sub-charges 13b) and 13c), the panel took into account the following extract from Ms Buchanan's statement in the investigation report in which she accepts that she did not provide water or pain relief to Patient K when requested:

> *'I brought her back from theatre + did a set of obs and said I would get someone to take her some water. I asked one of the health care assistants to take some water into RM 2, unbeknownst to me this was not done.*
>
> *'The patient rang her bell and when I went in she again asked for some water, when I then got.*
> *'She also asked for pain relief and I said I would get some. I asked my colleagues but both of them were in the middle of helping patients, I then had to put some blood up, and completely forgot about the analgesia.*
>
> *I can only apologise for this, it was not my intention to leave the patient in pain…'*

Accordingly, the panel found sub-charges 13b) and 13c) proved.

Charge 14

> *'That you, a registered nurse*
>
> *14. On 31 July 2019, when instructed to administer a blood transfusion:*
>
> *a. Did not obtain patient consent.*

b. *Did not provide the patient with the information leaflet.*
c. *Did not assess for transfusion associated circulatory overload.*
d. *Did not record the baseline NEWS.'*

This charge is found proved in respect of charge 14c) and 14d), and NOT proved in respect of charge 14a) and 14b).

In reaching this decision, the panel took into account the statement of Witness 1, and an email from Witness 1 dated 31 July 2019.

The panel noted that the evidence for all sub-charges in charge 14 is the same, and so decided to determine charge 14 holistically.

The panel considered that the only evidence it has for this charge comes from just one person, Witness 1, and that there is no corroborating evidence. It also noted that in the email dated 31 July 2019 it reports Ms Buchanan challenges this fact and asserts that she did obtain consent from the patient and provide them with the information leaflet. This represents a conflict in evidence which the panel is not able to resolve based on this limited evidence before it. Accordingly, the panel determined that charges 14a) and 14b) are not proved.

Regarding charges 14c) and 14d), the panel took into account Witness 1's email:

> *'I asked if the patient had been assessed for TACO, Gill was unaware of this. Gill turned to the second page of the pathway and missed it. I asked if the baseline NEWS had been recorded, they hadn't.'*

The panel noted this was a contemporaneous account of the incident, and indicates that Ms Buchanan accepted that she did not assess for the Transfusion Associated Circulatory Overload (TACO) or record the baseline National Early Warning Score (NEWS). Accordingly, the panel determined charges 14c) and 14d) are proved.

Charge 15

'That you, a registered nurse

15. On 31 July 2019 did not record the administration of medication to Patient L without prompting by Colleague A.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1, as well as Witness 1's email dated 31 July 2019.

The panel had regard to Witness 1's statement, which states that Witness 1 shadowed Ms Buchanan directly and observed her failing to record the administration of medication. This account was documented in an email on the same day:

> *'Gill stayed until the medication was taken. Gill left the chart in the patients [sic] room. Gill did not sign to say she had administered the medication, I had to remind Gill to sign for the medication. Gill realised as soon as I said she needed to sign. I also reminded Gill to time the chart.'*

The panel considered that this was a contemporaneous account of the incident, and noted that Witness 1's evidence is not challenged by any other information in the bundle. Therefore, on the balance of probabilities, the panel determined that this charge is found proved.

Charge 16

'That you, a registered nurse

16. On 3 October 2019 in relation to Patient M

a. On being asked how they could get to the bathroom said 'hop' or words to that effect

b. Did not assist Patient M to the bathroom.

c. Did not secure Patient M's gown.'

This charge is found proved in respect of charge 16c), and NOT proved in respect of charges 16a) and 16b).

In reaching this decision, the panel took into account the statements of Witness 1 and Witness 3, as well as Witness 3's local statement dated 23 October 2019, Ms Buchanan's local statement dated 23 October 2019, the investigation notes dated 13 November 2019, and emails from Witness 1 dated 4 and 15 October 2019 regarding the patient complaint.

The panel noted that the evidence for all sub-charges in charge 16 is the same and concerns the same patient, so decided to determine charge 16 holistically.

The panel took into account that Patient M made their original complaint to Witness 3, who wrote a local statement detailing the incident. This was corroborated in Witness 1's email of 4 October 2019, drafted after she had spoken to Patient M.

The panel noted that, in her local statement, Ms Buchanan's account of the incident differs materially. Ms Buchanan says that she remembers Patient M, and that she supported her to use the bathroom:

> *'Some time after her return she rang to say she needed the bathroom, I asked the patient if she had been shown how to use crutches by the physio prior to theatre to which she replied no, I then said I would help her across to the bathroom and proceeded to help her sit up and then she stood, I took her arm and using me as a support the patient proceeded to hop over to the bathroom, at no time did I leave her to go into the bathroom on her own…*
>
> *I ensured that she was at down on the toilet and closed the door, telling the patient to ring me when she was finished so that I could help her back to bed. I got called outside the room to answer a query and when I re-entered the patients [sic] room she had made her own way back to bed and had not rung the bell.'*

Given the disparity between this account and that of the reported patient complaint, and that the panel were unable to test the conflicting evidence, the panel was not satisfied that the evidence was sufficient to find charges 16a) and 16b) proved. Therefore, the panel found these charges not proved.

Regarding charge 16c) that Ms Buchanan did not secure Patient M's gown, the panel considered this was likely to have happened, having regard to the undisputed circumstances of the incident that Patient M was in a hurry to get to the bathroom. The panel therefore found charge 16c) proved.

Charge 17a)

'That you, a registered nurse

17. On 4 November 2019

a. Did not escalate the deterioration of Patient N.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the statement of Witness 3, as well as the local statement of 27 November 2019, and Ms Buchanan's local statement dated 29 November 2019 (incident 1).

Based on the information before it, the panel was not satisfied that Ms Buchanan had a duty to escalate Patient N. The panel had regard to the local statement, which concerned a patient that had been transferred to Peterborough City Hospital (PCH): *'GB explained the patient had been deteriorating and needed a transfer to PCH'.*

The panel also noted Ms Buchanan's own contemporaneous account dated 29 November 2019 which stated:

> *'The RMO received the results…and said he needed to speak to the consultant and anaesthetist. A set of observations were done around 1400hrs and then the RMO said he wanted a chest xray [sic] taken. This was done and then the RMO said that the patient was to be transferred out at the request of the consultant.'*

The panel reviewed the statements and concluded that the escalation appears to have already happened and a transfer was taking place at the point that Ms Buchanan took over on the later shift. Accordingly, the panel found charge 17a) not proved.

Charge 17b)

'That you, a registered nurse

17. On 4 November 2019

b. Did not provide Patient N with oxygen.'

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3, as well as the notes of the meeting between Witness 3 and Ms Buchanan dated 17 January 2020.

The panel noted the following from the meeting notes, and that they were signed by Ms Buchanan:

'Gill thought at this point in time that the patient did not require oxygen and therefore the NEWS score would not alter and the patient would not require more frequent monitoring and so continued hourly observations were appropriate'.

Accordingly, the panel found this charge proved in that Ms Buchanan did not provide Patient N with oxygen as she did not believe it was necessary.

Charge 17c), d), e)

'That you, a registered nurse

18. On 4 November 2019

c. Did not take observations of Patient N.

d. Delegated observation tasks of Patient N to Colleague B.

e. Did not review observations of Patient N conducted by Colleague B.'

These charges are found proved.

In reaching this decision, the panel took into account the statement of Witness 3, as well as the local statement of Ms Buchanan dated 29 November 2019 (incident 1), and notes from a meeting between Witness 3 and Ms Buchanan dated 17 January 2020.

The panel noted that sub-charges 17c), d) and e) concern the same patient and rely on the same evidence and so decided to determine these sub-charges together.

In Ms Buchanan's local statement, she states that *'I was concentrating on getting everything ready for the transfer that I focussed on that and forgot to do subsequent observations.'*

The panel noted the following from the meeting notes, which were signed by Ms Buchanan:

> *'Gill asked for a health care support worker to carry out the patients [sic] next observations whist she prepared for the patients [sic] transfer. I asked if she was aware that these were not done completely. Gill did not know of this. I asked Gill to reflect on this to which she replied that it would have been good practice to have checked that these observations were done and the patient remained stable.'*

From this, the panel determined that Ms Buchanan did not take the observations of Patient N, instead delegated these to Colleague B, and did not review the observations once taken.

Accordingly, charged 17c), d) and e) are found proved.

Charge 18

'That you, a registered nurse

18. On 23 November 2019 in relation to Patient O:

a. Incorrectly administered a 10 mg dose of Oxycodone.

b. Incorrectly recorded the administration of Ondansetron.

c. *Administered Oxycodone earlier than the prescribed time'*

This charge is found proved in respect of 18a) and NOT proved in respect of 18b) and 18c).

In reaching this decision, the panel took into account the statements of Witness 3 and Witness 4, as well as the local statement of Witness 3 dated 26 November 2019, Ms Buchanan's local statement dated 29 November 2019 (incident 2), the local statement of Colleague A dated 27 November 2019, and the patient records of Patient O.

The panel noted that sub-charges 18a), b) and c) concern the same patient and rely on the same evidence and so decided to determine these sub-charges together.

The panel had regard to Witness 3's local statement, which provides a contemporaneous record of a phone call to the Ward Sister reporting drug errors, and that Ms Buchanan had administered the wrong dose:

> *'On Sunday 24/11/19, [Sister], advised me (by phone call) that she had found several drug errors that she had identified Gill Buchanan as doing. Unfortunately this included a controlled drug errors. I discussed this with Matron yesterday (Monday 25/11/19) who advised that she wanted Gill to not to dispense any further medications, pending an investigation.*
>
> *Issues found were*
> 1. *5mg of Oxycodone MR prescribed, 10mg dispensed*
> 2. *2 medications that were due to commence on the 24/11 were given on the evening of the 23rd*
> 3. *Drug chart documentation of a dose of oxycodone IR being given and it documented in the Ondansetron section – separate drugs, although the right dose and drug were given'*

The panel took into account Colleague A's local statement, in which she confirms that she and Ms Buchanan incorrectly administered Oxycodone. The panel also took account of Ms Buchanan's own statement in which she describes the incident in detail and concludes *'I do not know how we gave the wrong dose'.*

On the information before it, and taking into account that Ms Buchanan accepts that the Oxycodone was incorrectly administered, the panel determined sub-charge 18a) proved.

The panel determined that there was insufficient evidence in the bundle to support sub-charges 18b) and 18c).

The panel saw no mention of Ondansetron anywhere in Patient O's records, and so could not corroborate the indirect report of this issue raised by the Sister and given by Witness 3. The panel found sub-charge 18b) not proved.

The panel noted that Oxycodone is mentioned in the records, but that there is no signature on 23 November 2019, and so there is no corroborative evidence that it was given earlier than the prescribed time to support the indirect report of this issue raised by the Sister and given by Witness 3. Accordingly, the panel found sub-charge 18c not proved.

Charge 19

'That you, a registered nurse

19. On or around December 2019 did not show Patient P dignity'

This charge is found NOT proved.

In reaching this decision, the panel took into account the statement of Witness 1, as well as email correspondence regarding a patient complaint dated 9 December 2019.

The patient's email of 3 December 2019 contains a detailed complaint from Patient P alleging that Ms Buchanan was very rude. The panel noted that there is no other information about this incident in the bundle and that there is no answer from Ms Buchanan. The panel noted this incident was to be investigated internally, however it has seen no further evidence regarding this.

The panel was reluctant to rely too heavily on the account of Patient P, who mentions in their complaint that they were affected by strong painkillers at the time of some of the alleged behaviour: *'I was very out of it because of the morphine'.*

In the absence of sufficient evidence, the panel accordingly determined that this charge is not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Buchanan'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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Buchanan's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC advised the panel that it should have regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The panel had regard to the NMC's statement of case in which the NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") and submitted that Ms Buchanan had breached numerous sections. The panel had regard to the terms of the Code in making its decision.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The panel heard and accepted the advice of the legal assessor, which included reference to a number of relevant judgements. These included *Roylance*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***6 Always practise in line with the best available evidence***
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***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.*
> *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*

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

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

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

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13 Recognise and work within the limits of your competence

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

13.4 take account of your own personal safety as well as the safety of people in your care

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

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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

20 Uphold the reputation of your profession at all times

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

20.9 maintain the level of health you need to carry out your professional role'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went on to consider whether Ms Buchanan's actions as set out in each of the charges found proved were sufficiently serious to amount to misconduct.

In relation to **charge 1a**, the panel determined that this was so serious to amount to misconduct. The panel took into account that as a registered nurse Ms Buchanan should have been aware of the necessity of escalating concerns to the relevant person but despite her knowledge and understanding, she made the decision to comply with the wishes of the patient rather than to exercise her professional judgment. The panel determined that when there is a requirement to escalate this should be done so that the necessary treatment can be delivered to the patient should it be required. The panel concluded that by not escalating Patient A's condition to the medical officer, Ms Buchanan placed the patient at a risk of future harm and therefore found that her actions amounted to misconduct.

In relation to **charges 1b(ii) and (iii)** the panel concluded that Ms Buchanan's actions were sufficiently serious as to amount to misconduct. The panel considered that these relate to routine assessments which, if the condition of the patient dictates are required, then should be completed. Further, the panel considered that as a registered nurse, such assessments would have been common practice and therefore Ms Buchanan should have been able properly to perform these without issue and a failure to do so is demonstrative of a serious departure from what would be appropriate in the circumstances. The panel determined that Ms Buchanan had a duty to perform the bloods and ECG assessments and she failed to complete them which had the potential for serious consequences.

In relation to **charge 2a**, the panel was made aware that Ms Buchanan did record her observations but did so in the wrong place. The panel took into account that there is conflicting evidence as to why the observations were incorrectly recorded but Ms Buchanan alleges that she had completed her recordings in line with the way which she

was trained to do so. The panel determined that Ms Buchanan recorded the observations but failed to adhere to the correct protocol. It could not be satisfied that this was sufficiently serious an error to amount to misconduct.

In respect of **charges 2b and 2c**, these involve failure to record the administration of codeine, and an incorrect record of the time of administration of paracetamol. The panel determined that Ms Buchanan's actions as set out in these charges had the potential for extremely serious repercussions. The panel considered that other staff members reviewing Ms Buchanan's recordings of the medications administered would be solely relying on her entries and an inaccuracy in or complete lack of information could have had the potential for a risk of overdose for those patients. The panel concluded that this was a serious departure from the proper standards expected of a registered nurse and amounted to misconduct.

In relation to **charge 3**, the panel considered that Ms Buchanan described having made a mistake by giving one patient a discharge letter which belonged to another patient. The panel took into account that she provided an explanation of when and how she realised that she had made the error. The panel noted that her failures in this charge were an unintentional breach of patient confidentiality. However, the panel determined that it was a mistake which was not sufficiently serious to amount to a finding of misconduct.

In relation to **charge 5**, the panel considered the circumstances in which this occurred. Ms Buchanan explained that she had left the room to obtain a fresh gown for Patient E and accepted that the patient was left naked for a period of time. Although the evidence confirms that Patient E was left in the room naked by Ms Buchanan, the panel did not have evidence to suggest that it was anything more than an innocent oversight by Ms Buchanan. The panel did not find that her actions were sufficiently serious to amount to misconduct.

In respect of **charge 6**, the panel took into account that a patient had not received their anticoagulant medication as a result of Ms Buchanan's actions. It determined that this had serious potential consequences for the patient for whom it was particularly important for their post operative care that they receive their medication. The panel concluded that Ms Buchanan's actions were sufficiently serious to amount to misconduct.

In relation to **charge 10**, the panel considered that there is conflicting evidence in relation to the context of which this occurred. It noted that Ms Buchanan has suggested in her account that she often tried to encourage patients to adjust their beds themselves to ensure their comfort and that her actions were not intended to be rude to the patient. The panel found that this was a plausible explanation for why she acted in the way that she did and therefore concluded that it was not sufficiently serious to amount to misconduct.

In relation to **charges 11 and 12** the panel considered that Ms Buchanan's actions had the potential for very serious consequences for Patient J. The panel concluded that Ms Buchanan's placed Patient J at a serious risk of harm on two occasions by administering a medication which was not prescribed to the patient and further, not documenting that she had done so. The panel considered that Ms Buchanan's response to this error was *"I cannot answer why I gave the incorrect drug. I can only assume that I thought I was reading Enoxaparin."* [PRIVATE]. The panel concluded that these were serious departures from what would be expected of a registered nurse and amounted to misconduct.

In relation to **charges 13b and 13c**, the panel considered that there was a delay in Ms Buchanan providing water and analgesia to the patient. The panel noted that she had asked her colleagues for assistance with these requests by Patient K but concluded that it was her responsibility to ensure that these were provided whether it was provided by her or a colleague. However, the panel concluded that this was not sufficiently serious to amount to misconduct.

In relation to **charges 14c and 14d**, the panel considered that Ms Buchanan was responsible for assessing for the TACO and recording the baseline NEWS but failed to do so. It took into account that there has been suggestion by Ms Buchanan that she was not completely trained and confident to carry out these assessments. The panel determined that these assessments having not been completed had the impact to interfere with safe conduct of a blood transfusion. The panel concluded that Ms Buchanan's actions as set out in these charges were sufficiently serious to amount to misconduct.

In relation to **charge 15**, the panel noted this incident of failing to record the administration of a medicine. The panel noted Ms Buchanan was subject to supervision during the time of

this specific incident and should have ensured that no errors were made. The panel considered that, even having had the supervision in place, she failed to record the administration of medication, which presents serious patient safety risks, and had to be reminded to do so. The panel concluded that Ms Buchanan's actions as set out in this charge is sufficiently serious to amount to misconduct.

In relation to **charge 16c**, the panel considered the circumstances in which this had occurred. The panel took into account Ms Buchanan's own account of the incident, which was plausible and partially justified her conduct. The panel had no cause to doubt that she believed the patient was in a hurry to reach the bathroom and that delaying to secure the gown may not have been in the patient's best interests. The panel was not satisfied that this is sufficiently serious to amount to misconduct.

In relation to **charges 17b, 17c, 17d and 17e**, the panel considered that these involved a deteriorating patient who Ms Buchanan failed to monitor or provide oxygen to. Ms Buchanan made the decision to delegate certain responsibilities but did not check as she should whether they had been completed or not. The panel determined that the responsibility for care of this patient was Ms Buchanan's and she failed to ensure that care was provided. Ms Buchanan failed to fulfil her nursing obligations in respect of these charges and her actions were sufficiently serious to amount to misconduct.

In relation to **charge 18a**, the panel considered that Ms Buchanan administered the wrong dosage of Oxycodone to a patient. The panel concluded that the importance of administering the correct dosage of medications to patients is crucial to ensuring they are not placed at a risk of harm. Further, the panel considered that this was not a one-off incident in which Ms Buchanan has made a drug administration error and that she has made others as set out in charges 11 and 12 [PRIVATE]. The panel found that Ms Buchanan's failure was serious and amounted to misconduct.

The panel found that Ms Buchanan's misconduct involved wide-ranging failures, namely a failure to escalate the deteriorating condition of a patient, failures to complete routine assessments on patients where required, record keeping failures in that she either incorrectly recorded the drug administration or did not record it at all, failure to administer medication, failure to administer the correct medication and failure to administer the

correct dosage of medication. The panel found that Ms Buchanan's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Given its multiple findings of misconduct, the panel was unable to conclude that Ms Buchanan could practise safely or professionally.

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

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision on impairment. 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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) [...].'

The panel determined that limbs a, b and c of the "test" are engaged. The panel finds that patients were put at risk of harm as a result of Ms Buchanan's misconduct. Ms Buchanan's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel went on to consider whether Ms Buchanan was liable in the future to repeat her misconduct.

Regarding insight, the panel took into account that Ms Buchanan had made some admissions at a local level but it did not have any evidence that she has addressed her failures in relation to these proceedings. Ms Buchanan has not engaged with the NMC in relation to these matters. The panel considered that Ms Buchanan has not demonstrated

an understanding of why her actions were wrong and how these actions put the patients at a risk of harm. Ms Buchanan has not demonstrated an understanding of how this impacted negatively on the reputation of the nursing profession nor has she demonstrated what changes she would implement in her nursing practice to ensure that her failures would not be repeated. [PRIVATE]. However, despite having these issues which caused her difficulties including administering medicine, Ms Buchanan continued to undertake her nursing tasks and 'had to guess sometimes' when reviewing the charts. The panel determined that this demonstrated a willingness to engage in unsafe nursing practice.

The panel took the view that the examples of misconduct in this case would be capable of being addressed. However, the panel had no evidence before it that Ms Buchanan has taken steps to address her misconduct nor has she provided any evidence that she has tried to strengthen her practice.

The panel considered that Ms Buchanan's misconduct did not relate to a single incident but relates to multiple incidents over a period of some four years. The panel determined that Ms Buchanan's misconduct was indicative of a pattern of behaviour involving a departure from the proper standards of practice which had the potential to place patients at a risk of harm. For these reasons, together with Ms Buchanan's lack of insight and the lack of any evidence to strengthen practice, the panel concluded that there is a risk of repetition of Ms Buchanan's misconduct.

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 concluded there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Buchanan's conduct engages the public interest because the public expect nurses to carry out the

fundamental aspects of nursing, particularly clinical assessments, medication administration and record keeping; the absence of a finding of impairment in this case would risk undermining public confidence in the profession.

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, it finds Ms Buchanan's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to direct the registrar to strike Ms Buchanan off the register. The effect of this order is that the NMC register will show that Ms Buchanan has been struck-off the register.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 10 January 2024, the NMC had advised Ms Buchanan that it would seek the imposition of a striking-off order if it found Ms Buchanan's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Buchanan'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:

- That the misconduct in this case created a serious risk of harm to patients
- That the misconduct was repeated over a significant period of time
- That Ms Buchanan's practice did not improve after the findings of previous internal disciplinary hearings and meetings and supportive supervision
- That there has been a lack of engagement from Ms Buchanan in relation to these proceedings
- That it has seen no evidence of insight or strengthened practice from Ms Buchanan

The panel considered the mitigating feature that Ms Buchanan showed remorse regarding some concerns at local level in her discussions with Witness 1 and Witness 2. It also noted Ms Buchanan gave evidence in a disciplinary hearing at the Hospital that she had some mental health issues for which she had been receiving treatment.

The panel first considered whether to take no action, but concluded this would be wholly inappropriate, considering the nature of the conduct. It considered that there is a pattern of misconduct from 2015 to 2019 that has resulted in Ms Buchanan being placed on performance plans, warnings and a disciplinary hearing which eventually resulted in her dismissal. Despite the Hospital providing supportive measures and supervision to assist Ms Buchanan over the years, Ms Buchanan continued poor practise, which put patients at risk of harm. This sanction would not address the ongoing public protection concern, nor would it satisfy the public interest concern.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Buchanan'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 Ms Buchanan's misconduct was not at the lower end of the spectrum and

that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Buchanan'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 took into account the SG. The panel was of the view that the misconduct in this case would in theory be capable of being remediated through retraining and reflection. However, the panel has seen no evidence of a willingness from Ms Buchanan to strengthen her practice or reflect on it. Accordingly, the panel is of the view that there are no practical or workable conditions that could be formulated given that the charges pertain to numerous clinical errors, which were not remedied despite her employer's supervision and performance plans. Ms Buchanan has not engaged with the NMC in the context of these proceedings.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel has seen evidence that Ms Buchanan repeated clinical failures despite numerous local investigations and support from the Hospital. The panel considered that, besides a risk of repetition, this was also indicative of deep-seated attitudinal concerns [PRIVATE]. Further, the panel has not seen anything from Ms Buchanan as to her current insight or reflection into the incidents. The panel concluded that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Buchanan's actions. Hence, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Ms Buchanan's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Buchanan's actions were serious, and that she knowingly practised unsafely and was willing to do so. The concerns about Ms Buchanan's practice do raise fundamental questions about her professionalism.

The panel determined that to allow Ms Buchanan to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. She has, through her actions, risked bringing the profession into disrepute, by adversely affecting the public's view of how a nurse should conduct themselves.

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

The panel also took account of notes from a disciplinary meeting on 25 June 2020, in which Ms Buchanan's colleague informed the meeting that *'GB intends to finish her career later this year, and would like to finish her career here at the Fitzwilliam'.*

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

This will be confirmed to Ms Buchanan in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC inviting the panel to impose an interim suspension order to cover the appeal period.

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 due to cover the appeal.

If no appeal is made, then the interim suspension order will be replaced by the striking-off order 28 days after Ms Buchanan is sent the decision of this hearing in writing.

That concludes this determination.