Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 5 February 2024 –Thursday 15 February 2024
Wednesday 10 April 2024 - Friday 12 April 2024
Wednesday 19 June 2024 – Friday 21 June 2024

Virtual Hearing

Name of registrant:	Lata Teelokee
NMC PIN:	00I4273E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 22 September 2003
Relevant Location:	Bristol
Type of case:	Lack of competence/Misconduct
Panel members:	Sophie Lomas (Chair, Lay member) Sally Underwood (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	Alain Gogarty (5 - 15 February 2024) John Bromley Davenport KC
Hearings Coordinator:	Taymika Brandy (5 - 15 February 2024) Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Uzma Khan, Case Presenter (5 - 15 February 2024) Represented by George Hugh-Jones KC, Case Presenter (10 – 12 April 2024) Represented by Jemima Lovatt, Case Presenter
Ms Teelokee:	Present and unrepresented
Facts proved by admission:	Charges 1)a)i), 1)e),1)f),1)h)i),1)j)ii),1)j)iv), 1)l)ii), 1)l)iii),1)m) (in its entirety), 1,)o)i),1)p) (in its entirety), 1)q), 1)r)iii), 1)t), 2), 6), 8) and 11)

Offer of no evidence:	Charges 1)b), 1)c), 1)d), 1)g) (in its entirety), 1)h)ii), 1)i), (in its entirety), 1)j)i), 1)j)iii), 1)l)i), 1)l)iiii), 1)l)iiiii),1)n), 1)r)i), 1)r)ii), 1)s), 3), 4), 5) (in its entirety) 6), 7), 10),12),13),14), 15) and 16
Facts proved:	Charges 1)a)ii), 1)k)i), 1)k)ii), 9
Facts not proved:	Charge 1)o)ii)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (12 months)**

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

Ms Khan, on behalf of the Nursing and Midwifery Council ('NMC') made an application for parts of this hearing to be held in private [PRIVATE]. The application was made pursuant to Rule 19 (3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported this application.

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

Having heard there will be reference to [PRIVATE], the panel determined to go into private session as and when such matters are raised [PRIVATE].

Decision and reasons on application to amend the charge

Ms Khan made an application to amend charge 1)h)i) pursuant to Rule 28. She submitted that the proposed amendment is to correct a typographical error in the charge in respect of the named medication. She explained this medication is called *'Clexane'* and that the amendment would properly reflect the evidence in this case. Further, she submitted that allowing this amendment would not result in any unfairness or injustice to you.

<u>Original charge</u>

h. On 3 August 2019:

i. Failed to administer Clexone medication to a patient;

<u>Proposed amendment</u>

h. *On 3 August 2019:*

i. *Failed to administer ~~Clexone~~* ***Clexane*** *medication to a patient;*

You indicated that you supported this application.

In reaching this decision, the panel took into account the submissions made by Ms Khan and that you raised no objection to this application. The panel noted that this proposed amendment, as applied for, would properly reflect the evidence in this case and would correct a typographical error in the charge. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by allowing the proposed amendment. The panel therefore granted the application to amend the charge.

Details of charges (as amended):

That you, a registered nurse:

1) Between September 2018 and February 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Staff Nurse in that:

   a) On 21 November 2018:

      i) Failed to check APTT for a patient who was receiving IV Heparin blood thinners;
      ii) Failed to administer a patient's prescribed fluid bolus

   b) On 29 November 2018 failed to administer pain relief when requested by the patient.

   c) On 2 June 2019 failed to complete any paperwork for your shift.

d) On 14 June 2019 failed to handover a medication chart to colleagues on the next shift.

e) On 17 June 2019 administered a patient's medication 2 hours late.

f) On 01 July 2019 failed to administer a patient's prescribed dose of medication at 22:00.

g) On 25 July 2019:

i) Failed to administer a patient's prescribed dose of medication at 08:00;
ii) Administered 500mg of paracetamol to a patient when 100mg (1g) was required;
iii) Incorrectly signed the medication record indicating that 1g of paracetamol had been administered;
iv) Failed to comply with instructions from a physiotherapist to mobilise a patient.

h) On 3 August 2019:

i) Failed to administer Clexane medication to a patient;
ii) Failed to record reasons why the medication had not been administered.

i) On 4 August 2019:

i) Failed to continue the administration of a dextrose infusion to a patient who was on an insulin infusion;
ii) Failed to ensure a patient's PCA (Patient Controlled Analgesia) was connected and operating properly.

j) On 6 September 2019:

i) Failed to document a patient's GCS (Glasgow Coma Scale) score;
ii) Administered the patient's medication 1 hour late;

iii) Administered fluids 3½ hours late;
iv) Only recorded the patient's temperature once during your shift

k) On 21 September 2019 failed to change, when required, a patient's:

i) ART line transducer;
ii) Ventilator tubing.

l) Between 7 and 8 October 2019 failed to complete:

i) Catheter care plan;
ii) Skin care bundle after 02:00
iii) Pressure area medical device checklist after 01:00;
iv) Stool chart;
v) Food chart.

m) Between 4 and 5 November 2019:

i) Failed to complete the collar care plan
ii) Failed to complete the enhanced care paperwork.

n) On an unknown date in 2019 failed to check and/or notice that no fluid had drained from a patient's spinal fluid drain.

o) On 10 November 2019:

i) Failed to carry out regular pressure area care;
ii) Incorrectly prepared 13 units of insulin for a patient who required 25 units of insulin;

p) On 18 December 2019:

i) Failed to administer medication on time;

ii) Failed to document patient's fluid input and output every 2 hours.

q) On 9 January 2020 incorrectly reported a patient's GCS as 3 when the patient had a GCS of 10.

r) On 16 February 2020:

i) Failed to complete an adequate care plan;
ii) Failed to adequately plan and/or prepare for patient's care;
iii) Failed to provide adequate handovers.

s) On 3 March 2020 failed to complete care plans.

t) Between 20 July 2020 and 14 January 2021 completed only 1 of the 10 competencies required to practise as a theatre scrub nurse.

2) On 15 September 2018 left a patient who required enhanced care with a non-clinically trained colleague.

3) Between 28 and 29 October 2018 failed to communicate effectively and/or compassionately in that you were rude to a patient.

4) On 29 October 2018 failed to attend, without unnecessary delay, to a patient who required personal care.

5) On 29 November 2018 failed to communicate effectively and/or compassionately in that you:

a) Failed to introduce yourself to a patient;
b) Spoke harshly to the patient;
c) Failed to respond when told you were hurting the patient whilst re-positioning the NG tube.

6) On 22 March 2019 failed to adequately safeguard a patient's belongings when carrying out a patient transfer.

7) Between 10 and 11 April 2019 used physical restraints on all 4 limbs of a patient without clinical justification.

8) On 4 June 2019 failed to offer and/or provide toileting assistance to a patient.

9) On 13 June 2019 failed to re-position a patient for approximately 6 hours when the patient required re-positioning every 2 hours.

10) On 17 June 2019 failed to offer assistance to a patient in that you instructed the patient's relative to assist him with a sponge.

11) On 20 June 2019 failed to carry out enhanced care observations on a patient who required level 3 enhanced care observations every 15 minutes.

12) On 25 July 2019 failed to communicate effectively and/or compassionately in that you were rude and abrupt to a patient.

13) On 26 July 2019 failed to communicate effectively and/or compassionately in that you were abrupt to a patient.

14) On 2 September 2019 failed to inform a patient of your intention prior to administering a painful stimuli in order to assess consciousness level.

15) On 20 September 2019 failed to provide any care to a patient during your shift.

16) Between 23 and 24 September 2019 failed to respond to a patient's low oxygen alarm.

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

AND in light of charges 2 – 16 above, your fitness to practise is impaired by reason of your misconduct.

Background

You joined the Register in 2003 as a Registered Adult Nurse.

The NMC received a referral on 16 December 2020 from the Director of Nursing at North Bristol NHS Trust ('the Trust'). At the time of the concerns, you were employed at the Trust as Band 5 Nurse on the Intensive Care Unit ('ICU') from January 2018 - July 2020 and as a Band 5 Theatre Scrub Nurse from July 2020 - February 2021.
Whilst working on the ICU, [PRIVATE], you subsequently returned to work in August 2018. Upon your return to work on 28 August 2018, a Performance Improvement Plan was implemented to address the following issues: to follow [PRIVATE] policy; to accept criticism and support and reflect on own performance; to complete competences for IV's, arterial lines, bloods and tracheostomies; to ensure patients are not left alone; and to complete outdated e-learning. This Performance Improvement Plan was completed and signed off by your Line Manager at the material time, on 9 September 2018.

Colleague C became your Line Manager later in September 2018. It is alleged that a number of concerns occurred between September 2018 – February 2021 relating to patient care, communication with colleagues and patients, professional behaviour, medication management and administration and record keeping. The alleged concerns were reported to Colleague C by your colleagues, some of which were also raised by patients and subsequently reported by your colleagues. These concerns form the subject of the charges.

Between March and July 2020, the Trust decided that it was appropriate to remove you from the clinical environment due to a number of factors, namely, the Covid-19 Pandemic, your need for supervision and [PRIVATE].

On 20 July 2020, following mutual agreement between you and the Trust, you were redeployed from ICU and commenced a new role as a Band 5 Theatre Scrub Nurse.

You worked in this role till February 2021.You were placed on an 8-week Preceptorship programme whilst working supernumerary during this period. It is alleged that during this time, concerns were raised regarding your ability to work competently as a Theatre scrub nurse.

Throughout your time in both roles as an ICU Nurse and as a Theatre Scrub Nurse, you [PRIVATE].

Admitted facts

Prior to the commencement of the hearing, you indicated to the Case Presenter and Legal Assessor that you wished to make admissions to some of the factual allegations. You were provided with a copy of the charge sheet with your proposed admissions highlighted in yellow. Thereafter subject to one minor amendment you agreed that this document accurately set out the admissions that you wished to make.

The panel was provided with this document and you confirmed that this properly reflected the charges you wished to make admissions to, namely charges 1)a)i), 1)e),1)f),1)h)i),1)j)ii),1)j)iv), 1)l)ii), 1)l)iii),1)m) (in its entirety), 1,)o)i),1)p) (in its entirety), 1)q), 1)r)iii), 1)t), 2), 6), 8) and 11). You deny that your fitness to practise is impaired by reason of misconduct/lack of competence.

The panel accepted the advice of the legal assessor that included reference to Rule 24 (4) which states:

> *'(4)… the Chair shall enquire whether the registrant wishes to make any admissions— (a) as to the alleged facts; and (b) where the allegation is of a kind referred to in article 22(1)(a) of the Order, as to whether her fitness to practise is impaired'*

In accordance with Rule 24(5) the Chair announced that the facts of charges 1)a)i), 1)e),1)f),1)h)i),1)j)ii),1)j)iv), 1)l)ii), 1)l)iii),1)m) (in its entirety), 1,)o)i),1)p) (in its entirety), 1)q), 1)r)iii), 1)t), 2), 6), 8) and 11) were found proved by way of your admissions.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Khan pursuant to Rule 31 to admit the hearsay evidence exhibited and relied upon by Colleague C, namely, emails sent to Colleague C, detailing reports of alleged concerns by colleagues. She submitted that this evidence is relevant and contemporaneous to the events that occurred.

Ms Khan accepted that having heard the oral evidence of Colleague C regarding these alleged concerns and what was within her own knowledge and involvement, it is apparent that she predominantly seeks to rely on the accounts given to her by third parties set out in the above-mentioned emails. She submitted that Colleague C was responsible for collating information and that her evidence has been presented to the panel in this way.

Ms Khan submitted that Colleague C has been fair in providing an account which demonstrates that she was not involved in the alleged incidents and that she had explained in her oral evidence the limited extent she was involved and that she had not directly investigated the incidents reported to her. Further, she submitted that Colleague C has also given evidence in respect of her involvement with you and your Performance Management Plan. Ms Khan submitted that Colleague C had informed the panel that she was your Band 7 Line Manager, however there were also Band 6 Nurses that were involved in managing the day-to-day affairs.

Ms Khan acknowledged that on some occasions, there was a delay in reporting the incidents to Colleague C, however where this was the case, an explanation has been provided as to why that delay may have been caused. She submitted that notwithstanding this, the reports outlined in the emails include dates and the names of individual involved or identifiable information in respect of patients, such as reference to patient bed numbers. She submitted that the evidential value of these reports is significant. Further, she submitted that the reports of these incidents also contain specific details in respect of the charges.

Ms Khan invited the panel to consider the relevant principles as set out in the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), specifically, paragraph 45 and paragraph 56 when considering this application. Paragraph 56 states:

i. *whether the statements were the sole or decisive evidence in support of the charges;*

ii. *the nature and extent of the challenge to the contents of the statements;*

iii. *whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*

iv. *the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*

v. *whether there was a good reason for the non-attendance of the witnesses;*

vi. *whether the Respondent had taken reasonable steps to secure their attendance; and*

vii. *the fact that the Appellant did not have prior notice that the witness statements were to be read.*

Ms Khan addressed the panel on each of principles in paragraph 56 of *Thorneycroft*.

Ms Khan submitted that some of the evidence that Colleague C relies on is supported by the evidence of Colleague A, therefore, on some occasions Colleague C's evidence is not the sole or decisive evidence in support of a charge. She submitted that Colleague A was able to provide direct evidence in respect of the allegations that she was involved in. Ms Khan further submitted that Colleague C's evidence supports the account that you have shown a lack of competence over a period of time and the number of reported incidents evidence this. She submitted that although the authors of these emails have not been called, it does not mean that the panel are unable to consider the relevance and the importance of the accounts provided by them.

Ms Khan submitted that whilst it is detrimental to you, in that you are unable to cross-examine those who reported the incidents, the panel can still reflect a degree of fairness by taking this into account and subsequently attaching the appropriate weight to the evidence it has heard. She submitted that it would be prejudicial to the NMC if this evidence were not admitted, and this outweighed the prejudice to you if the evidence was admitted. She submitted that whilst it is accepted that Colleague C's involvement in respect of the local investigation of these allegations was limited, the panel may still take into account the evidence that was gathered.

Ms Khan acknowledged that you are unrepresented, however, she submitted that you have made some admissions to the allegations reported in the emails. She invited the panel to take into consideration your admissions to the factual charges when assessing the entirety of an email that might contain those allegations.

Ms Khan submitted that it is difficult to properly consider whether there was any suggestion that those reporting the incidents had reasons to fabricate their allegations as they are not present at the hearing. Notwithstanding this, she submitted that the authors of the emails are working professionals and whilst the panel are yet to consider your oral evidence, it has not been suggested at this stage that there was any unfair treatment of you to this effect. She invited the panel to consider the contemporaneous nature of these reports and the detail that has been provided in some of the emails.

Ms Khan submitted that these are serious allegations. Regarding whether there is a good reason for the nonattendance of those reporting the incidents, she stated that the authors of these emails were not called by the NMC to attend. She submitted that whilst there is not a clear explanation for this, taking into account the number and consistency of the allegations, she submitted that the NMC may have decided not to call these authors in view of an expeditious disposal of the case.

Ms Khan conceded that there is no evidence pertaining to whether or not the NMC had taken reasonable steps to secure the attendance of those that had sent the emails to Colleague C.

Ms Khan submitted that you were given prior notice of the three NMC witnesses that were due to attend and that only these three witnesses were to be called.

Ms Khan submitted that this hearsay evidence is highly relevant to the charges and invited the panel to consider whether, in the circumstances of this case, it is fair to admit this hearsay evidence. She submitted that the NMC's position is that it is both fair and relevant to admit the hearsay evidence and invited the panel to admit the evidence for the reasons set out above.

Whilst you made no formal submissions in respect of this application, you did explain that you had found cross-examination of Colleague C frustrating because she did not have direct knowledge of any of the allegations you were seeking to ask questions about.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor referred to the Judgment of Lord Justice Rimer in the case of *NMC v Ogbonna* [2010] EWCA Civ 1216 and to the cases of *El Karout v NMC* [2019] EWHC 28 (Admin); *Pope v the General Dental Council* [2015] EWHC 278 (Admin) and *Thorneycroft*, paragraph 56 (set out above) and paragraph 45, that states:

> *"1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in he case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."*

In reaching its decision, the panel had regard to the principles set out in the case *Thorneycroft* at paragraphs 45 and 56, and it also bore in mind that you are not legally represented at this hearing. The panel took into account the submissions made by Ms Khan, accepting that on initial assessment of Colleague C's witness statement, it would

appear that the witness had direct knowledge of the alleged incidents. However, the panel considered that during the course of Colleague C's oral evidence, it became clear that she was not a direct witness to the allegations, had not investigated any of the allegations and that she relies almost exclusively on the reports of incidents contained in emails sent to her.

The panel considered that many of the emails are the sole or decisive evidence in respect of the charges. The panel noted that the NMC have not called the authors of the emails exhibited by Colleague C to give evidence, and therefore, you are unable to cross examine these authors. The panel was of the view that this would result in unfairness towards you, as you contest some of the charges and this evidence cannot be tested. The panel acknowledged that whilst there has been no suggestion that the authors of these emails had reasons to fabricate their allegations, it had regard to the underlying context to these incidents, including that you had felt under close scrutiny by your colleagues. The panel noted that your colleagues had been requested to document and report any problems that they witnessed. Further, the panel bore in mind the seriousness of the charges alleged and the adverse effect it would have on you if these were proven.

The panel was not provided with any information regarding whether the NMC had made attempts to obtain witness statements or call the authors to give evidence; it acknowledged that Ms Khan conceded this in her submissions. The panel also took into account that the purpose of these emails was to report alleged incidents to be considered at a local level by the Trust. Notwithstanding that the reports make reference to times and dates relevant to the charges, the panel noted these were not intended for use at these regulatory proceedings and therefore, these emails do not contain signed declarations as opposed to the other witness statements before it.

The panel further noted it had no evidence from any local investigation and therefore, it had no material that it could use to test the accuracy of the information within the emails and the reliability of the author.

The panel therefore concluded that where an email is the sole and decisive evidence on a particular charge then it should not be admitted. The panel was of the view that admitting this hearsay material into evidence would be unfair and prejudicial to you

given the reasons set out above. The panel could not be satisfied that this evidence was demonstrably reliable or alternatively that there was some means of testing its reliability. In all the circumstances, the panel did not accede to this application.

Decision and reasons on application to offer no evidence

Ms Khan made an application to offer no evidence in respect of the charges that were subject to the sole or decisive hearsay evidence of Colleague C. She submitted that, in light of the panel's decision to not admit the hearsay material into evidence (as above), there is no longer a realistic prospect of proving those factual allegations.

Ms Khan outlined the background of this case and adopted her submissions in respect of the hearsay application above. She informed the panel of the NMC's decision to not obtain statements from the authors of the emails that were exhibited by Colleague C.

Ms Khan referred the panel to the NMC guidance titled 'Offering no evidence' ('the Guidance') (Reference: DMA-3) and took the panel to the parts of the NMC Guidance which are relevant to the circumstances of this case. She reminded the panel of its power to direct further investigation and to obtain further evidence and statements from the authors of the emails. However, she submitted that due to the passage of time since these allegations, a degree of sensibility should be applied in considering whether it is viable to ask these authors to recall these specific incidents and to produce a statement. In conclusion, she invited the panel to accept this application to offer no evidence as it is proportionate in the circumstances.

You did not oppose this application.

The panel accepted the advice of the legal assessor which included reference to the case of *Professional Standards Authority v NMC and X* [2018] EWHC 70 (Admin) and the NMC Guidance.

In reaching its decision, the panel took into account Ms Khan's submissions and her earlier submissions in respect of the hearsay evidence application. The panel had regard to the NMC Guidance, noting that the NMC Guidance states that offering no evidence will only be appropriate if:

'[…] the state of the evidence has changed since case examiners made a finding of case to answer

the charge relies on the evidence of a witness who cannot attend a hearing, and an application to rely on their statement as hearsay evidence has been rejected […]'

The panel bore in mind its earlier findings regarding the hearsay application and considered that the state of evidence had changed in that, as the case progressed, it became apparent that Colleague C had no direct knowledge of the alleged incidents. The panel also considered that it had not been provided with any evidence relating to any local investigation. Whilst the panel had determined to not admit the sole or decisive hearsay evidence of Colleague C, it noted that there remains sufficient evidence before it to consider in due course the other charges that you are contesting and some that you have admitted. The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the charges proved where Colleague C's inadmissible hearsay material was the sole or decisive evidence in respect of the charge.

The panel acknowledged its power to direct the NMC to conduct further investigations and its power to compel the attendance of witnesses. It notes that the subject matter of these charges arose from a referral made to the NMC on 16 December 2020. The witness statement of Colleague C is dated 22 August 2022, by that stage no witness statements had been taken from the authors of the emails that were the subject of the hearsay application. Thereafter, a decision was made within the NMC to rely largely on the witness statement of Colleague C and not to obtain any witness statements from the authors of the emails.

The panel has carefully considered this chronology of events so that it can make an informed decision whether or not to accept the NMC's proposal to offer no evidence in relation to those charges affected by the hearsay ruling. It has had the benefit of this case being opened to it and the opportunity to hear lengthy evidence from Colleague A and Colleague C. The panel noted that the emails ranged from 2018 to 2021, some over five years ago, and involved numerous persons with knowledge of discrete matters. The evidential position is further prejudiced by the failure to conduct a robust

internal investigation which would have enabled witness statements to be taken when matters were fresh in the potential witnesses' minds. Further, it would have afforded you an opportunity to give your account and/or explanation in relation to the concerns that had been raised.

The panel concluded that it would be neither realistic nor proportionate, at this stage, to require the NMC to investigate matters that go back to 2018-2021, given the passage of time and the absence of any investigation at the material time. The panel acknowledged the adverse effect that the passage of time would have on the ability of witnesses to accurately recall events. The panel further concluded that the overarching objectives of public protection and maintaining public confidence in the profession can still be achieved by its consideration of the substantial number of remaining allegations.

Accordingly, the panel acceded to the NMC's application to offer no evidence in respect of the charges particularised above.

This hearing went adjourned part heard on 15 February 2024. The hearing resumed on 10 April 2024.

Decision and reasons on facts

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

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:

- Colleague A: Band 6 registered nurse who worked with you on the ICU.

- Colleague C: Band 7 registered nurse who was your line manager at the material time.

The panel also heard evidence from you under affirmation.

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

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

Charge 1)a)ii)

> "1) Between September 2018 and February 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Staff Nurse in that:
> a) On 21 November 2018:
> ii) Failed to administer a patient's prescribed fluid bolus"

This charge is found PROVED.

In reaching this decision, the panel took into account Colleague A's evidence and your evidence.

The panel accepted that you were the nurse in charge of a patient on 21 November 2018 who required a fluid bolus. The panel was of the view that administering the fluid bolus was within your remit, responsibility and capability as a Band 5 registered nurse.

The panel considered Colleague A's evidence. In her NMC witness statement she stated:

"The registrant was on the day shift on 21 November and I came on the night. … On the registrant's other patient there was a fluid bolus that had been prescribed but not given. When the nurse checked with the doctor the fluid bolus had been prescribed on the morning ward round and the doctor had told the registrant about the bolus needed… it was noticed by the nurse at evening handover that fluids had been prescribed but not given."

The panel had regard to an email sent by Colleague A to Colleague C dated, 30 November 2018. The panel noted that this email was sent nine days after the incident. The email stated *"Lata was on the day shift of November 21st and I came on the night… On her other patient, there was a fluid bolus that had been prescribed but not given. When the nurse checked with the doctor the fluid bolus had been prescribed on the morning ward round and the doctor had told Lata about the bolus needed. Both her patients had incomplete paperwork. I spoke to Lata the next day about the mistakes and she just said she forgot."*

The panel considered your evidence. It noted that you did not dispute that you were caring for the patient that day and that the fluid bolus was orally prescribed. You stated in your oral evidence that two nurses were required to administer the fluid bolus however everyone was busy and could not assist you. You also stated that the doctor had told you about the fluid bolus but he had not prescribed the fluid bolus for you to administer it. You further stated that the doctor had put the prescription in the medical notes rather than the nursing notes and so, you had not seen it.

The panel noted that you did not escalate that you thought the prescription for the fluid bolus had not been written despite knowing that it needed to be administered to the patient. You denied that you said to Colleague A at the material time that you 'forgot' to administer the fluid bolus. The panel found that you have provided several different accounts and that your evidence was inconsistent. You did however accept that you were responsible for giving the fluid bolus and had not done so.

The panel considered the evidence before it and determined that on 21 November 2018, you failed to administer a patient's prescribed fluid bolus. The panel therefore find this charge proved.

Charge 1)k)i) and ii)

> "1) Between September 2018 and February 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Staff Nurse in that:
> k) On 21 September 2019 failed to change, when required, a patient's:
> i) ART line transducer;
> ii) Ventilator tubing."

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Colleague C, Colleague A and your evidence.

The panel considered the evidence of Colleague C. She stated in her NMC witness statement *"On 21 September 2019, another example of the registrant's failure to provide suitable patient care was reported. On that date, the registrant had not changed a patient's ART line transducer or ventilator tubing when it was out of date and should have been changed, but she did change the patient's catheter bag which was not due to be changed."*

The panel considered the evidence of Colleague A. In her NMC witness statement she stated

> *"I was working a shift with the registrant. During the shift the registrant didn't change the ART line transducer or ventilator tubing on her patient when it was out of date.*
>
> *An ART line transducer is what we use to measure blood pressure… The line has to be changed every 72 hours.*

On the giving set a sticker is placed with the date so it's easy to see when the line needs to be changed. This information is also recorded on the patient's chart.

The issue was that the registrant hadn't changed the label, the label was still from the 72 hours previously. This meant that the registrant hadn't changed the line because the sticker was stuck on the line which is the part that needed to be changed.

It was the night nurse who informed me of the error and the 72 hour period had just ended when the error was discovered. The transducer needed to be changed in line with Trust policy…"

The panel had regard to an email from Colleague A to Colleague C, dated 21 September 2019. The panel noted that this email was sent on the same day as the incident. The email stated *"Just to say on the 21st of Sept Lata didn't change the ART line transducer or ventilator tubing on her patient when it was out of date. She did change the catheter bag which had only been changed the day before and had been dated so unsure why it was changed."*

The panel had regard to Colleague A's oral evidence. In respect of the ART line transducer, charge 1)k)i), she said *"…that has to be changed every 72 hours and the ventilator tubing, we change every seven days… On the actual giving set that connects the bag of saline to the arterial line, there's a sticker that goes on it and it says the date that it was changed and it's part of our checks. Every day we then check that that's in date and we also on our ICU charts that we used to use there would be space for where lines were going out date and it would be documented there what date the lines were gone in….And it's part of our safety checks that we sign for it start of our shift to say that we've checked that everything's in date."*

When Colleague A was asked if the sticker's placement would then give an indication as to whether or not the line has actually been changed, she stated "*it couldn't have been*

changed and not labelled … because the old label was stuck to the bit needed changing."

In respect of the ventilator tubing, charge 1)k)ii), Colleague A said she knew that the ventilator tubing had not been changed a*s "that's dated the same, it has a sticker put on it and it's also documented on the ICU chart when it's changed. So there's two places of documentation"* Colleague A accepted that there is normally a longer period before the ventilator tubing would need to be changed but on this day both were due to be changed. Colleague A stated that ventilator tubing needs to be changed every seven days.

The panel had regard to your evidence. In what appears to be your response to the charges, you state in relation to 'September 2019, k) i) and ii)', *"Everything was changed by the previous staff but she did not sign but handed over to me that only the catheter line was meant to be change. (I followed the handing over and at the end of my shift I got complaint that I did not change the lines arterial line transducer and the ventilator tubing). I was hoping to get the staff to sign it but he was the agency staff."*

In your oral evidence, you stated that you agreed that the ART line transducer needs changing every 72 hours. You stated that the sticker says when it has expired and that there is separate documentation which says when it should be changed. You stated that the agency nurse told you that she had changed it along with the ventilator tubing on the previous shift but that you did not check the sticker. You said that you did check the documentation was signed for and stated that it was fine. You said that if the ART line transducer or the ventilator tubing was wrongly dated then you would have checked with the agency nurse, but you could not do so as you did not have their telephone number. You stated that Colleague A got it wrong, and that the documentation was fine; it was signed for by two people. You said sometimes when doing night shift staff get confused with the dates. You said that this was for the agency staff to complete. You accepted that it was your job to check the documentation which you said you did, and you saw it was signed for. You said that it was an important job.

The panel had regard to your written response to the NMC and your oral evidence. From those two pieces of evidence, you have presented conflicting accounts. The panel noted that whilst you were on shift on 21 September 2019, you did not raise any issues regarding an incorrect date being recorded or needing to contact the agency staff for further follow up on the documentation they completed. The panel considered that if there had been any issues noted by you in relation to incorrect dates or missing signatures, this would have been escalated during that shift. The panel had no evidence before it that it had been escalated. The evidence, in fact suggested that you were unaware of any issue until it was pointed out the following day. On that basis, the panel did not find your explanation plausible. The panel found that on 21 September 2019 you failed to change, when required, a patient's ART line transducer and ventilator tubing. The panel therefore determined charges 1)k)i) and 1)k)ii) proved.

Charge 1)o)ii)

> "1) Between September 2018 and February 2021 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Staff Nurse in that:
> o) On 21 September 2019 failed to change, when required, a patient's:
> ii) Incorrectly prepared 13 units of insulin for a patient who required 25 units of insulin"

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Colleague C, Colleague A and your oral evidence.

The panel considered Colleague C's evidence. In her NMC witness statement, she stated *"On 10 November 2019, … When preparing Insulin for which a prescription*

required 25 units, the registrant drew up 13 units. Her colleague advised that it was only 13 units, however, registrant insisted it was 25."

The panel considered an email from Colleague A to Colleague C and other colleagues dated 10 November 2019 which states *"[Lata] checked insulin with [Colleague E] that was supposed to be 25 units and Lata had drawn up 13 units. [Colleague E] said that you've only drawn up 13 units but Lata said its 25 units so [Colleague E] just topped the insulin up to 25. I haven't discussed this with Lata as I never got that far in my meeting with her due to her reaction."*

The panel considered Colleague A's oral evidence. She repeated the information in her NMC witness statement but then stated that she was not present at the material time of this incident and that Colleague E had told her about it after it occurred. The panel noted that this was the only evidence in relation to this charge.

The panel considered your oral evidence. You stated that another nurse asked you check insulin with her. You said that you drew up the insulin but at the same time the nurse in charge, Colleague A, told you that she needed to speak with you. You said that this is when the other nurse said she could manage. You said that you did not finish drawing up all of the insulin so she (the other nurse) must have checked it with someone else before giving the patient the insulin.

The panel considered that the sole and decisive evidence provided by the NMC in relation to this charge was hearsay evidence. The panel bore in mind the nurse who you handed over this task to, Colleague E, had not provided a statement and was not at the hearing and you therefore did not have the opportunity to cross examine or test her account. The panel considered that in respect of this charge there was insufficient evidence before it. The panel therefore found this charge not proved.

Charge 9

"On 13 June 2019 failed to re-position a patient for approximately 6 hours when the patient required re-positioning every 2 hours."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague C, Colleague A and your oral evidence.

The panel considered the evidence of Colleague C. In her NMC witness statement she stated:

> *"I exhibit a statement from [Colleague D] …, in which she explains how, on 12 and 13 June 2019, a patient cared for by the registrant reported pain due to not being moved overnight (approximately 6 hours). This omission carries a risk of creating pressure sores, and it must be recorded every day. It is rare for a patient such as this one not to be high risk, in which case they would have to be moved every 2 hours. The registrant did not record any such movement after 23:00 until her shift ended in the morning."*

Colleague C exhibited Colleague D's local statement which stated:

> *"Our long stay patient in Pod D had reported to myself and the doctors that she was not happy with the nurse that was looking after her on the night of 12th, 13th June, one of the points that she had been raised was she was in a lot of pain due to not being moved all night. It was Lata that was looking after her on those nights, she had failed to document on both the patient chart and the pressure area care chart any turning of her patient from 23:00hr onwards."*

The panel considered the evidence of Colleague A. In her NMC witness statement she stated:

"Also the registrant's patient was in tears to the day nurse that she hadn't been rolled for 6 hours during the night shift. It was documented on the ICU chart was that patient had been on her back for 6 hours.

Patients should be rolled every 2 hours. If they are independent and can roll themselves that's fine and we would document independent movement but otherwise we have to move the patient every 2 hours to stop pressure sores and to check they are clean. This patient distressed as she couldn't move herself. The registrant would have been aware that the patient needed to be moved as it was documented in the patient's notes."

The panel had regard to an email from Colleague A to Colleague C (and other colleagues), dated 10 November 2019, which states:

"On the night shifts of the 12th and 13th June Lata looked after a patient … her patient was in tears to the next day nurse that she hadn't been rolled for 6 hours during the night shift. Documented on the ICU chart was that patient had been on her back for 6 hours…"

The panel had regard to Colleague A's oral evidence. She said that *"as I went to leave from handing over at the whole pod then the I could hear a patient was crying to her day nurse and she was just very upset that she hadn't been moved for six hours and was just very uncomfortable…"* Colleague A confirmed in her oral evidence that his particular patient should be rolled every two hours, and this was the policy on this ward.

The panel considered your oral evidence. You accepted that you had not rolled the patient and that the patient needed repositioning every two hours and three colleagues (in total) were required to turn the patient. You stated that you had called your colleagues to assist you, six times over six hours however you were unable to get assistance. When responding to panel questions, you stated that you had not documented this, or any reason, why the patient had not been repositioned on the records. Nor did you mention this at handover. The panel was of the view that even if

you could not get assistance, it remained your responsibility to ensure that the patient was repositioned every two hours and to document your attempts to do so.

The panel considered the evidence before it and concluded that on 13 June 2019, you failed to re-position a patient for approximately 6 hours when the patient required re-positioning every 2 hours. The panel therefore find charge 9 proved.

This hearing went adjourned part heard on 12 April 2024. The hearing resumed on 19 June 2024.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted

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

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

Query from the panel

Before hearing submissions in relation to lack of competence, misconduct and impairment, the panel queried with Ms Lovatt as to why charge 1 was charged as lack

of competence and the remaining charges were charged as misconduct. The panel noted that the misconduct and lack of competence charges were similar in nature.

Ms Lovatt explained that the lack of competence charges were clinical issues that the Trust was aware of and that you were subject to an improvement plan throughout this time period to see if your nursing practise could be improved. She submitted that it would be disproportionate to charge them as misconduct as there was a recognised issue which were being addressed in a supportive environment.

Ms Lovatt submitted the remaining charges fall outside of the clinical improvement plan. She submitted that the misconduct charges focus on your interaction with patients, patient care, safeguarding issues and non-clinical care.

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 practice.'*

Ms Lovatt invited the panel to take the view that the facts found proved in charge 1 amount to a lack of competence. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision. She identified the specific, relevant standards where your actions amounted to a lack of competence. She submitted that the facts found proved in charge 1 show that your competence at the material time was unacceptably below the standard expected of a Band 5 registered nurse, based on a fair sample of your work. This could have put patients at risk. She submitted that your conduct in this charge took place over a period of time and that it could not be said that this was a one-off incident which supports a finding of lack of competence.

You said that you have tried your very best to give your patients the care they needed. You said that due to staff shortages complaints started to accumulate against you and made you look as though you are not fit to practise. You stated that you are a good nurse. You noted that you have accepted some of the charges and that you should have escalated issues as soon as possible which you have learned for the future.

Submissions on misconduct

Ms Lovatt referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Lovatt invited the panel to take the view that the facts found proved in charges 2, 6, 8, 9 and 11 amount to misconduct. She referred the panel to the Code in making its decision and identified the specific, relevant standards where your actions amounted to misconduct. She referred the panel to the relevant guidance. She submitted that your actions in each charge, admitted and found proved, placed people receiving care at risk which, if discovered, would undermine the public's trust and confidence in all nurses.

You repeated your earlier submissions in that you said you have tried your very best to give your patients the care they needed. You said that due to staff shortages complaints started to accumulate against you and made you look as though you are not fit to practise. You stated that you are a good nurse. You noted that you have accepted some of the charges and that you should have escalated issues as soon as possible which you have learned for the future.

Submissions on impairment

Ms Lovatt 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. Ms Lovatt referred the panel to the

relevant NMC guidance. She also applied the principles outlined in the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin) to this case.

Ms Lovatt submitted that the panel will need to consider your insight and steps that you have taken to strengthen your practice. She referred the panel to your reflective statement in your response bundle, noted that you accepted a number of charges, that you have expressed remorse for the impact of your actions and you have identified some improvements that you have made which should benefit your practice. However, she submitted that your behaviour did not arise in unique circumstances and a number of incidents took place over a period of time which suggests a risk of repetition in the future.

You stated that whilst you were working you kept up to date with your training but accepted that there were sometimes delays. You provided the panel with documentation demonstrating some of the competencies you completed whilst in employment in the Trust. You stated that you have done communication training, in your own time, to improve your communication with your patients. You noted that you were [PRIVATE] placed on the performance plan in 2019. [PRIVATE]. You explained that after each shift you had a discussion about how the shift went and you said to the panel that you felt the improvement plan put pressure on you due to being constantly monitored. You said ultimately, you were suspended.

You told the panel that you love being a nurse. You said that you have found it difficult to get a job at the moment as employers want to know why with your training and experience, you want to work as a care assistant. You said that your work recently has been related to computing and business administration and you have undertaken some training in various fields since your suspension.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

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:

8.2 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

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

The panel noted that breaches of the Code do not automatically result in a finding of lack of competence and/or misconduct.

The panel bore in mind, when reaching its decision, that you 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 the charges found proved in charge 1. The panel noted that some of the sub charges in charge 1, in isolation, do not amount to a lack of competence. The panel took into consideration that you were practising under a performance management plan with support and monitoring from your colleagues and the Trust, however concerns with your practice still occurred. It noted that you felt that the performance plan made you feel nervous. It took into consideration that you are an experienced intensive care nurse who was caring for only one patient per shift, who typically had the least serious medical issues, as you had a reduced workload. In addition these incidents took place over a significant period of time.

The panel concluded that your practice was below the standard that one would expect of the average registered nurse acting in your role in that you did not have an adequate level of knowledge, skill and judgment for your job. The panel therefore concluded that your performance demonstrated in charge 1, when considered collectively, amounts to a lack of competence.

The panel considered your conduct in charges 2, 8, 9 and 11. The panel noted that your conduct in these charges demonstrated a disregard for the safety of patients and that you did not prioritise patients, did not escalate concerns for these patients appropriately, and demonstrated poor judgment and communication. It had regard to Colleague C's witness statement, she stated *"…I requested the registrant attend a communication course because I was concerned she wasn't communicating effectively with staff and patients. Sometimes if we need help, we need to be assertive to ensure that we actually*

get it and the registrant lacked this skill, she was always very quiet and would try and manage on her own. Communication with patients was a reoccurring theme as will be discussed in this statement, I don't think the registrant was ever purposely unkind to patients I just don't think she knew how to communicate with them effectively." The panel was of the view that your conduct was not an isolated incident and demonstrated a pattern of behaviour. The panel was of the view that you did not maliciously disregard patient safety or have any intent to cause patient harm. Nonetheless your actions put patients at risk.

The panel concluded your conduct in charges 2, 8, 9 and 11, when considered collectively, are serious enough to amount to misconduct.

The panel was of the view that your conduct as outlined in charge 6, where you failed to adequately safeguard a patient's belongings when carrying out a patient transfer, was not serious enough to amount to misconduct. It noted that you were with another member of staff who was supervising you and who had also forgotten the patient's belongings.

The panel found that your actions did fall seriously short of the standards expected of a registered nurse and that your conduct in charges 2, 8, 9 and 11 amount to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence and misconduct found, your 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/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 found limbs a, b and c of Dame Janet Smith's "test" were engaged in this case.

The panel found that patients were put at an unwarranted risk of harm due to your lack of competence and misconduct. Your 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 your insight is developing. It noted your admissions to some of the charges and that in one of your early reflective accounts to the NMC you stated *"Yes, I could have done things differently by accepting that I did need support and help from my work. [PRIVATE]."* The panel was of the view that this demonstrated your insight into the difficulties you faced at the material time.

The panel also noted that you have demonstrated a limited understanding of how your actions put the patients at a risk of harm, why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. It noted that you have shown remorse for your actions however during the hearing you have sought on occasion to blame the supervision and monitoring by your colleagues during your personal development plan for your continued mistakes.

The panel noted that a significant period of time has passed since this reflective statement was submitted. It took into account that it had no recent reflective accounts from you that demonstrate how your insight has developed, in relation to why these

incidents occurred at the material time and [PRIVATE], since a referral was first made to the NMC about your practice. [PRIVATE].

The panel was satisfied that the lack of competence and misconduct charges in this case are capable of being addressed. It noted that the concerns identified are related to your clinical practice. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you provided training competences which you successfully completed whilst you were working in the Trust dated 2018 and 2019. It bore in mind that it had no evidence of any relevant recent training that you had successfully completed.

The panel took into consideration that you have not worked as a nurse for a number of years, and it had no evidence before it of how you have retained your nursing skills. It noted you have sought work as a health care assistant but have been unsuccessful in your attempts.

The panel was not satisfied that you could currently practise safely and professionally without restriction. It was of the view that there is a risk of repetition based on your still developing insight and the lack of evidence before it that you have strengthened your nursing practice in relation to concerns identified. 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 are 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, which 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, in this case, a finding of impairment on public interest grounds was required. It bore in mind that the patients and their family members had expressed concerns with your nursing practise. The panel took into account that the issues of clinical competence, as identified in this case, would undermine the

confidence in the nursing profession if left unaddressed. The panel was of the view that members of the public would expect that nurses on the NMC register are able to practise safely, competently and effectively.

The panel therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Lovatt invited the panel to impose a conditions of practise order for a period of 12 months in light of the finding that your fitness to practise is currently impaired. She outlined the aggravating and mitigating features of the case. She provided submissions in relation to the appropriateness of each sanction that is available to the panel.

You accepted that you made some errors in your nursing practice. You accepted that whilst you are not perfect, you are a good nurse. You stated that you would not make these same mistakes in the future and you would like to return to nursing as soon as possible. You said that you never intended to harm your patients. You said that this process has been difficult for you. You stated that you were willing to complete any training as required to ensure that your patients were in a safe environment under your

care so that you could return to nursing. You said that you were willing to comply with a conditions of practise order to return to nursing.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of wide-ranging clinical mistakes over a period of time whilst receiving support and supervision.
- Your conduct put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- [PRIVATE]
- You made early admissions to the majority of charges.
- Remorse
- You have had a long period of safe and effective practice prior to these incidents.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the*

spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that your lack of competence and misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that other than these incidents, you have had an unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. You have expressed a willingness to strengthen your nursing practice with the appropriate safeguards in place. The panel was of the view that a suspension order or a striking-off order would not allow you the opportunity to address the concerns that have been identified in this case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse. Further, the panel was of the view that it is in the public interest to return a good nurse back to safe and effective nursing practice.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must limit your nursing practice to one substantive employer.
>
> 2. You must ensure that you are supervised any time you are working. Your supervision must consist of:
>   - Working at all times on the same shift as, but not always directly observed by, a registered nurse of Band 5 or above.
>
> 3. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about

- Communication with patients and colleagues
- Documentation
- Medication administration
- Escalating concerns
- Assertiveness and resilience

You must:

- Send your case officer a copy of your PDP seven days before any NMC review hearing.
- Send your case officer a report from your line manager, mentor or supervisor seven days before any NMC review hearing. This report must show your progress towards achieving the aims set out in your PDP.

4. You must engage with your line manager, mentor or supervisor on a frequent basis to ensure that you are making progress towards the aims set out in your PDP, which include:
    - Meeting with your line manager, mentor or supervisor at least every month to discuss your progress towards achieving the aims set out in your PDP.

5. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.

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

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

8. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months. The panel was of the view that this would provide you with sufficient time to strengthen your practice and work towards the areas identified in the conditions of practice order.

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

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC and future attendance at any NMC hearing.
- A reflective statement covering the following areas:
    - How your actions put the patients at a risk of harm.
    - The impact your actions had on patients, colleagues and the reputation of the nursing profession.
    - [PRIVATE].
- The completion of any training which is relevant to the concerns identified.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Lovatt. She submitted that an interim conditions of practice order was necessary on the ground of public interest and

public protection to cover any potential period of appeal. She invited the panel to make an interim order for a period of 12 months.

You said that you understood the need for an interim order.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 12 months to cover any potential period of appeal.

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

That concludes this determination.