Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 16 May 2024 – Friday 17 May 2024

Virtual Meeting

Name of Registrant:	Karen Faith Campbell
NMC PIN	90D0317E
Part(s) of the register:	Registered Nurse (Sub Part 2) RN2: Adult nurse, level 2 (2 June 1992) Registered Nurse (Sub Part 1) RN1: Adult nurse, level 1 (19 September 1998)
Relevant Location:	Cheshire
Type of case:	Misconduct
Panel members:	Rachel Forster (Chair, lay member) Pam Campbell (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Simon Walsh
Hearings Coordinator:	Catherine Blake
Facts proved:	Charge 1a, 1b, 1c i, 1c ii, 1c iii, 1d, 2 (in its entirety), 3 (in its entirety)
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel had regard to the signed witness statement of the case officer, which stated:

> *'On 10 April 2024, I sent a notice of meeting to the above home address informing them of the meeting taking place on or after 14 May 2024. I attach a copy of the letter I sent as exhibit 3.'*

The panel also had sight of a Royal Mail 'Track and trace' printout showing that a delivery to Ms Campbell's home address was signed for on 12 April 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, date and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Ms Campbell 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 1 August 2022 failed to ensure Patient A's safety in that you:
    a. Failed to carry out clinical observations during your initial visit;
    b. Failed to promptly call the co-ordinator for assistance or advice during your initial or subsequent visit;
    c. Failed to manage/ escalate the care of Patient A in that you failed to:
        i. Promptly inform Colleague A of Patient A's deterioration when you returned to the office/during handover, following your initial visit;
        ii. Promptly call a GP during or following your visit/s;
        iii. Promptly call an ambulance during or following your visit/s;
    d. Failed to 'ACT NOW' in accordance with the NEWS2 guidelines.

2. On 1 August 2022, you failed to make a clear and accurate record of your visits to Patient A on EMIS, in that you recorded:
    a. one visit when you had made two visits;
    b. that you had taken observations at 12.30 when you had not;
    c. that you had left Patient A in the care of his father at 12.30 when you had not;
    d. that you had called 999 at 12.30 when you had not.

3. Your actions as specified at any of the charges at 2a. – 2d. above were dishonest, in that you intended to mislead others to believe that you:
    a. had carried out one visit to Patient A when you knew that you had carried out two visits;
    b. That you had carried out observations at 12.30 when you knew that you had not;
    c. That you had left Patient A in the care of his father at 12.30 when you knew you had not;
    d. That you had called 999 at 12.30 when you knew you had not.

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

Background

The charges arose whilst Ms Campbell was working as a community nurse with Alderley Edge Medical Centre ('the Medical Centre'), employed via Langley Clark Agency ("the Agency"), on behalf of East Cheshire NHS Trust ('the Trust') when the events giving rise to this investigation arose.

It is alleged that on 12 August 2022, Ms Campbell attended Patient A at their home. Ms Campbell failed to escalate Patient A who had signs of clinical concern; Patient A was oedematous, filling up with fluid, looking unwell, grey and their fingertips were cyanosed.

At the handover at the Medical Centre, Ms Campbell was asked if she had taken observations and what she had done to escalate the situation; Ms Campbell responded that she had no equipment other than a thermometer so had returned to the Medical Centre. Ms Campbell was given equipment and was told to visit Patient A again urgently for observations and to escalate the matter to a General Practitioner (GP).

Ms Campbell visited Patient A and on her return to the Medical Centre, advised that Patient A's oxygen saturation level was 76%, i.e. very low. Ms Campbell had not called 999 and said that she had left Patient A in the care of their father. Ms Campbell was told to call 999.

The clinical records made by Ms Campbell on the Egerton Medical Information System (EMIS) record a single entry timed at 12:30 that observations had been taken.

Decision and reasons on facts

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: Colleague A, Community Caseload Holder at the Trust at the time of the incident acting as co-ordinator.
- Witness 2: District Nurse at the Medical Centre at the time of the incident.

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

The panel also noted that in the statement of case there were quotations from an undated document containing Ms Campbell's reflections. This document had not been provided to the panel. The panel asked to see the whole document and was provided with it and took it into account in making its decision.

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

Charge 1a)

'That you, a registered nurse

1. *On 1 August 2022 failed to ensure Patient A's safety in that you:*
    a. *Failed to carry out clinical observations during your initial visit'*

This charge is found proved.

In reaching this decision, the panel took into account the information in the NMC bundle which included the witness statements of Witness 1 and Witness 2, the EMIS record dated 1 August 2022, and the Datix dated 2 August 2022.

The panel saw evidence in the EMIS record that Ms Campbell had carried out observations on 1 August 2022 at 12:30 where the temperature, blood pressure, stats and pulse were recorded.

However, the panel also saw evidence that Ms Campbell did not in fact carry out the clinical observations at the initial visit at 12:30 but completed them at a later visit approximately two hours later. The panel noted in particular the following:

- The Datix dated 2 August 2022 regarding the home visit on 1 August 2022:
    'Clinical observations not taken as reports equipment not available.'
- Witness 1's witness statement:
    'I then asked Ms Campbell if she had carried out any clinical observations to which the Registrant replied that she hadn't because she did not have any equipment.'

- Witness 2's contemporaneous notes of 1 August 2022:

  'Karen was asked if she had taken any observations but said she only has a thermometer.'

- The GP entry onto Patient A's EMIS record on 1 August 2022:

  'Karen kindly went back to check [observations]'

There was therefore a conflict of evidence before the panel. However, given that Ms Campbell herself had stated that she had not recorded observations at her first visit due to not having the necessary equipment with her and that this account was supported by several witnesses, the panel preferred this evidence over the single EMIS entry.

The panel gave significant weight to Witness 2's comments as they were notes made on the day of the incident. It also regarded the information in the Datix as particularly compelling as it was made the day after the incident.

The panel noted that agency nurses at the Medical Centre were reported to not always have all necessary equipment with them to carry out required observations. However, the panel noted the witness statement of Witness 1:

> *'Even if Ms Campbell did not have equipment she needed to perform the necessary observations on Patient A she could have called the co-ordinator who would have been able to provide her with advice and assistance. Ms Campbell could have also performed manual checks or observations on a patient…'*

The panel considered the witness statement of Witness 1 that Patient A was displaying significant signs of deterioration in that they were:

> *'oedematous (this means [they were] swollen with an excessive accumulation of fluid and that [they] could hardly walk. Ms Campbell advised me that [their] fingertips were cyanosed (this means they were a bluish-purple suggestive of poor blood circulation and/or not having enough oxygen) and grey and [they] were short of breath.'*

The panel considered the clinical signs Ms Campbell reported back at handover and considered that these were significant enough that she ought to have known clinical observations were necessary. The panel did not consider that a lack of necessary

equipment was sufficient to justify not taking the observations as there was an established procedure for agency nurses to have the appropriate equipment delivered if required.

Further, the panel concluded that Ms Campbell failed to ensure patient safety by not taking the observations required at her initial visit to Patient A. As a registered nurse, she ought to have known that it was vital to take Patient A's observations in view of his clinical presentation.

The panel noted that the way the observations are recorded on the patient notes make it seem as if these were recorded at the time of the initial visit. This does not appear to be an accurate chronology as the panel noted a conflict of evidence between the EMIS record, witness statements and Datix report regarding when the observations were taken. The panel preferred the evidence of the witnesses that the observations were added after the initial visit as the accounts were consistent and were either recorded on the day of the incident or shortly afterwards.

Accordingly, the panel concluded that Ms Campbell had a duty to carry out the clinical observations at the initial visit and failed to do so.

The panel therefore finds this charge proved.

Charge 1b)

'That you, a registered nurse:

1. *On 1 August 2022 failed to ensure Patient A's safety in that you:*
   b. *Failed to promptly call the co-ordinator for assistance or advice during your initial or subsequent visit'*

This charge is found proved.

In reaching this decision, the panel took into account the information in the NMC bundle, in particular the witness statements of Witness 1 and Witness 2.

The panel noted the witness statement of Witness 1, which outlines the correct protocol for agency nurses where there is a patient of concern:

> *'If once the agency staff has attended the patient and it becomes apparent there is concern about the patients' health, the agency staff would then be expected to contact the co-ordinator for advice and request equipment to be bought[sic] to them. They could also request an additional staff member to attend the patient for support. If the patients' needs appeared less urgent, the agency nurse could return to office[sic] to collect the equipment themselves and return to patient'.*

The panel also noted the witness statement of Witness 2, which states that Ms Campbell was aware of Patient A's deteriorating condition:

> *'She made a reference to a particular patient and said he'd blown up like a Michelin man and that his lips were blue.'*

This was corroborated in the contemporaneous note made by Witness 2 on 1 August 2022:

> *'Karen began to handover and mentioned that her patient had "swollen up like a Michelin man and wasn't right"'*

On the basis of this evidence, the panel determined that there was a duty for Ms Campbell to call the coordinator for advice immediately when she had observed this. It must have been apparent to Ms Campbell that there was a cause for concern and, as a registered nurse, she had a duty to act. The panel determined that she failed in this duty as she did not inform the care coordinator until back at the Medical Centre and at the end of the handover.

The panel also considered the chronology of events in Witness 2's contemporaneous notes which state that Ms Campbell returned to the Medical Centre to have lunch after the initial visit at Patient A's home and did not raise Patient A's condition with the coordinator until over an hour later at the end of the handover meeting which commenced at 13:30. The panel considered that a prompt response would have required Ms Campbell calling the coordinator from Patient A's home, or going to fetch the correct equipment and immediately returning to Patient A's home to complete the observations. Due to the

contemporaneous nature of the notes, the panel prefers Witness 2's evidence that Ms Campbell delayed contacting the coordinator regarding Patient A.

The panel next considered Ms Campbell's subsequent visit to Patient A's home. The GP's note on the EMIS record at 14:25 confirm that Ms Campbell took the necessary observations and recorded Patient A's NEWS2 trigger threshold score. According to the NEWS2 guidelines, Patient A's presentation required the clinical response of an immediate call to 999 and for the GP and caseload holder/co-ordinator to be notified. The response period is denoted as 'ACT NOW', which the panel considered to imply that 999, the GP, and the caseload holder/co-ordinator should be contacted immediately.

To determine who the caseload holder was in this case, the panel had regard to the witness statement of Witness 1, who interprets Ms Campbell's compliance with the NEWS2 guidelines and identifies themselves as the caseload holder:

> *'If the symptoms are new for the patient that would require an immediate call to 999 and notification to the GP and caseload holder (me)…Ms Campbell did not follow the NEWS2 guidelines.'*

Regarding patient safety, the panel considered Witness 1's statement that *'failure to escalate patient concerns especially with the NEWS2 policy could result in the patient's condition deteriorating significant or a fatality'.*

The panel determined that promptness in this case is characterised by acting during or immediately after the visit. Having seen evidence that Ms Campbell returned to the clinic after her initial visit and proceeded to have lunch before informing Colleague A (Witness 1) of Patient A's deterioration. At the subsequent visit, Ms Campbell informed the co-ordinator after approximately 30 minutes rather than phoning her immediately.

The panel concluded that Ms Campbell failed to contact the coordinator promptly, and in doing so failed to ensure patient safety.

Accordingly, the panel found this charge proved.

Charge 1c) i)

‘That you, a registered nurse:

1. *On 1 August 2022 failed to ensure Patient A’s safety in that you:*
    c. *Failed to manage/ escalate the care of Patient A in that you failed to:*
        i. *Promptly inform Colleague A of Patient A’s deterioration when you returned to the office/during handover, following your initial visit’*

This charge is found proved.

In reaching this decision, the panel took into account the Datix report, the witness statements of Witness 1 and Witness 2, as well as Witness 2’s notes of 1 August 2022.

- Witness 1’s witness statement:

    ‘On 1 August 2022 I returned to the office at midday and was joined by the other members of the team. Ms Campbell came into the office and started working on the computer and at 13:30 I called handover.’

    ‘At the end of handover, I enquired if anyone had any concerns that they would like to raise and at this point Ms Campbell advised that her patient, Patient A was unwell.’

- Witness 2’s witness statement:

    ‘Karen was one of the first other people back, I think she arrived back around 1 pm, I can’t recall the exact time. She came in, I was on my computer, and started eating her lunch. The office wasn’t busy, it was just the four of us that I can recall. As time was ticking, we initiated the handover… Karen didn’t initiate any conversation and there was some time between her arriving and speaking during the handover.’

    ‘We were chatting about the patients, it was all very relaxed, and there didn’t seem to be any major issues. Karen hadn’t come forward with any concerns, but when [Witness 1] invited her to speak, she made a reference to a particular patient and said he’d blown up like a Michelin man and that his lips were blue…’

The panel also considered the chronology offered in Witness 2's notes of 1 August 2022:

'Returned back from visits for lunchtime handover'

'Karen present in the office at this time'

'Team sat to handover'

'Myself, K and [Witness 1] handed over and discussed at length some issues some of minor importance.'

'Karen sat and ate her lunch and was involved in the handover.'

'Karen began to handover and mentioned that her patient Patient A had "swollen up like a Michelin man and wasn't right".'

The panel noted the corroborating evidence of Witnesses 1 and 2 that Ms Campbell did not inform Witness 1 of Patient A's deterioration until prompted at the end of the handover meeting. The panel also determined that as Witness 2's notes are a contemporaneous account, these carry significant weight.

The panel considered the evidence and concluded that Ms Campbell returned to the Medical Centre following her initial visit, and did not inform Witness 1 of Patient A's deterioration until prompted at handover which began at 13:30. This left a gap of at least 30 minutes in which Ms Campbell could have informed Witness 1 about Patient A. Given the seriousness of Patient A's symptoms the panel found that Ms Campbell had a duty to do this promptly.

Having found charge 1b proved, that panel has determined Ms Campbell had a duty to manage/escalate Patient A's care at the initial visit and failed to do so by not informing Witness 1 of Patient A's deterioration promptly on her return to the Medical Centre.

The panel saw evidence that Ms Campbell returned to the Medical Centre after her initial visit, had her lunch, listened to colleagues talk about other more minor incidents at the handover, and only reported about Patient A when she was asked at the end of the

handover. The panel found that this did not amount to being prompt and accordingly found this charge proved.

Charge 1c) ii)

'That you, a registered nurse:

1. *On 1 August 2022 failed to ensure Patient A's safety in that you:*
    c. *Failed to manage/ escalate the care of Patient A in that you failed to:*
        ii. Promptly call a GP during or following your visit/s'

This charge is found proved.

In reaching this decision, the panel took into account the Datix dated 2 August 2022, the witness statement of Witness 1, the EMIS record made by Ms Campbell on 1 August 2022, the internal statement made by Witness 1 dated 7 September 2022, and Ms Campbell's undated reflection.

The panel considered this charge in relation to the initial visit and the subsequent visit.

Initial visit

The panel has seen conflicting evidence that Ms Campbell called the GP or an ambulance during, or immediately following, the initial visit to Patient A's home. In Ms Campbell's EMIS record she states that '*On arrival back to the clinic, I phone 999 for an ambulance'*.

This is contradicted by the statement of Witness 1:

'I then asked Ms Campbell if she had informed the emergency services of the GP. Again, Ms Campbell responded that she hadn't.

…

'Ms Campbell could have also phoned the GP to ask for advice or she could have called 999 immediately. Ms Campbell failed to do any of these and only thought to escalate Patient A's condition when prompted to do so.'

The panel prefer the evidence of Witness 1 as it is supported by the contemporaneous notes made by Witness 2 that Ms Campbell '*was informed to contact the GP asap and that she should have contacted someone at the time of visit'.*

It is also supported by an internal statement of Witness 1 dated 7 September 2022, which states *'I asked Karen if she had informed the GP? Karen replied she had not, but was thinking of going to see them'.*

Subsequent visit

The panel took into account Ms Campbell's undated statement to the Trust, which describes a phone call she made to the GP during her subsequent visit to Patient A. On the basis of this information, as corroborated by the GP's EMIS record, the panel determined that Ms Campbell likely did escalate Patient A's care to the GP during the second visit. The GP's EMIS record at 14:25 stated that '*Karen kindly went back to check obs and I spoke to Karen and [Patient A]'*. This implies that Ms Campbell was at Patient A's home when she made the call.

The panel determined that Ms Campbell did not promptly call a GP during or following her initial visit to Patient A's home, but acknowledged that she did so on her second visit. Given the severity of Patient A's presentation, the panel determined that Ms Campbell's failure to call the GP at the initial visit was serious. The panel noted that she had subsequently spoken to the GP at the Medical Centre and that the GP and the co-ordinator had told her to return to Patient A's home to take observations and report back.

Having regard to their findings at charge 1b), and Patient A's presentation, the panel determined that Ms Campbell did not promptly call a GP during or immediately following her initial visit to Patient A's home when she had a duty to, and in doing so failed to ensure Patient A's safety.

Accordingly, the panel found this charge is found proved.

Charge 1c) iii)

'That you, a registered nurse:

1. On 1 August 2022 failed to ensure Patient A's safety in that you:

c. Failed to manage/ escalate the care of Patient A in that you failed to:

iii. Promptly call an ambulance during or following your visit/s'

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 as well as Witness 1's internal statement, and the Datix dated 2 August 2022.

The panel noted that during her first visit, because no observations had been taken the requirement to call an ambulance did not fall strictly within established guidelines. Nevertheless, the panel considered that a serious deterioration in Patient A's condition should have alerted Ms Campbell to the need to escalate the situation and seek guidance on the way forward, which may include advice on whether an ambulance was necessary. However, the for the second visit Ms Campbell was required to call emergency services as she had completed the observations and had access to the NEWS2 scoring system and guidelines as outlined in charge 1b, which required her to 'ACT NOW'.

The panel noted the statement of Witness 1:

'I then asked Ms Campbell if she had informed the emergency services of the GP. Again, Ms Campbell responded that she hadn't.

…

'Ms Campbell could have also phoned the GP to ask for advice or she could have called 999 immediately. Ms Campbell failed to do any of these and only thought to escalate Patient A's condition when prompted to do so.'

The panel prefer the evidence of Witness 1 as it is supported by the Datix which states '*No ambulance called'*, as well as the internal statement of Witness 1 dated 7 September 2022 which states:

'I asked Karen if she had informed the emergency services? Karen replied she had not.'

…

'Myself and colleague [Witness 2] asked if Karen had rang an ambulance, she said no'.

The panel saw evidence that Ms Campbell was asked on returning to the Medical Centre whether she had called an ambulance. She responded that she had not and that Patient A's father had said that he would call one. Witness 2 then advised Ms Campbell to call the ambulance herself and relay the appropriate information. Ms Campbell then called the ambulance after unsuccessfully attempting to call Patient A's father.

The panel find that Ms Campbell did not call 999 during either visit to Patient A's home, or immediately after leaving as the word 'promptly' would require. The panel finds that Ms Campbell failed to call an ambulance after her initial visit, and should have made a prompt call for the ambulance at Patient A's home or immediately upon leaving Patient A's home at the subsequent visit.

Accordingly, the panel find this charge proved.

Charge 1d)

'That you, a registered nurse:

1. *On 1 August 2022 failed to ensure Patient A's safety in that you:*
    d. *Failed to 'ACT NOW' in accordance with the NEWS2 guidelines.'*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1, Ms Campbell's undated reflective statement, and the NEWS2 guidelines.

The panel had particular regard to the witness statement of Witness 1, which interpreted the results of Patient A's clinical observations and provides that Patient A's scores added up to 7 on the day:

> *'…a score of 5 or more …requires the community nurse to 'ACT NOW'. If these symptoms are new for the patient that would require an immediate call to 999 and notification to the GP and caseload holder (me)…Ms Campbell did not follow the NEWS2 guidelines.'*

The panel acknowledged that Ms Campbell did call the GP during her second visit, albeit after being asked to do so by Witness 2, but did not fulfil all the requirements of the NEWS2 procedure in that she did not call 999 nor inform the co-ordinator.

Having regard to this, and having found charge 1c) proved that Ms Campbell did not act promptly, nor did she perform all of the clinical responses in the guidelines, the panel determined that she failed to 'ACT NOW' in accordance with the NEWS2 guidelines and in doing so, failed to ensure Patient A's safety.

Accordingly, the panel found this charge proved.

Charge 2a)

'That you, a registered nurse:

2. *On 1 August 2022, you failed to make a clear and accurate record of your visits to Patient A on EMIS, in that you recorded:*
    a. *one visit when you had made two visits'*

This charge is found proved.

In reaching this decision, the panel took into account Ms Campbell's entry into the EMIS record at 12:30 on 1 August 2022, and the statement of Witness 1.

The panel noted Ms Campbell's EMIS entry of 1 August 2022 and that she recorded only one domiciliary visit to Patient A that day. However, the panel noted that the evidence in

the bundle, especially those sections quoted above at charge 1, made it clear that Ms Campbell made two visits to Patient A's home on 1 August 2022.

The panel further noted the witness statement of Witness 1:

> *'Ms Campbell failed to undertake observations during her initial visit to Patient A and failed to properly record her visits on the Egerton Medical Information System ('EMIS').*
>
> *…*
>
> *'Ms Campbell attended Patient A on two occasions on 1 August 2022, once before lunch / handover at the office and once afterwards. There is only one EMIS entry by her for that date; it is timed 12:30, i.e. before she returned to the office around 12:45 for lunch and the handover.'*

The panel noted that a duty to make clear and accurate records is a fundamental aspect of nursing practice. Having found that Ms Campbell only recorded one of the two visits she made, this charge is found proved.

Charge 2b)

'That you, a registered nurse:

2. *On 1 August 2022, you failed to make a clear and accurate record of your visits to Patient A on EMIS, in that you recorded:*
    b. *that you had taken observations at 12.30 when you had not'*

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1 regarding the entry in the EMIS, which states:

> *'The entry completed by Ms Campbell says that she '*checked his observations Temp 36.5, BP 140/70. Sats 79, Pulse 94'. *At the handover at around 13:30 she*

told me that she had not taken any observations. In [the GP's] EMIS entry for the same day, timed at 14:25 she says 'Karen kindly went back to check obs…'

In light of this, and of having found charge 1a) proved, the panel concluded that Ms Campbell's recorded observations were not contemporaneous nor an accurate record of what happened, as these were in fact taken and recorded during her second visit to Patient A on 1 August 2022. Accordingly, the panel found this charge proved.

Charge 2c)

'That you, a registered nurse:

2. *On 1 August 2022, you failed to make a clear and accurate record of your visits to Patient A on EMIS, in that you recorded:*
    c. *that you had left Patient A in the care of his father at 12.30 when you had not.'*

This charge is found proved.

In reaching this decision, the panel took into account Ms Campbell's EMIS record of 1 August 2022, and the statement of Witness 1.

The panel noted conflicting evidence in the bundle as to when Patient A's father returned home. The panel had regard to Ms Campbell's entry into the EMIS record, *'I left [Patient A] in the care of his dad'* and noted that this was recorded against the 12:30pm domiciliary visit.

The panel compared Ms Campbell's account to Witness 1's witness statement:

'Patient A's father had been out at the shops during Ms Campbell's first visit with Patient A and when Ms Campbell went back again the second time Patient A's father had returned.

…

'When Ms Campbell returned to the office after the second visit, she told me that Patient A's father had been out at the shops during her first visit with Patient A and when she went back again the second time Patient A's father had returned…'

Having previously determined that Ms Campbell's patient record was inaccurate as at charge 2b), the panel did not give much weight to her evidence and preferred the evidence of Witness 1. The panel determined that, on the balance of probabilities, Patient A's father was most likely absent when Ms Campbell left Patient A at 12:30 after her first visit, even though she may have spoken to him on the phone. Therefore, this charge is found proved.

Charge 2d)

'That you, a registered nurse:

2. *On 1 August 2022, you failed to make a clear and accurate record of your visits to Patient A on EMIS, in that you recorded:*
    d. *that you had called 999 at 12.30 when you had not.'*

This charge is found proved.

In reaching this decision, the panel took into account Ms Campbell's EMIS report, Witness 1's witness statement, and the Datix.

In the EMIS record, Ms Campbell recorded at 12:30 on 1 August 2022 that *'On arrival back to the clinic, I phoned 999 for an ambulance'.*

The panel compared this to Witness 1's statement:

'When asked at handover around 13:30, Ms Campbell told me she had not called 999.'

The panel also considered the evidence in the Datix that *'No ambulance called. Agency nurse returned to office. Handed over that patients[sic] dad was ringing ambulance'.*

Ms Campbell's patient record was inaccurate as at charge 2b), the panel did not give much weight to her evidence and preferred the evidence of Witness 1 and the Datix. The panel determined that, on the balance of probabilities, Ms Campbell had not called 999 at 12:30 on 1 August 2022. Therefore, this charge is found proved.

Charge 3)

'That you, a registered nurse:

3. *Your actions as specified at any of the charges at 2a. – 2d. above were dishonest, in that you intended to mislead others to believe that you:*
    a. *had carried out one visit to Patient A when you knew that you had carried out two visits;*
    b. *That you had carried out observations at 12.30 when you knew that you had not;*
    c. *That you had left Patient A in the care of his father at 12.30 when you knew you had not;*
    d. *That you had called 999 at 12.30 when you knew you had not.'*

This charge is found proved.

In reaching this decision, the panel took into account the witness statements in the bundle, as well as Ms Campbell's entry into the EMIS record.

The panel noted that Ms Campbell's account has consistently conflicted with the witness statements in the bundle. The panel found her entry into the EMIS record dated 1 August 2022 to be incorrect as set out in charges 2a, 2b, 2c, and 2d.

The panel took a holistic approach in applying the test of dishonesty as outlined in *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* to this charge. Having found all previous charges proved, the panel determined that the information recorded on the EMIS was incorrect and Ms Campbell knew that it was incorrect when she made the entry. Further, the panel determined that in making the incorrect entry, Ms Campbell intended to mislead others into believing that what she had written down was true.

Accordingly, the panel finds this charge proved in its entirety.

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 Campbell'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 Campbell's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had 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 NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Ms Campbell's actions amounted to misconduct. In particular, the NMC submitted that she had breached the

following sections of the Code: 1.2, 1.4, 3.1, 8.1, 8.5, 8.6, 10.1, 10.2, 20.3, 13.1, 13.2, 15.2, 15.3, 16.1, 16.4, 17.1, 19.1, 20.1, 20.2, and 20.8.

The NMC requires the panel to bear in mind its overarching objective to protect the public. 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (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 Campbell's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

1 ***Treat people as individuals and uphold their dignity***

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*

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

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

8 ***Work cooperatively***

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

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

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

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

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

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

13 Recognise and work within the limits of your competence

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*

15 Always offer help if an emergency arises in your practice setting or anywhere else

15.2 *arrange, wherever possible, for emergency care to be accessed and provided promptly*

15.3 *take account of your own safety, the safety of others and the availability of other options for providing care*

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

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*

16.4 *acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so*

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*

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Campbell failed to recognise the prompt action required for a deteriorating patient. The panel has not seen any evidence that Ms Campbell recognised the seriousness of Patient A's condition, or that she made any efforts to manage or escalate their care promptly. The panel found that Ms Campbell acted as if Patient A's treatment could have waited when it should have been managed immediately, and she ought to have recognised the urgency of the situation and the severity of Patient A's case. The panel noted Witness 1's witness statement: '*failure to escalate patient concerns especially with the NEWS2 policy could result in the patient's condition deteriorating significant or a fatality'.* The panel also noted that subsequent professionals who attended Patient A alerted him to the risk of death without medical intervention, such was the seriousness of Patient A's condition. The panel determined that Ms Campbell failed to prioritise patient safety and put Patient A at serious risk of harm.

The panel considered that accurate record keeping is a fundamental aspect of nursing practice. Having found all charges proved that Ms Campbell knowingly made false records regarding Patient A's care, the panel determined this to be a significant breach. Furthermore, the panel considered that knowingly making an incorrect record is a breach of the duty of candour.

The panel considered the NMC Guidance on serious concerns which are difficult to put right. The guidance states that in such circumstances the panel would be greatly assisted by hearing from the nurse themselves.

The panel noted Ms Campbell's undated reflection that Patient A was adamant in not wanting to go to hospital, however the panel did not consider that this justified her initial failure to manage the situation appropriately. Under these circumstances, and according to the policy, Patient A's condition ought to have triggered her to immediately call for support. The panel also noted that after taking observations and noting the oxygen saturation to be so poor, Ms Campbell could have called for an ambulance with paramedics and additional equipment, which would not necessarily have resulted in Patient A being taken to hospital. Such a course of action would have resulted in Patient A having access to immediate treatment including oxygen therapy.

The panel found that Ms Campbell'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 Campbell's fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that Patient A was put at risk of harm as a result of Ms Campbell's misconduct. Ms Campbell's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that it has not seen any evidence of insight on Ms Campbell's behalf, and that Ms Campbell has not engaged at all with NMC proceedings. The panel noted Ms Campbell's reflective statement in which she states *'I don't understand I did everything I'm supposed to do. Yet I'm the one what has to suffer with no work'.* The panel considered that this indicates Ms Campbell has not considered how her actions impacted others, particularly Patient A, or how they impacted the reputation of the nursing profession. The panel also considered that Ms Campbell does not appear to have acknowledged her misconduct, or see why what she did was wrong.

The panel determined that Ms Campbell has not demonstrated insight into her actions. Further, the panel has not seen any information to explain why Ms Campbell acted the way she did, nor has it seen any evidence of concern or care for a vulnerable patient by Ms Campbell.

The panel was satisfied that whilst the misconduct in this case is difficult to remediate, it is not impossible to address. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Campbell has taken steps to strengthen her practice. As there has been no detailed reflection or engagement from Ms Campbell, the panel has no evidence to suggest that the concerns have been remediated. It was of the view that there is a real risk of significant harm to the public, and a risk of repetition, if Ms Campbell's practice was found not to be impaired.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case as it concerns a

community nurse failing to take prompt action following a home visit with a seriously deteriorating patient, which a reasonable member of the public would find shocking. An informed member of the public would also be extremely concerned to learn about the dishonesty in this case. The panel therefore also finds Ms Campbell's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 9 April 2024, the NMC had advised Ms Campbell that it would seek the imposition of a 12-month suspension order if it found Ms Campbell's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Campbell'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 also took into account that it has not seen any evidence of remorse or strengthened practice by Ms Campbell.

As required by Article 29(3) of the Nursing & Midwifery Order 2001, the panel first considered (pursuant to Article 29(4)) whether to undertake mediation or to take no further action. It considered that both of these would be inappropriate as neither would restrict Ms Campbell's practice. The public would therefore not be appropriately protected.

The panel then moved on to consider the available sanctions, as set out in Article 29(5). The panel determined that a caution order would be inappropriate as it would also not restrict Ms Campbell's practice and would not provide appropriate protection to the public.

The panel next considered whether placing conditions of practice on Ms Campbell'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 is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the lack of engagement and remediation offered by Ms Campbell. Furthermore, the panel concluded that the placing of conditions on Ms Campbell registration would not adequately address the seriousness of this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel determined that a maximum period of suspension would also serve to mark the gravity of the misconduct in this case.

The panel did seriously consider strike-off given the charge of dishonesty and the fact that Ms Campbell has not engaged at all with NMC proceedings and has not demonstrated any strengthening in practice or reflection. Furthermore, there are charges relating to falsifying documents and breaches of the duty of candour, which are particularly serious. However, the panel has been guided by the principle of applying the least restrictive sanction. It noted that Ms Campbell's misconduct was a single isolated incident, and wished to afford Ms Campbell a further opportunity to engage and strengthen her practice. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Campbell's case to impose a striking-off order.

Therefore, the panel determined to impose a suspension order to allow Ms Campbell an opportunity to engage with the NMC and provide evidence to a future panel which would assist it in determining whether she has reflected on her failings, remediated her conduct, and reflected on the impact of her actions on the patient and the reputation of the profession.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by the following from Ms Campbell:

- Engagement with the NMC
- Attendance at a future review
- Full reflection on failings showing insight into the impact of her clinical failings on patients and colleagues and the nursing profession as a whole
- Evidence of additional relevant training in recognising deteriorating patients
- Evidence of additional training in the duty of candour
- An explanation as to her current working situation and intentions going forward
- Testimonials from her current employer which address the regulatory concerns

This will be confirmed to Ms Campbell in writing.

Interim order

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public. 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 in order to allow time for any possible appeal to be resolved.

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

That concludes this determination.