Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 5 August – Friday 9 August 2024,
Thursday, 10 October – Friday, 11 October 2024,
Monday 21 October – Friday 25 October 2024,
Monday, 4 – Friday 8 November 2024

Virtual Hearing

Name of Registrant:	**Darren Adams**
NMC PIN	92Y1556E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (25 March 1995)
Relevant Location:	Wellingborough
Type of case:	Misconduct
Panel members:	Christine Nwaokolo (Chair, Lay member) Sharon Peat (Registrant member) David Anderson (Lay member)
Legal Assessor:	Oliver Wise (5-9 August 2024, 4 November 2024) Graeme Henderson (10-11 October 2024) Ian Ashford-Thom (21-25 2024)
Hearings Coordinator:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Case Presenters Matthew Kewley (5-9 August 2024, 10-11 & 21-25 October 2024, 4-5 November 2024) and Grace Khaile (6- 8 November 2024)
Mr Adams:	Present and represented by Bramble Badenach-Nicolson, Counsel instructed by the Royal College of Nursing (RCN)

Charges struck out at a preliminary hearing:	Charges 4, 5, 6, 9c, 10, 15, 27, 28, 29, 33, 40
Charges not pursued by the NMC and dismissed:	Charges 37, 39
No case to answer:	Charges 11, 12, 14, 16d, 17, 41, 42, 45b
Facts proved by admission:	Charges 1a, 1b, 1c, 2, 3a, 3b, 3c, 3d, 7a, 7b, 7c, 8a, 8b, 8c, 9a, 9b, 13a, 13b, 13c, 13d, 16a, 16b, 16c, 18a, 18b(i), 18b(ii), 18b(iii), 19(i), 19(ii), 19(iii), 21, 22, 23, 24a, 24b, 24c, 25a, 25b, 25c, 25d, 26a, 26b, 26(1), 26(2), 30a, 30b, 31, 34, 35, 38, 44, 47a, 47b, 47c, 47d, 47e, 47f
Facts proved:	Charges 30c, 32a, 32b, 32c, 43a, 43b, 43c, 46b
Facts not proved:	Charges 20(i), 20(ii), 20(iii), 36a, 36b, 36c, 36d, 45a, 46a, 48a, 48b
Fitness to practise:	Impaired
Sanction:	Conditions of practice order – 18 months
Interim order:	Interim conditions of practice order – 18 months

Details of charge

That you being a registered nurse between 2017 and 2019

Whilst working at Pathdfields Lodge Home

1. On the 2nd April 2017,
   (a) did not lock Resident A's medication in a secure place in the clinic room ***Proved by admission***
   (b) instead placed it in an unlocked cupboard in the nurses' office. ***Proved by admission***
   (c) Inaccurately recorded in your time management form that the medication had been stored in an appropriate way. ***Proved by admission***

2. On the 4th April 2017, did not administer Resident A's morning medication of Alendronic acid. ***Proved by admission***

3. Further to (2) did not

   (a) Communicate this to staff ***Proved by admission***
   (b) Mention it at handover. ***Proved by admission***
   (c) Make an entry in the 24 hour report and communication record and ***Proved by admission***
   (d) Explain why the medication had been refused. ***Proved by admission***

~~4. On or about the 7th April 2017, administered night time medication to Residents D and N when in fact their morning medication was due to be administered to them.~~

~~5. Before the administration referred to at (4) above, did not do the following~~

~~(a) Check the name of the drug, the dose and the time for administration against the MAR chart and blister pack~~

~~(b) Make the same checks against the blister pack.~~

~~6. After the said administration at (4) , did not~~

~~(a) make any record in Resident D's and N's nursing notes and 24 hours report and communication record~~

~~(b) create a Datix incident record~~

~~(c) inform other nursing staff at handover~~

~~(d) ensure that one of the residents received his levothyroxine that day.~~

7. Between the 6th and 7th April 2017,whilst managing Resident B's PRN co-codamol pain relief did not record the actual time any co-codamol was given

   (a) On the nursing notes. ***Proved by admission***

   (b) On the 24 hour report and communication record and on ***Proved by admission***

   (c) The MAR Chart. ***Proved by admission***

8. Insofar as a time was provided by you as to Resident B's co-codamol

   a) on the PRN administration record of 21.15 pm on the 6th April
      Proved by admission
   b) at 07.20 am on the Daily Progress notes for the 7th April at time of feed
      Proved by admission
   c) at 06.00 am by ticking feed and "meds" on the 7th April 2017
      Proved by admission

you did not provide a clear or consistent picture as to the time of administration thereby potentiating delay in Resident B's pain relief.

9. On the 6th and 7th April 2017, did not fully complete entries in Resident C's notes as to her blood sugar levels

   (a) At 06.00 hours and then again at 17.00 hours in the 24 hour report and communication record ***Proved by admission***
   (b) As to the actual times that any blood sugar levels were monitored in the Daily Progress Notes. ***Proved by admission***
   ~~(c) To deduce patterns between the ingestion of food and variation in the blood sugar level.~~

~~10. Further to (9) above, recorded inconsistent entries in relation to the same monitoring of blood sugar levels, in that~~

   ~~(a) On the 6th April 2017 on the Insulin Administration recorded 6.4 blood sugar level and 34 insulin given~~
   ~~(b) On the same day on the 24 hour Report and Communication record entered blood sugar 8 and insulin given at 200.~~

11. On the 11th June 2017, did not supply Resident M with her respite PRN paracetamol when requested. ***No case to answer***

12. Further, in not administering Resident M's PRN medication on the 11th June 2017, did not record

   (a) The reason why Resident M was requesting PRN medication. ***No case to answer***
   (b) The time it was requested. ***No case to answer***
   (c) Why it was not administered ***No case to answer***

13. On the 13th June 2017, whilst tasked with Resident C's care and insulin treatment did not record in the nursing notes

    (a) ~~Record in the notes~~ any diabetic observations ***Proved by admission***
    (b) ~~Record~~ any concerns arising out of the diabetic monitoring. ***Proved by admission***
    (c) ~~Record~~ Resident C's blood sugar levels. ***Proved by admission***
    ~~(d)~~ any insulin injection given. ***Proved by admission***

14. On the 13th June 2017,

    (a) did not administer Resident O's anti-hypertensive medication, Atorvastatin ***No case to answer***
    (b) Signed inaccurately on Resident O's MAR Chart that you had administered the Atorvastatin. ***No case to answer***
    (c) Recorded in the Disposal Medication Book that Resident F (who was not prescribed atorvastatin but rather zoplicone) had refused Atorvastatin and spat it out. ***No case to answer***
    (d) Made no entry on Resident F's MAR chart. ***No case to answer***
    (e) Attempted to give Resident F Atorvastatin in error in that this was prescribed to Resident O not F. ***No case to answer***

~~15. On the 13th June 2017~~

~~(a) You attempted to administer medication to Resident G covertly.~~
~~(b) You made no entry as to whether the medication was administered or not and if not why not.~~
~~(c) You did not record the reason for any covert medication or its failure.~~
~~(d) You did not record why the medication had been refused.~~

~~(e) You did not hand over to the next shift the status in which Resident G stood in relation to medication.~~

16. On the13th or 14th June 2017,

    (a) You were aware or should have been aware that Resident H had not had her anti-convulsant medication for some 8 days or thereabouts
    Proved by admission
    (b) You were aware that Resident H was prone to refuse medication
    Proved by admission
    (c) You were aware that permission was in place to use covert medication.
    Proved by admission
    (d) Did not administer Resident H's anti-convulsant medication. ***No case to answer***

17. On the 14th June 2017

    (a) Carried two unfinished insulin pens in one kidney dish ***No case to answer***
    (b) Did not lock the insulin pens in the medication trolley or in the nurses' clinic.
    No case to answer
    (c) Instead of (b) left the unfinished insulin pens in the kidney dish on a radiator in the residents' lounge. ***No case to answer***

18. On or shortly after the 28th September 2017, due to performance concerns, you were placed by Pa~~d~~thfields Lodge Home on a Performance Management Plan ["PMP"], which plan imposed ***Proved by admission***

    (a) Supervision of all administration of medication until competency was assessed
    (b) Periodic medication supervision assessments, in particular on the
        (i) 11th Oct 2017 ***Proved by admission***
        (ii) 18th Oct 2017 ***Proved by admission***
        (iii) 1st Nov 2017 ***Proved by admission***

19. In the course of these assessments, failed in key elements as to your

(i) understanding of accountability for drug administration error. ***Proved by admission***
(ii) understanding of the reporting procedures for a drug error ***Proved by admission***
iii) demonstrating a thoughtful approach to drug administration and residents ***Proved by admission***

20. In relation to 19 (iii),

(i) Did not talk sufficiently to residents to offer assistance and/or compassion
(ii) Did not sufficiently assess the Residents' needs by discussing such matters with them.
(iii) In particular, did not sufficiently discuss their medication needs, such as PRN which would need discussion and a caring response

21. On the 11th October 2017, at the first assessment, took the telephone to answer a call in the middle of a medication round. ***Proved by admission***

22. On the 18th October 2017, at the second assessment, took some 2 hrs and 40 minutes to complete the morning medication round. ***Proved by admission***

23. On the 18th October 2017, at the second assessment, became disorganised and/or flustered and mixed up the colour coding of the blister packs such as to dispense an orange pack (for pm) instead of a yellow one (for lunch) ***Proved by admission***

24. On the 18th October 2017, upon Resident J refusing his medication,

(a) placed the medication in its pot on the medication trolley and then forgot to take any further action. ***Proved by admission***

(b) did not properly identify and/or label what the drug actually was ***Proved by admission***

(c) Did not dispose of the medication in the dedicated clinical waste bin. ***Proved by admission***

25. On the 19th October, having decided with Colleague 1 that risperidone should be withheld from Resident F on the grounds that she was already sedated.

a) You had removed the drug from its blister pack. ***Proved by admission***

b) You knew that (a) meant the drug had to be disposed of at the end of the round ***Proved by admission***

c) You forgot to do this and retained the tablet in your pocket. ***Proved by admission***

d) You did not dispose of the medication in the dedicated clinical waste bin. ***Proved by admission***

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26. On the 28th October 2017, knowing that

(a) Pathfields Care Home required any administration by you of medication to be under the supervision of a qualified third party ***Proved by admission***

(b) The measure at (a) was implemented in order to protect the residents until Pathfields Lodge otherwise deemed you competent. ***Proved by admission***

(1) Nevertheless undertook an unsupervised medication round dispensing and/or administering a full medication trolley. ***Proved by admission***

(2) Did not inform Colleague 2, an agency nurse that you were confined to administer medication under supervision. ***Proved by admission***

~~27. On the 1st November 2017, at the third assessment did not sign the MAR charts to confirm that medication had been given in relation to Resident K and one other.~~

~~28. On or about the 1st November 2017,~~

~~(a) Left Resident J unsupervised in his room with his medication for some 1 ½ hours when his care plan only authorised such an approach for 30 minutes.~~

~~(b) Did not ensure that Resident J took the medication.~~

(c) ~~Insofar as Resident J sought not to take his medication, did not record a "refusal" in code on the MAR chart.~~

~~29. On the 1st November 2017, at the third assessment, at the end of the medication round did not administer two Residents, K and L, with their lunch time medication.~~

30. On the 1st November 2017, at the third assessment, in relation to Resident H, a sufferer of tonic-clonic seizures and consequential lethargy

(a) Delegated to a support worker the task of administering Sodium Valproate, keppra and carbamazepine to Resident H covertly ***Proved by admission***

(b) Prior to (a) and/or any decision to administer such drugs did not assess Resident H for lethargy and/or suitability to have the drugs. ***Proved by admission***

(c) In the light of (b) and generally, your delegation of this task was inappropriate.

And whilst working at Midland Care Home ;

31. On the 15th March 2018 or 16th March 2018 did not replace Resident EE's Buprenorphine seven day patch. ***Proved by admission***

32. In the approximate periods

(a) February 2018 to April 2018
(b) Leading up to August 2018
(c) Leading up to February 2019

You did not manage your time effectively and/or efficiently in that you were late in completing your morning medication rounds.

~~33. On the 4th and 5th August 2018, you did not sign for a number of different unknown medications on the MAR charts for unknown residents~~

34. On the 13th, 18th and 19th August 2018 you gave Resident GG his anti-convulsant medication Levetiraceram before 20.00 pm when it was prescribed to be given at night time between 21.00 and 22.00 hours ***Proved by admission***

35. On the 13th, 18th and 19th August 2018, you signed on Resident GG's MAR record that you had administered the drug Levetiracetam at the prescribed night time between 21.00 and 22.00 hours. ***Proved by admission***

36. Your entries at Charge 35 were dishonest in that you knew

(a) You had not administered the drug between 21.00 and 22.00 hours and/or

(b) You knew the drug had been administered earlier by yourself and/or.

(c) You were not in the Home at 21.00, your shift having ended at 20.00 hours and/or

(d) Your entries were designed to conceal that you had given the drug at the wrong time.

37. On the 10th August 2018, upon Resident P's dressing coming off,

    (a) At about 11.00 am, Colleague 3 informed you of this for your attention.

    (b) By 11.30 am or thereabouts, you sought only to address the issue by advising that Resident P's under-pants be removed and she be placed on her side.

    (c) Despite repeated requests from Colleague 3 ~~and Colleague 4~~, you left Resident P unattended in the position described at (b).

    (d) You did not attend to Resident P's dressing until approximately 16.00 pm to 16.30 pm.

38. On the 13th August 2018, you gave Resident FF a metformin tablet when the same had been discontinued on or prior to the 7th August 2018. ***Proved by admission***

39. On the 5th September 2018, you signed on Resident AA's MAR chart that you had given him Co-Careldopa when in fact you had not.

~~40. On or about the 5th September 2018, you missed medication that was required to be given to Resident LL.~~

41. On the 5th September 2018, signed on Resident HHs MAR chart that you had given him paracetamol when in fact you had not. ***No case to answer***

42. On the 31st December 2018, you did not administer Frusemide to Resident CC and yet you signed his MAR Chart as if you had. ***No case to answer***

43. On the 30th January 2019, acting as witness to the administration of controlled drugs by another to Residents BB and KK

(a) You countersigned the relevant controlled drug record for both residents before the person giving the drug had made their entry on the record.
(b) You did not check the stock after the administration of the drugs
(c) You did not notice that there were discrepancies in Resident BB's and KK's controlled drug records.

44. On or about the 22nd February 2019, left approximately a month's supply of medication unlocked on the ground floor of the home. ***Proved by admission***

45. On or about the 3rd March 2019,

(a) did not heed advice from the emergency service, Telemed, that antibiotic treatment for Resident CC's cellulitis should be chased from out of hours providers on or about the 4th March 2019
(b) did not thereafter provide verbal and written handover details to the same effect as (a) ***No case to answer***

46. On the 15th March 2019, either

(a) recognised that unknown medication was low in supply or
(b) ought to have recognised that it was in low supply

and did not order medication stocks to be replenished.

47. On the 17th May 2019,

a) dispensed medication from both ground floor trolleys whilst both were open ***Proved by admission***

b) dispensed medication to Residents CC and II together without returning to sign off their MAR charts individually. ***Proved by admission***
c) Placed medication for Resident JJ in the pocket of your tabard. ***Proved by admission***
d) Administered medication to Resident HH without returning to the medication trolley to sign off the MAR chart ***Proved by admission***
e) Distributed medication to Residents CC and II whilst holding more than one medication pot and without returning to the trolley. ***Proved by admission***
f) answered the phone in the course of the medication round. ***Proved by admission***

48. On the 26th March 2019,

(a) did not escalate Resident DD's care for medical review notwithstanding high blood sugar readings at 14.15 pm, 15.55 pm, 18.25 pm and 20.00 pm
(b) Did not sign Resident DD's MAR chart for the administration of insulin at 18.00 hours.

And in the light of the above, your fitness to practise is impaired by virtue of your misconduct

Background

This is a case brought by the Nursing and Midwifery Council against Mr Adams, and it arises out of two separate referrals that were made to the NMC.

The first referral was received by the NMC in March 2018 and came from the Huntercombe Group, which owned a home which will be referred to as Pathfields Lodge. You worked at Pathfields Lodge between July 2016 and January 2018, and the allegations that arise from Pathfields Lodge are charges 1 to 30.

After the first referral was received, a second referral was received on 2 August 2019 from a different employer, the Midlands Care Home.

After you left Pathfields Lodge, you went on to successfully secure employment at the Midlands Care Home and you worked there between February 2018 and May 2019 and the allegations arising out of that second referral are those charges 31 to 48.

The vast majority of the issues in this case relate to your clinical practice and largely your medication practice. The one main exception relates to an alleged issue of dishonesty, and this arises at charge 36 and relates to record keeping. The dishonesty relates to the alleged concealment of medication allegedly being given at the wrong time.

Charges struck out at a preliminary hearing

Charges 4, 5, 6, 9c, 10, 15, 27, 28, 29, 33, 40 were struck out at a preliminary hearing conducted by this panel.

Charges not pursued by the NMC and dismissed

Mr Kewley informed the panel that due to witnesses, Witness 8, Witness 9 and Witness 10's non engagement with the hearing, the NMC would no longer be pursuing charges relating to their evidence, these being charges 37 and 39. The panel accepted this position and these charges were formally dismissed.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Badenach-Nicolson that there is no case to answer in respect of charges 11, 12, 14, 16d, 17, 30c, 36, 41, 42, 45b and 46. This application was made under Rule 24(7).

The NMC does not oppose the application in relation to charges 11, 12, 14, 16d, 17, 41, 42 and 45b.

Ms Badenach-Nicolson provided written submissions to the panel which she supplemented with oral submissions. She made her submission under the second limb of *Galbraith* [1981] 1 WLR 1039 which states that there will be no case for a nurse to answer where, at the close of the NMC case, there is some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, or the nurse's fitness to practise being found to be impaired. In these circumstances, she submitted that these charges should not be allowed to remain before the panel.

Charge 30(c)

> *On the 1st November 2017, at the third assessment, in relation to Resident H, a sufferer of tonic-clonic seizures and consequential lethargy, in light of* ***charge (b),*** *and generally, your delegation of this task was inappropriate.*

In respect of charge 30c, Ms Badenach-Nicolson submitted:

> *"a) There is insufficient evidence to prove that such delegation was inappropriate, primarily because the NMC have not called any clinical expert to give evidence as to the same.*
>
> *b) Nina Bailey's oral evidence was that she was unaware of the position at Pathfields as to the qualification of support workers.*
>
> *c) There is no record of any conversation between Nina Bailey (or anyone else) and the support worker involved."*

Charge 36:

> *Your entries at Charge 35 were dishonest in that you knew*

(a) You had not administered the drug between 21.00 and 22.00 hours and/or

(b) You knew the drug had been administered earlier by yourself and/or.

(c) You were not in the Home at 21.00, your shift having ended at 20.00 hours and/or

(d) Your entries were designed to conceal that you had given the drug at the wrong time.

Ms Badenach-Nicolson submitted the following in respect of charge 36:

"a) Rachel Liporada was clear in her oral evidence in response to my question 'You didn't believe at the time that he was being dishonest, did you?': 'I don't think it's about dishonesty. It's about the practice'.

b) Moreover, Rachel Liporada accepted that she did not raise concerns with the Registrant about his honesty at the time: 'No. I don't think so at that time. But the practice is not following the prescribing. It was a mistake'.

c) Rachel Liporada also confirmed that the Registrant did not deny his mistake".

Charge 46

On the 15th March 2019, either:

(a) recognised that unknown medication was low in supply or

(b) ought to have recognised that it was in low supply

and did not order medication stocks to be replenished.

In respect of charge 46 Ms Badenach- Nicolson submitted:

"a) Helen Hepworth confirmed under cross-examination that she could not recall what medication this charge related to, nor whose medication this was.

b) Helen Hepworth became aware of the issue when the Registrant reported on Sunday 17 March 2019 that there was missing stock.

c) Helen Hepworth's response was 'Sounds reasonable' to my putting to her that the allegation is that Mr Adams should have ordered more on 15 March 2019 and that this was a difficult issue because no one knows which medication it was, nor how many doses were left on 15 March 2019. It therefore followed that either there was one dose left on the Saturday 16 March 2019, or there were none left by the Sunday, 17 March 2019 and the nurse on shift on 16 March 2019 simply had not bothered to order new stock.

d) We do not have any corresponding MAR charts to confirm whether the unknown resident went without their medication on Saturday 16 March 2019".

Mr Kewley provided written submissions which stated:

"The NMC does oppose the submission on each of the charges addressed below.

Charge 30(c) – inappropriate delegation

8. The panel's attention is drawn to the evidence of Nina Bailey at paragraphs 53 to 56 of her witness statement.

9. In summary, Nina Bailey states that during the course of a medication round the Registrant delegated the task of covertly administering a resident's sodium valproate, Keppra and carbamazepine to a support worker. Nina Bailey was concerned that the Registrant had not assessed the resident himself and had not considered whether it was safe to administer the medication. Nina Bailey also

explains that the resident had reportedly had a seizure the previous night and was extremely lethargic and sleepy.

10. In oral evidence the panel heard from Nina Bailey about the issue of whether support workers were trained to give medication at the home. However, it is submitted that this issue may be something of a red herring. This is because the procedure for giving covert medication to this particular resident was covered by the instructions contained within the resident's medication care plan.

*11. The care plan begins at **P330**. The care plan explains that there is a clear link between the resident refusing to take medication and an immediate increase in seizures which then put the resident at greater risk of injury when dropping to the floor. The care plan notes that the decision to permit covert administration for this resident was made following an MDT meeting including a doctor and the named nurse.*

*12. The care plan explains that whilst it is advisable to allow the carer to give the food/drink containing the covert medication to the resident, this must always be under the observation of the nurse (**P331**).*

13. It appears, therefore, that the resident's care plan did envisage that carers would give the food containing the covert medication to the resident but only under the observation of a nurse.

14. Is not accepted by the NMC that any expert evidence is required (as argued in paragraph 14(a) of the Registrant's skeleton argument) in order to prove that the delegation was inappropriate. The Registrant's actions of delegating the task to a carer appear to be inconsistent with the resident's own care plan and this alone would be sufficient for a panel to find that the Registrant's actions were inappropriate.

15. It is submitted, therefore, that there is a case to answer in respect of charge 30(c).

Charge 36 – dishonesty

16. As the panel will be aware, the correct approach to determining issues of dishonesty was identified by Lord Hughes in ***Ivey v Genting Casinos [2017] UKSC 67*** *at [74]:*

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.*

17. The panel is reminded that dishonesty is an inference to be drawn by the panel from primary facts. It is not ordinarily a matter of comment or opinion for an individual witness. To that extent, it is submitted that Rachel Liporada's comment about dishonesty (as described at paragraph 15(a) of the Registrant's skeleton argument) is of little relevance to charge 36. It is accepted, however, that there is no witnesses have reported any concerns about the Registrant's honesty or probity.

18. The panel is reminded of the evidence of Rachel Liporada at paragraphs 34 to 38 of her witness statement.

*19. In summary, Rachel Liporada states that on 13 August 2018 the Registrant signed Resident GG's MAR chart to indicate that he had administered the nighttime dose of levetiracetam (RL/14 at **P670**). She states that the nighttime dose was due between 2100 and 2200. However, Rachel Liporada's evidence is that the Registrant could not have given the medication at nighttime because his shift finished at 2000 (which was before the nighttime medication was due). Rachael Liporada states that the same event also occurred on 18 and 19 August 2018.*

20. The MAR chart gives the appearance, therefore, that the nighttime dose of levetiracetam was administered at the correct time to the resident on 13, 18 and 19 August 2018.

21. By reason of his admissions to charges 34 and 35, the Registrant has accepted that he did in fact administer the medication at the incorrect time on 13, 18 and 19 August 2018 but signed the resident's medication record to indicate that it was given at the correct time.

22. Rachel Liporada's evidence was that levetiracetam is an anti-convulsant drug that needed to be given every 12 hours to prevent seizures. She stated that if a dose of levetiracetam was given too early it would not last until the next dose was due.

23. Reviewing the Registrant's entries on the resident's MAR chart gives the appearance that he correctly administered the nighttime dose of levetiracetam as prescribed on 13, 18 and 19 August 2018 when that was not the case. The Registrant has, therefore, recorded something on the MAR chart which was not in fact correct. It is submitted that the act of signing a medication record to confirm that you have given medication at the correct time when that was not the case at least raises a case to answer in respect of those entries being dishonest.

24. By August 2018 the Registrant was, plainly, a highly experienced nurse. He would have been capable of interpreting a MAR chart and understanding that anticonvulsant medication needed to be given in accordance with the instructions of the prescriber.

25. It is submitted that the there is a case to answer on charge 36.

46 – ordering medication supply on 15 March 2019

26. The panel's attention is drawn to the evidence of Helen Hepworth at paragraphs 24 to 27.

27. Helen Hepworth explains that the Registrant did not order medication on Friday 15 March 2019 which meant that medication for a resident was out of stock by Sunday 17 March 2019 which led to a resident not receiving their prescribed dose.

28. Helen Hepworth explains that the Registrant was working in the home on 15 and 17 March 2019. Helen Hepworth states that the Registrant should have realised that the medication was running low on 15 March 2019 and should have ordered more on 15 March 2019.

29. Helen Hepworth also states, in fairness, that the other nurses on 14 and 16 should also have realised and took action. However, it is submitted that this does not detract from the Registrant's own responsibility. Helen Hepworth states that the Registrant was working on the last weekday before the medication would run out and therefore he was ultimately responsible for ordering the medication (HH para 29).

*30. Helen Hepworth also refers to exhibit AS/15 (exhibit bundle **P470**) which was a note prepared on 19 March 2019 in relation to this incident. Helen Hepworth recorded within this note that the Registrant was on duty on the Friday and that*

it should have been noted by him that stocks were low but he failed to order more medication.

31. The Registrant's handwritten comments on AS/15 do not appear to dispute that he failed to order medication on the Friday – his comments appear to be directed towards explaining that other staff should also have spotted the issue as well.

32. The mischief of this charge is about failing to ensure that there was an adequate supply of medication at the home for a resident. It is submitted that the name of the specific medication or the name of the specific resident in question is immaterial to charge 46.

33. In these circumstances it is submitted that there is a case to answer on charge 46".

The panel took account of the written and oral submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage in relation to charges 30c 36 and 46. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you have a case to answer.

The panel noted that the NMC was not opposing the application in respect of charges 11, 12, 14, 16d, 17, 41, 42 and 45b. The panel accepted Mr Kewley's concessions in respect of these charges and determined that there is no case to answer in respect of charges 11, 12, 14, 16d, 17, 41, 42 and 45b.

In respect of charge 30c, the panel considered that clinical expert evidence was not needed in relation to this charge. The panel was of the view that there had been sufficient evidence to support charge 30c at this stage and, as such, it was not prepared, based on

the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 36, the panel considered that it is ultimately a matter for the panel to decide whether you were being dishonest. At this stage, the panel was satisfied that there was evidence from which it could properly infer that your state of knowledge or belief as to the facts was such that it would have been regarded as dishonest by the standards or ordinary decent people. What weight the panel gives to any evidence and whether it draws any such inference, remains to be determined at the conclusion of all the evidence.

In respect of charge 46, the panel considered that it did not necessarily follow that the responsibility upon other nurses to order medication stocks detracted from evidence suggesting it was your responsibility to recognise that medication was in low supply and reorder stock. The panel was of the view that there had been sufficient evidence to support charge 46 at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The following charges remain to be determined at the facts stage; charges 20, 30c, 32, 36, 43, 46 and 48.

Decision and reasons on facts

Ms Badenach-Nicolson informed the panel that you made admissions to charges 1a, 1b, 1c, 2, 3a, 3b, 3c, 3d, 7a, 7b, 7c, 8a, 8b, 8c, 9a, 9b, 13a, 13b, 13c, 16a, 16b, 16c, 18a, 18b(i), 18b(ii), 18b(iii), 19(i), 19(ii), 19(iii), 21, 22, 23, 24a, 24b, 24c, 25a, 25b, 25c, 25d, 26a, 26b, 26c, 26(1), 26(2), 30a, 30b, 31, 34, 35, 38, 44, 47a, 47b, 47c, 47d, 47e and 47f.

The panel therefore found these charges proved by way of your admissions.

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 Kewley and Ms Badenach-Nicolson.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Registered Manager at Pathfields Lodge Care Home;
- Witness 2: Nurse Consultant Pathfields Lodge Care Home;
- Witness 3: Clinical Services Manager at Midland Care Home;
- Witness 4: Contract Monitoring Officer for Northampton County Council;
- Witness 5: Registered Nurse at Midland Care Home;
- Witness 6: Registered Manager at Conifer Lodge, Huntercombe Group;
- Witness 7: Operations Manager at Midland Care Home.

The panel also heard evidence from you under oath.

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

Charges 20(i), 20(ii) and 20(iii)

In relation to 19 (iii),

(i) Did not talk sufficiently to residents to offer assistance and/or compassion
(ii) Did not sufficiently assess the Residents' needs by discussing such matters with them.
(iii) In particular, did not sufficiently discuss their medication needs, such as PRN which would need discussion and a caring response

These charges are found not proved.

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

Whilst present at Pathfields Lodge, Witness 6 was asked to support, supervise and assess your medication competency in light of developing concerns around your medication practice. Witness 6's evidence is that on 18 October 2017, she observed you not talking to residents, not offering reassurance nor showing compassion, not communicating with residents nor assessing their needs.

The panel also had sight of the medication competency assessment form which contains a competency for showing a '*thoughtful approach to drug administration'* which Witness 6 marked as 'not achieved' on 18 October 2017.

You said you are normally more chatty but you were aware that you were being supervised and focused on getting through the medication round in good time. You said you didn't think you were 'cold' but you were probably more formal than usual.

The panel considered that the amount you spoke to residents is highly subjective and may have been dependent on how well you knew the residents and whether you were in the company of a supervisor at the time.

The panel was not given specific examples where you did not talk sufficiently to residents to offer assistance or compassion. The panel was not referred to any care notes and saw no evidence of harm or neglect of residents or that any of the residents had any needs unmet including the need for PRN medicine due to a lack of discussion by you.

The panel found your evidence to be credible and accepted your account of the events giving rise to this charge. The panel determined the NMC had not provided sufficient evidence to find this charge proved.

The panel therefore found charges 20(i), 20(ii) and 20(iii) not proved.

Charge 30c

On the 1st November 2017, at the third assessment, in relation to Resident H, a sufferer of tonic-clonic seizures and consequential lethargy

(a) …

(b) …

(c) In the light of (b) and generally, your delegation of this task was inappropriate.

This charge is found proved.

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

Witness 6 carried out the third assessment with you on 1 November 2017. Witness 6 stated that Resident H had experienced a seizure during the night and was reported to be extremely lethargic. However, Witness 6 stated that she observed that you did not check or assess the resident (to make sure it was safe to administer medication) before instructing the support worker to administer the medication covertly.

During your evidence you accepted that you delegated this task to the care worker and that you did not do an assessment of Resident H before delegating the task. You said that the care worker was familiar with Resident H and you trusted that they would give you a handover. You said that you were outside the room in the corridor, but you could not recall whether the door was open or closed.

The panel had sight of Resident H's care plan which clearly states that the covert medication must be administered under the direct observation of the nurse.

The panel found the evidence of Witness 6 to be credible and reliable and accepted her account of the incident. The panel also took into account that you accept that the incident happened as described by Witness 6. The panel determined that your delegation of this task was inappropriate.

The panel therefore found charge 30c proved.

Charge 32a, 32b and 32c

In the approximate periods

a) February 2018 to April 2018
b) Leading up to August 2018
c) Leading up to February 2019

You did not manage your time effectively and/or efficiently in that you were late in completing your morning medication rounds.

These charges are found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 5, Witness 6 and Witness 7.

The panel had sight of three separate near contemporaneous written notes which document issues around your ability to complete medication rounds in a timely manner:

- file note of 14 April 2018;
- file note of 20 August 2018;
- file note of 1 February 2019.

The notes span a period of around ten months, and each identified the same issue around your inability to complete medication rounds in a timely manner. The panel heard evidence from Witness 5, Witness 6 and Witness 7 who all stated that you were late in completing the morning medications rounds.

Your evidence is that you accept that you were taking longer than usual to complete the morning medication round as you would get distracted and have to deal with other issues which you thought would take only a few minutes.

The panel took into account that you may well have received interruptions during your medication rounds. The panel also heard that you took and made phone calls which were not relevant to the medication round nor were they emergencies. However, part of a registered nurse's role is to be able to manage their time and balance the competing priorities in order to deliver safe and effective care in a timely manner to residents.

The panel accepted the evidence of the witnesses and determined that you were not managing your time effectively or efficiently which led to you being unable to complete medication rounds in an acceptable time. The panel therefore found charges 32a, 32b and 32c proved.

Charge 36a, 36b, 36c and 36d

Your entries at Charge 35 were dishonest in that you knew

a) You had not administered the drug between 21.00 and 22.00 hours and/or
b) You knew the drug had been administered earlier by yourself and/or.
c) You were not in the Home at 21.00, your shift having ended at 20.00 hours and/or
d) Your entries were designed to conceal that you had given the drug at the wrong time.

Charges 36a, 36b, 36c and 36d are found not proved.

In reaching this decision, the panel took into account your evidence.

You accepted during your oral evidence that you did not administer the drug between 21.00 and 22.00, that you had administered the drug earlier and that you were not in the Home at 21.00, because your shift ended at 20.00.

The panel took into account that you accepted your actions at a, b and c. However, the panel should not find any of charges 36a, 36b, 36c, and 36d proved unless it is satisfied, in accordance with the stem of charge 36 that you were dishonest.

You explained that there was a collective decision in an informal meeting between staff, which included you, that the resident would be given the drug earlier than generally prescribed. You explained that this resident would go to bed early in the evening and he disliked being disturbed. You told the panel that in order not to disturb him after he had

gone to bed, medication was given early to ‘maintain safety and decrease incidents’ with this resident.

You said that your entries were not designed to conceal that you had given the drug at the wrong time, and you said there was no reason for you to be dishonest about the time the drug was administered. You said you signed so that it was clear you had given the medication, and it would not be administered again by the night shift. You told the panel that these details were explained to the agency staff nurse at handover.

The panel found your explanation of this incident to be plausible. It concluded that there had been poor communication between staff regarding the decision to give the resident the drug early. The panel bore in mind that you have previously taken responsibility for other errors you have made. The panel considered that while this practice of administering medication other than at the time it was listed to be administered constituted poor practice, it was not done dishonestly. The panel determined that your entries were not intended to conceal that you had given the drug at the wrong time.

It therefore found charges 36a, 36b, 36c and 36d not proved.

Charge 43a

On the 30th January 2019, acting as witness to the administration of controlled drugs by another to Residents BB and KK

a) You countersigned the relevant controlled drug record for both residents before the person giving the drug had made their entry on the record.
b) …
c) ...

This charge is found proved.

In reaching this decision, the panel took into account your evidence.

The panel has heard evidence that on 30 January 2019 you acted as the second checker involved in the administration of controlled drugs to residents BB and KK.

Your evidence is that you do not recall much about this incident or anything about the agency nurse you were checking the medication with. However, you were clear in your evidence that you did not administer the drug.

The panel had sight of the extracts of the controlled drugs book for Residents BB and KK. The panel noted that you had signed the controlled drugs book for both residents but the nurse who administered the medication had not done so. The panel determined that it follows that you must have signed the book before the nurse who administered the medication made any entry in the book. It therefore found charge 43a proved

Charge 43b and 43c

On the 30th January 2019, acting as witness to the administration of controlled drugs by another to Residents BB and KK

a) ...
b) You did not check the stock after the administration of the drugs
c) You did not notice that there were discrepancies in Resident BB's and KK's controlled drug records.

These charges are found proved.

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

Witness 5 stated in her evidence that that she did a stock count on the following day and found that the remaining balance was in fact 14 rather than 13. The panel had sight of the entry dated 31 January 2019 made by Witness 5 in Resident KK's controlled drug book to correct the balance to 14.

Your evidence is that your usual practice would be to count the remaining balance of medication, although you said you do not recall doing so on this occasion. You accepted that to simply subtract one tablet from the previous balance without counting would perpetuate any errors in the record.

The panel was of the view that if you and the other nurse did in fact count the balance it seems unlikely that you would both get the wrong outcome. The panel determined that a more likely explanation is that on this occasion there was no physical count, which is why Witness 5's count the following day identified an error in the remaining balance.

The panel determined that you did not check the stock after the administration of the drugs, and you did not notice that there were discrepancies in Resident BB's and KK's controlled drug records. It therefore found charges 43b and 43c proved.

Charge 45(a)

In light of the panel's decision to find no case to answer on charge 45(b), the NMC did not invite the panel to find charge 45a proved. The panel therefore found charge 45a note proved.

Charge 46

On the 15th March 2019, either

a) recognised that unknown medication was low in supply or
b) ought to have recognised that it was in low supply

and did not order medication stocks to be replenished.

Charge 46b is found proved.

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

Your evidence is that other nurses should have recognised as well that the medication was in low supply and ordered it. In your oral evidence you accepted that you were the nurse in charge of residents on the floor in question on 15th March 2019.

Witness 3's evidence is that you did not order medication on Friday 15th March 2019, which meant that medication for a resident was out of stock by Sunday 17th March 2019, which led to that resident not receiving their medication as prescribed.

Witness 3 explains that you were working in the home on 15th and 17th March 2019 and you should have realised that the medication was running low on 15th March 2019 and should have ordered more that day. Witness 3 stated that you were working on the last weekday before the medication would run out and therefore you were ultimately responsible for ordering the medication.

The panel accepted the evidence of Witness 3. The panel noted that Witness 3 also stated, in fairness, that the other nurses completing medication rounds on 14th and 16th March 2019 should also have realised and taken action. However, the panel determined that this does not detract from your own responsibility. The panel determined that you ought to have recognised that the medication was in low supply and ordered stocks to be replenished. The panel therefore found charge 46b proved.

Charge 46a, which is charged alternatively to charge 46b, is found not proved.

Charge 48a

On the 26th March 2019,

a) did not escalate Resident DD's care for medical review notwithstanding high blood sugar readings at 14.15 pm, 15.55 pm, 18.25 pm and 20.00 pm
b) ...

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

Witness 4's evidence is that she attended the home for a visit on 26 March 2019. During that visit she became concerned about Resident DD who had recently returned to the home following a short hospital admission due to an episode of hyperglycaemia. Resident DD was returned to the home with a new regime to manage their blood glucose levels. A dose of insulin was to be given that evening by staff in the home and blood glucose levels recorded 4 hourly to monitor the effect of the new regime. In addition, you told the panel that you were monitoring Resident DD's conscious level and other vital signs and recording these on a NEWS chart which the panel had sight of. This was to help identify any deterioration in Resident DD's condition that may have occurred in association with their raised blood glucose levels. You told the panel Resident DD exhibited no signs of deterioration and remained well despite the high blood glucose levels, consequently you were not unduly concerned about Resident DD as these high glucose levels were in the process of being managed. However, you did contact Telemed and 111 services for advice as requested to do so by Witness 4. The panel had sight of the nursing note for 26 March 2019 which show that advice was obtained from Telemed and 111 services during the evening with regard to Resident DD's raised blood glucose levels.

The panel has sight of an entry in the notes made by you following the call to Telemed stating '*on this occasion telelmed has been brief and responsive as information was already on system and intervention was timely'*.

The panel found your explanation regarding this incident plausible and noted that Witness 4 has no clinical expertise. The panel determined that your call to Telemed and 111 was evidence that you had in fact escalated Resident DD's care for medical review. It therefore found charge 48a not proved.

Charge 48b

On the 26th March 2019,

a) …
b) Did not sign Resident DD's MAR chart for the administration of insulin at 18.00 hours.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

Witness 4's evidence is that she reported her concerns by email dated 27 March 2019. Within the email she stated that she checked a MAR chart for the resident and noted that a signature was missing for 1800 insulin which she stated, '*Darren advised he forgot to sign but has administered*'. It also had sight of Witness 4's supplementary witness statement dated 10 November 2022.

The panel did not have sight of an updated MAR chart following Resident DD's discharge from hospital. It noted the instructions on the hospital discharge note, that the insulin to be given on the day of discharge and subsequently was different to that on the MAR chart as

a new regime was being introduced. It accepted that this was instead of, not in addition to, the insulin prescribed on the MAR chart.

The panel determined that there was no requirement for there to be a signature on the MAR chart for the administration of insulin on 26 March 2019 at 6pm. It therefore found charge 48b not proved.

Fitness to practise

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

The panel, in reaching its decision, 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

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

Mr Kewley provided written submissions. He invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and identified the specific, relevant standards where the NMC say your actions amounted to misconduct.

The written submissions in relation to Misconduct stated:

> *"The facts in this case engage different aspects of the Registrant's nursing practice. These include issues around medication administration, record keeping and communication with professional colleagues (i.e handing over).*
>
> *At the material time (2017 to 2019) the Registrant was a highly experienced nurse who had practised for many years without any previous regulatory findings. The panel also heard that the Registrant had practised previously in a range of different nursing environments and had regularly administered medication as part of his prior nursing experience.*
>
> *One of the unusual aspects of this case is that it appears from the evidence that the Registrant did in fact possess the skills required to practise, at least on occasions, in accordance with the expected standards of a registered nurse. For example, the Registrant was able to pass a medication competency assessment carried out by [Witness 5]. In addition, the Registrant was able to answer questions from [Witness 7] about the correct procedures to follow and potential risks ... This is not a case, for example, of a newly qualified nurse who has never managed to perform to the required standard.*
>
> *Whilst the underlying cause of the issues appears to be largely unexplained, one issue was noted by [Witness 7] to be that the Registrant was taking short cuts in his practice and was failing to adhere to the required standards. This point is noted in exhibit TS/15 ('final statement dated 28 May 2019') in which [Witness 7] stated:*

'DA appeared to be fully aware of correct procedures and consequent risks of malpractice as he answered questions correctly and without hesitation…. despite this awareness what is most concerning is that DA stated that deviation from the correct procedure was his choice without any pressure or circumstances pushing him to do so. He found it acceptable and normal practice to make shortcuts during a normal medication round … this is all with knowing and being fully aware of the risks do the residents… he is repeatedly failing to realize the importance of why we have correct procedures in place…'

Many of the issues in this case do not appear to arise from any sort of lack of technical knowledge or training. For example, answering the phone during medication rounds (21, 47(f)), putting dispensed medication in a pocket (25(c) and 47(c)), failing to recognise and take action when medication was in low supply (46), leaving a month's supply of medication unlocked (44), giving medication that had been discontinued (38), delegating the administration of anti-convulsant medication to an untrained carer (30(c)) and not recording the time that PRN pain relief was given (7/8).

In addition to the clinical failings, the panel also heard that a decision was made by Pathfields to restrict the Registrant from giving medication due to concerns about his practice. However, on 28 October 2017 the Registrant administered medication to residents without supervision in direct contravention of this restriction and did so without informing [the Nurse]. The Registrant's disregard for the restriction placed on his practice further placed residents at an unwarranted risk of harm.

The Registrant repeatedly, across two separate places of employment, failed to practise safely and effectively which placed numerous residents at an unwarranted risk of harm. The panel may conclude, therefore, that the Registrant's actions

constitute a serious falling short of what would have been proper in the circumstances such that they amount to misconduct.

As noted in paragraph [3] above, misconduct and impairment are matters for the panel's own judgment rather than for the parties. However, it is acknowledged that charge 16 (a) to (c) is unlikely to amount to misconduct. It is acknowledged that the mischief of charge 16 was captured in 16(d), namely the alleged failure to administer Resident H's medication. In light of the panel's no case to answer decision on charge 16(d), it is acknowledged that the remaining admitted parts of charge 16(a) to (c) do not amount to a failure without 16(d)."

Mr Kewley moved on to the issue of impairment and addressed the panel in the written submissions on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin)and *Kimmance v General Medical Council* [2016] EWHC 1808 (Admin). He also referred the panel to NMC guidance DMA-1.

The written submissions in relation to impairment stated:

"*If the panel finds that any of the facts amount to misconduct, the panel must consider whether the Registrant's fitness to practise is currently impaired...*

It is submitted that limbs (a), (b) and (c) of the Dame Janet Smith questions are engaged in this case. The Registrant's actions placed multiple residents at an unwarranted risk of harm. The Registrant repeatedly failed to practise safely and effectively in accordance with the standards expected of a registered nurse. The NMC's guidance DMA-1 explains that the fundamental tenets of the nursing profession are standards outlined in the Code which are structured around four

themes which include, relevant to this case, the requirements to practise effectively and preserve safety. The Registrant's actions, and the resulting risk of harm to residents, are likely to have brought the nursing profession into disrepute and breached fundamental tenets of the nursing profession.

In order to make an assessment of future risk, the panel may wish to consider whether the Registrant has strengthened his practice such that the risk of repetition can now be described as low. This involves making an assessment of matters such as the Registrant's level of insight into the concerns and any practical steps that he has taken to reduce the risk of repetition.

As to the Registrant's level of insight, it is accepted that the Registrant has shown some insight in the sense that he made a number of early admissions to the charges. However, it is submitted that his level of insight is far from complete. There does not appear to be any evidence of recent reflection addressing (a) the reasons why the Registrant believes these events happened (b) what the Registrant now feels about these events with the benefit of hindsight (c) the Registrant's assessment of how his actions placed residents at a risk of harm (d) what he has learned since these events and (e) how he would approach matters differently in the future. In addition to the widespread clinical failings, it is likely that the panel would particularly wish to assess the Registrant's level of insight in relation to his failure to comply with the medication administration restriction that was placed on his practice by Pathfields Lodge (charge 26).

In addition to assessing the Registrant's level of insight, the panel may also wish to consider any practical steps that have been taken to demonstrate that any subsequent learning has been embedded into the Registrant's nursing practice across the areas of medication administration, record keeping and communication with colleagues. Relevant evidence might include:

a. evidence showing a sustained period of safe nursing practice post-

Midlands Care Home without any repetition of the issues;
b. evidence of medication training with a practical and supervised/assessed element;
c. evidence of a reading log showing the Registrant's attempts to keep his knowledge up to date since leaving Midlands Care Home;
d. any testimonial evidence from a registered nurse who has had the chance to directly observe the Registrant's clinical practice since the events in question.

It is acknowledged that the issues in this case are, in principle, capable of being remediated. It is submitted, however, that the Registrant has not yet shown full insight into the concerns and has not taken sufficient steps to strengthen his practice. As such, the risk of repetition remains high. It is submitted that the Registrant's fitness to practise is, therefore, currently impaired on public protection grounds and public interest grounds".

Ms Badenach-Nicolson provided written submissions which stated:

"It is submitted that the focus of misconduct allegations is on behaviour, rather than skills or knowledge and it is for this reason that such allegations usually include ethical violations, dishonesty or abuse of patients.

Lack of competence refers to an ongoing inability to perform tasks or duties to the required standard over a sustained period and focuses on skills, knowledge and capability.

Whilst the Registrant accepts that he was an experienced nurse at the time of the proved allegations, it is denied that any of the charges relate to the Registrant's behaviour. Rather, they are all failures which relate to issues stemming from a lack of skill or capability, which can, for the most part, be fairly characterised as clerical errors. It is therefore submitted that the proved allegations are more logically characterised as

amounting to a lack of competence, rather than misconduct.

Where the errors relate to a judgment call made by the Registrant, it is submitted that this is owing to the fact that the Registrant was under significant pressure of time and was unable to manage those demands appropriately.

It is submitted that it is clear from the NMC's witness evidence on the proved allegations that the primary reason for the errors was time management and/or a lack of capability, rather than a behavioural issue on the part of the Registrant.

Having regard to the commentary in Nandi as summarised in paragraph ***Error! Reference source not found.*** *above, the Panel are invited to conclude that none of the proved allegations in this case, whether taken individually or considered together, could be regarded as 'deplorable' by the Registrant's fellow nurses.*

It is therefore submitted that the none of the proved charges, whether individually or together, amount to misconduct. The NMC's case therefore falls at the first hurdle of the impairment stage and, accordingly the allegation that the Registrant's FTP is impaired must also fail.

Submissions - impairment

Further and alternatively to the above, if the Panel finds that the facts proved or admitted do amount to misconduct, the Registrant relies on the 12-page bundle provided to the Panel on 4 November 2024 by the Royal College of Nursing, enclosing 11 certificates dated April 2024, all of which were obtained as a result of the Registrant undertaking training in the core areas of practice underpinning the allegations before this Panel.

Not only does the aforementioned training demonstrate insight on the part of the Registrant in relation to the allegations, but it is also evidence of his dedication to the

profession and keenness to improve, as touched upon in several witness statements of the NMC witnesses.

The Panel will consider the fact that the Registrant was open and honest with his colleagues at Pathfields and Midland Care Home in 2017 and 2018 in relation to his mistakes. That willingness to engage and learn has continued during these proceedings. It is submitted that the Registrant is capable of practising 'kindly, safely and professionally.

Conclusion

It is for the above reasons that the Registrant submits the Panel cannot properly find that the proved allegations amount to misconduct.

Accordingly, the Panel cannot properly conclude that the Registrant's FTP is impaired as a result of any misconduct."

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

*"**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

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

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

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

20 uphold the reputation of your profession at all times

To achieve this, you must:

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel identified four areas of concern in respect of the findings made by the panel:

- Failure to store drugs safely;
- Failure to administer medicines as prescribed;

- Failure to accurately record the details of medicines administered including of controlled drugs;
- Failure to adhere to policies regarding medicines management.

The panel noted that at time the charges arose, you were a highly experienced nurse who had practised for many years without any concerns being raised to the NMC about your practice. The panel noted that you had practised previously in different nursing environments and had regularly administered medication.

The panel noted that it appeared that you did in fact possess the skills required to practise in accordance with the expected standards of a registered nurse and you were able to answer questions about your practice. However, you failed to implement your knowledge and this led to errors and unsafe practice putting residents at unwarranted risk of harm. In particular, the panel took into account and accepted the evidence of Witness 7, who noted that you were taking short cuts in your practice and were failing to adhere to the required standards and organisational policies. Witness 7 stated:

> *'DA appeared to be fully aware of correct procedures and consequent risks of malpractice as he answered questions correctly and without hesitation…. despite this awareness what is most concerning is that DA stated that deviation from the correct procedure was his choice without any pressure or circumstances pushing him to do so. He found it acceptable and normal practice to make shortcuts during a normal medication round … this is all with knowing and being fully aware of the risks do the residents… he is repeatedly failing to realize the importance of why we have correct procedures in place…'*

The panel noted that your actions were repeated for a prolonged period across two separate places of employment despite support being provided by your employer, which placed numerous residents at an unwarranted risk of harm. The panel determined that you made a conscious choice to disregard policy and directions. It was particularly concerned

that you behaved in this manner while being subject of a restriction not to administer medication unsupervised, you nevertheless went on to do so. The panel considered the failures in your practice related to fundamental nursing skills.

The panel concluded that your actions constitute a serious falling short of what would have been proper in the circumstances..

The panel therefore concluded that your 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, 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/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) ...'*

The panel found limbs a, b and c engaged in the *Grant* test. The panel found that patients were put at risk as a result of your misconduct by your:

- Failure to store drugs safely;
- Failure to administer medicines as prescribed;
- Failure to accurately record the details of medicines administered including of controlled drugs;
- Failure to adhere to policies regarding medicines management.

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

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.
Regarding insight, the panel took into account that you made admissions to a number of the charges. However, the panel noted that you had not provided any written reflections. It considered that you have not provided evidence of your understanding of how your actions put the patients at risk of harm and the potential impact on them. Nor have you demonstrated an understanding of how your actions impacted negatively on the reputation of the nursing profession. The panel was of the view that you have not provided evidence about how you would behave differently in the future. The panel determined that you had demonstrated minimal insight into your misconduct.

The panel also took into account the online training certificates you provided some of which were relevant to the charges found proved. However, the panel noted that these training certificates did not disclose any assessment details and there was no evidence that you have been able to implement your learning in practice.

The panel is of the view that there is a significant risk of repetition based on the lack of evidence of insight or strengthened practice. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found your fitness to practise impaired on the grounds of public interest.

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

Decision and reasons on application for your oral evidence to be held in private

Ms Badenach-Nicolson made a request that your oral evidence be held in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Khaile on behalf of the NMC, indicated that she made no observations on the application and that it is a matter for the panel.

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

[PRIVATE] the panel determined to hold the entirety of your oral evidence in private.

Sanction

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

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.

Oral evidence

[PRIVATE]

Submissions on sanction

Ms Khaile submitted that the appropriate sanction in this matter is a conditions of practice order with a review hearing for a period between 12 to 24 months. She referred the panel to the NMC Guidance DMA 1, which notes that proportionality is an important factor.

Ms Khaile submitted that although the panel has heard evidence from you in respect of insight, this is still limited and needs to be further developed. She also referred the panel to the evidence of training and development you have provided.

Ms Khaile submitted that there have been repeated clinical failures across two places of employment and the conduct found proved put residents at unwarranted risk of harm.
In terms of sanctions, she submitted that given the seriousness of the charges found proved, no action and a caution order would be insufficient to protect the public and would

not address public interest concerns. She submitted that a conditions of practice order would be appropriate in this case. She submitted that conditions of practice may be appropriate when there are identifiable areas of practise in need of improvement and assessment, no evidence of general incompetence and there is evidence of a willingness to respond positively to retraining. She suggested specific conditions limiting your practice to one substantive employer, supervision and meetings with a line manager.

Ms Badenach-Nicolson provided written submissions to the panel which stated:

"By way of a brief chronology, the Registrant was first made subject to an interim COPO on 22 August 2019. These conditions are appended to this skeleton at Appendix 1.

The Registrant understands that the NMC's sanction bid is one of a Conditions of Practice order for 12 – 24 months. For the avoidance of doubt, the Registrant accepts that a measure of restriction is required in order to allow him to practice safely and he would welcome conditions similar to those at Appendix 1 and focusing on the following key areas:

(a) Limiting his practice to one substantive employer
(b) Supervision by another nurse when administering medication
(c) Regular meetings with a line manager or similar to discuss performance
(d) Providing the NMC with a report from a line manager prior to any review of the substantive order

For completeness, the Registrant remained subject to conditions until 5 February 2024 when the interim COPO was replaced with an interim suspension order. The Registrant did not attend, nor was he represented. Submissions were sent by the Royal College of Nursing on the Registrant's behalf, requesting that the interim COPO continued unchanged.

It is submitted that it was unusual for the Panel to do this at the night review of the interim COPO. No challenge was raised in response to this decision at the time [PRIVATE] and because it was in the Registrant's interests to have the substantive hearing in this matter concluded as soon as possible. Any challenge to the interim order decision would have caused further delays. It is within this context that the Panel is invited to give little weight to the fact that the Registrant has most recently been subject to an interim suspension order.

The facts and chronology of this matter is clear evidence that a COPO is the appropriate order for the Panel to make: the fact that, by his own admission, the Registrant made similar mistakes at Pathfields Care Home to those he made at Midland a year later is proof of the fact that he requires a set of stringent conditions within which he can safely return to practice. Putting it another way, a suspension order will not achieve safe practice but will delay the commencement of what the Registrant accepts is a practice which needs developing and assistance by way of support from colleagues and from the NMC.

The Registrant has demonstrated insight into the allegations in three key respects:

(a) Admissions: not only did the Registrant admit a great number of allegations contemporaneously i.e. when he was confronted with the issues by his colleagues at Pathfields and Midland Care Homes, he has made appropriate concessions before this Panel

(b) Learning: the Registrant has recently undertaken a series of training sessions targeting the specific areas in which failings have either been admitted or found proved by the Panel in these proceedings

(c) Keenness to engage with conditions: the Registrant will speak to the fact that he is keen to engage with a set of conditions as he returns to practice

As set out in the NMC guidance, the relevance of a nurse's insight is that they understand the problem and have demonstrated their attempts to address the same. It is submitted that the Panel can rest assured that the Registrant has learned from his mistakes and, owing to the enormity of the NMC process to date, he will ensure he does not fall back into the same pattern of making mistakes.

The Registrant will supplement the above points in oral evidence [PRIVATE]".

The panel accepted the advice of the legal assessor.

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:

- You have demonstrated limited insight into your failings.
- A pattern of misconduct over a period of 18 months at two different places of employment.
- Your misconduct put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- You made admissions to a number of charges.
- You have demonstrated some insight and a willingness to develop this further.
- You have undertaken relevant training to address the concerns.

- Personal mitigation. [PRIVATE].

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 not protect the public nor be in the public interest to take no further action.

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *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 considered that there was no evidence of attitudinal problems. Conditions would address the areas of your practice in need of retraining and enable monitoring and assessment of those identified areas.

The panel accepted your evidence that you would be willing to comply with conditions of practice and that conditions would protect patients during the period they are in place.

The panel had regard to the fact that these incidents happened several years ago and that you are a highly experienced nurse who had previously practised for many years with an unblemished record. 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.
The panel determined that a conditions of practice order for a period of 18 months would allow you the opportunity to address the concerns whilst in employment.

Balancing all of these factors, the panel determined 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.

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.

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 confine your nursing practice to a single employer. It must not be an agency and you must not undertake bank work.

2. You must not undertake medicines administration including controlled drugs and/or record on MAR charts and in controlled drug books without supervision by another registered nurse until you have sent your case officer evidence that you have been assessed undertaking medicine rounds for at least 8 patients/residents on three occasions. At least one of these assessments must include controlled drug checking, counting, administering and recording. These assessments must be carried out on 3 different days by an assessor who must be a registered nurse who is in a senior position to yourself, such as:
    - clinical lead
    - clinical educator
    - home or ward manager
    - deputy home or ward manager

    This condition will continue until you have sent your case officer evidence that you have successfully completed these 3 assessments, at which point it will be discharged.

3. You must keep a reflective practice profile. The profile will:
    - Detail examples of occasions when you have been involved with medications management (ordering, receiving, storing, administering, recording, disposing or returning medications, including controlled drugs).

- Set out the circumstances of the situation, your role and that of others and your reflections on what went well and what could be improved. Note good practice when you see it and consider how you can improve your own practices. This will be a personal record for your use.
- Include a summary that will detail what you have learnt and how you plan to implement it in the future.

The summary sheet only must be sent to your NMC case officer at least 7 days prior to the review hearing to demonstrate your learning and development.

5. You must work with line manager, mentor or supervisor (or their nominated deputy) to create a personal development plan (PDP). Your PDP must address the concerns regarding time management and medicines administration.

6. You must send a copy of your PDP and a report from your line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance and your progress towards achieving the aims set out in your PDP to the NMC at least 7 days before any NMC review hearing or meeting.

7. 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 name, postal address, email address and telephone number.

8. 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, postal address, email address and telephone number of the organisation offering that course of study.

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

10. You must tell your NMC case officer, within seven days of your becoming aware of:
    a. Any investigation started against you.
    b. Any disciplinary proceedings taken against you.

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

The period of this order is for 18 months. The panel determined that this is an appropriate amount of time to enable you to return to the workplace, strengthen your practice and fully develop your insight.

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 including attendance at any future review hearing.
- Evidence of recent training and education undertaken.
- Testimonials from a line manager or supervisor that detail your current work practices.

This decision 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 order takes effect. The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Khaile. She submitted that an interim conditions of practice order which is in the same terms as the substantive order is necessary for a period of 18 months to cover the appeal period.

Ms Baden-Nicolson confirmed that she had no objection to the application.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the appeal period.

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.