Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 11 – Friday 15 November 2024
Monday 18 November 2024

Virtual Hearing

Name of Registrant:	Megan Patricia Ann Lawrence
NMC PIN	83E0647S
Part(s) of the register:	Registered Nurse – Sub Part 1 RN7 General Nurse L2 – May 1986 RN1: Adult Nurse L1 – January 1997
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, lay member) Kathryn Smith (Registrant member) David Anderson (Lay member)
Legal Assessor:	Angus Macpherson (11 – 15 November 2024) Ian Ashford-Thom (18 November 2024)
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Shaun McPhee, Case Presenter
Mrs Lawrence:	Present and unrepresented
Facts proved by admission:	Charges 1a(i), 1a(ii), 1a(iii), 1a(iv), 1b and 5
Facts proved:	(the stem of) Charge 1, Charges 2, 3, and 4
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**

Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered nurse, while working for the North Camp Surgery:

1. On an unknown date did not follow safe procedure for administering medication in that you:
    a. Altered the prescription label on a box of Haldol Decanoate prescribed to Patient A by:
        i. Crossing through the name of Patient A;
        ii. Overwriting the name of Patient B;
        iii. Crossing through the prescribed dosage for Patient A;
        iv. Overwriting a new dosage for Patient B.

    b. Administered Haldol Decanoate prescribed for Patient A to Patient B.

2. On or around 26 November 2021 did not ensure Child A's immunisation record was updated.
3. On 26 November 2021 administered Depo-Medrone to Patient C who was prescribed Depo-Provera.
4. On 30 November 2021 administered Depo-Medrone to Patient D who was prescribed Depo-Provera.
5. On 6 December 2021 incorrectly documented that Patient E had received a Vitamin B12 injection when they had not.

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

Background

The NMC received a referral in relation to your practice as a registered nurse whilst employed as a practice nurse at North Camp GP practice (North Camp).

It is alleged that, on an unknown date, you failed to follow safe procedures in administering medication in that you allegedly altered the prescription label on a box of Haldol Decanoate prescribed to Patient A by crossing out Patient A's name and prescribed dosage, and replacing them with Patient B's name and a new dosage for Patient B.

On or around 26 November 2021, it is alleged that you failed to update Child A’s immunisation record, despite being tasked with and responsible for doing so. This error was discovered only after the child’s mother contacted the surgery to confirm whether the vaccination records were up to date, at which point it was revealed that the immunisation records had not been properly completed.

It is alleged that you mistakenly administered Depo-Medrone, a steroidal anti-inflammatory, to two patients who were prescribed Depo-Provera, a contraceptive. Specifically, on 26 November 2021, you allegedly administered Depo-Medrone to Patient C, who was prescribed Depo-Provera, and on 30 November 2021, you allegedly did the same for Patient D, who was also prescribed Depo-Provera. This was discovered when another member of staff noticed the batch numbers of the medication administered by you recorded in the medical notes were not batch numbers of Depo-Provera.

On 6 December 2021, it is alleged that you incorrectly documented that Patient E had received a Vitamin B12 injection when they had not.

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

During the course of the hearing, the panel invited submissions from Mr McPhee and from you in relation to hearing this case in private [PRIVATE].

Mr McPhee made an application for parts of this case to 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). [PRIVATE].

You indicated that, although you did not oppose the application, you were happy for matters to be explored fully in an open hearing.

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 go into private session in connection with those matters as and when such issues are raised [PRIVATE].

Decision and reasons on application to admit hearsay evidence

On day one of the hearing, the panel heard an application made by Mr McPhee under Rule 31 to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and, Mr McPhee submitted that whilst the NMC had made sufficient efforts to ensure that this witness was present at this hearing. He stated the NMC had made repeated requests to Witness 1 and despite these requests Witness 1 was unwilling to attend either in person or virtually. Mr McPhee informed the panel that Witness 1 was the practice manager at North Camp at the relevant time and she provided her written statement and within that she agreed to give evidence at a hearing should she be required to do so. He informed the panel that, since providing her statement, Witness 1 has disengaged. He further informed the panel that she no longer works for North Camp, no longer lives in the UK [PRIVATE].

Mr McPhee submitted that Witness 1 now resides in another country, and as such, there are no reasonable means available to compel her attendance so that she could give evidence before the panel in this jurisdiction.

Mr McPhee informed the panel that members of the NMC staff including the case coordinator and the hearings coordinator have engaged with Witness 1 prior to this hearing to encourage and support her to give evidence. Nonetheless, Witness 1 has declined to do so.

Mr McPhee submitted that the NMC has made all reasonable efforts to secure Witness 1's attendance, but unfortunately that has not secured Witness 1's attendance at this hearing. He submitted that given Witness 1's exceptional personal circumstances, the panel should consider admitting this evidence as hearsay evidence.

Mr McPhee referred the panel to the NMC's guidance on 'Evidence' reference DMA-6 which sets out that the principal consideration for the panel is that of fairness. He

submitted that the panel must carefully consider and weigh fairness to you in all the circumstances.

Mr McPhee submitted that in this case, it would be fair to admit the written statement of Witness 1. He stated that although the contents of the statement could not be subjected to cross examination, it could be challenged in other ways.

Mr McPhee submitted that you are present at the hearing, you are aware of the contents of the statement and you are able to challenge it by way of questions to Witnesses 2 and 3 who are due to give evidence at this hearing.

You submitted that you did not object to the Witness 1's statement being allowed into evidence as hearsay evidence.

Decisions on reason to defer the hearsay application until after NMC's witness evidence

Mr McPhee received questions from the panel about whether Witness 1's evidence might be sole or decisive in respect of the outstanding charges due to the lack of clarity, at this point, regarding the evidence of Witness 2. Mr McPhee explained that Witness 2 has been recently called by the NMC as a substitute witness to give the evidence that Witness 1 was unable to give in person. Witness 2's written statement merely exhibited the written statement and documents of Witness 1.

Mr McPhee then made a further application to effectively pause the hearsay application until the conclusion of the NMC's live evidence. He invited the panel to reserve its ruling on the application until after all the live evidence in the case has been presented.

You submitted that you had no objection to Mr McPhee effectively renewing his hearsay application once the evidence from the NMC's witnesses has concluded.

The panel heard and accepted the advice of the legal assessor.

The panel has decided not to rule immediately on whether the hearsay evidence will be allowed. Instead, it decided to wait until the end of the live evidence of the NMC's witnesses. The panel concluded that this would allow a complete understanding of the case before making a decision on whether the written statements of Witness 1 should be allowed into evidence. It concluded that only when it has heard from the NMC's live witnesses would it be able to evaluate whether the hearsay evidence is sole and decisive and assess how it fits into the overall body of evidence. The panel concluded that at the end of the evidence from the NMC's witnesses it would be able to determine whether the written statement of Witness 1 is fair and relevant to the charges in this case.

Renewed hearsay application

On day two, after the conclusion of the NMC's live evidence, Mr McPhee addressed concerns that the panel had expressed during his initial application to admit Witness 1's hearsay statements. He submitted that now the panel has had the benefit of hearing live evidence from Witnesses 2 and 3, it could conclude that Witness 1's evidence is neither sole nor decisive. He reiterated his primary submissions on this matter and submitted that he simply renewed his application to admit the written statements of Witness 1 into evidence on the basis that it is both fair and relevant to do so.

You indicated that you did not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

Panel's decision on hearsay application

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and it is signed by her.

The panel took into account that the statements from Witness 1 are not the sole or decisive evidence in the case. They are corroborated by other evidence, including the testimony of Witnesses 2 and 3 and other supporting documentation. It considered that the content of the written statements from Witness 1 closely mirror the evidence provided by Witness 2, with the key distinction being that Witness 2 did not conduct the audit whereas Witness 1 made the initial enquiries into the allegations. The panel considered the written statements to be relevant to the issues at hand. It considered that although Witness 1 could not be cross-examined, her evidence was tested by way of challenge to the testimony of other witnesses and the documentary evidence submitted to this hearing.

The panel concluded that there is a reasonable and cogent explanation for the non-attendance of Witness 1. It determined that the NMC had made reasonable efforts to secure her attendance at the hearing and it noted that Witness 1 could not be compelled to attend due to her being in another jurisdiction. The panel noted that Witness 1 has relocated to another country to provide care for an unwell relative and therefore found the reason for non-attendance to be reasonable, noting Witness 1's unwillingness to give evidence by way of a video link.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 1 to that of written statements. The fact that Witness 1's written statements would be admitted as hearsay evidence does not, in the panel's view, introduce any inherent unfairness to you, particularly as it is corroborated by other evidence that the panel has heard.

The panel was mindful of the issue raised by you that there may be a motive behind Witness 1's complaints about your behaviour, suggesting that the allegations in this case stem from the breakdown of a relationship between you and Witness 1. However, It is

noted by the panel that, despite your suggestion that there might have been a motive, there is no opposition to the application for the admission of the hearsay evidence.

After considering all relevant factors, including the corroborative nature of the evidence, the reason for the witness's non-attendance, and the lack of opposition, the panel concluded that it would be fair and appropriate to admit the written statements of Witness 1 as hearsay evidence. It concluded that there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel also noted that the weight to be given to this evidence would be determined once all other evidence had been considered and evaluated.

Decisions and reasons on application to admit documents into evidence

The panel heard from the legal assessor who informed the panel that you wished to introduce your solicitor's letter dated 14 March 2022 which was addressed to North Camp. He informed the panel that the NMC are resisting this letter going before the panel. He told the panel that the letter is a settlement proposal in respect of the dispute between you and North Camp. He further informed the panel that it recites your case particularly in relation to the breakdown of the relationship between you and Witness 1.

You informed the panel that the reason for the solicitor's letter is because at the time the Royal College of Nursing could not represent you as you had already been suspended from your role. You stated that you employed the solicitor as you had no one else to give you guidance in how to deal with the allegations by North Camp. You stated that the letter provides further evidence in relation to the breakdown of your relationship with Witness 1. You informed the panel that the letter does not dismiss the fact that mistakes were made but provides some context in relation to motive behind the allegations.

Mr McPhee informed the panel that he opposed the panel seeing the documents and further admitting it into evidence. He submitted that the panel has heard that this document relates to an employment rights claim. He stated that you accepted that it is

relevant only insofar as it relates to the breakdown in relationship with between you and Witness 1. He submitted that the document is wholly collateral and irrelevant to the charges. On that basis he invited the panel not to allow it into evidence. He submitted that, having reviewed its contents, there is nothing in the solicitor's letter that speaks to the charges. He acknowledged that you accepted having made mistakes and he clarified that nothing contained within the letter will change that position.

The panel heard and accepted the advice of the legal assessor.

The panel carefully considered the request to admit the solicitor's letter dated 14 March 2022 into evidence. The panel noted that the letter was a settlement proposal related to the dispute between you and North Camp and that it primarily addresses the breakdown in the relationship between you and Witness 1. While it noted that you explained that the letter provides context to the allegations and the circumstances surrounding the breakdown of the relationship, the panel, having heard the submissions from both you and Mr. McPhee, concluded that the letter is not directly relevant to the charges before it.

The panel also noted that the breakdown of the relationship between you and Witness 1 appears to have taken place in December 2021, a period of time after the alleged conduct had already taken place. The panel acknowledged that the breakdown in your relationship with Witness 1 appeared to stem from an entirely separate matter, which occurred after the events pertinent to the charges in this case. Furthermore, the panel was satisfied that, as Witness 1's evidence was admitted as hearsay, it could take into account the information you provided regarding a potential motive stemming from the breakdown of the relationship. The panel would then consider the weight to be given to Witness 1's evidence when assessing the facts and any unfairness could be mitigated. The panel agreed that the letter is collateral to the issues at hand and does not provide additional evidence that would assist in determining the facts of the case. As such, the panel decided not to admit the solicitor's letter into evidence.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you in relation to the charges that you admit to. You informed the panel that you made admissions to charges 1a(i), 1a(ii), 1a(iii), 1a(iv), 1b and 5. You clarified that although you admit to the sub charges set out in charge 1, you did not admit to the stem of charge 1.

The panel therefore finds charges 1a(i), 1a(ii), 1a(iii), 1a(iv), 1b and 5 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 McPhee on behalf of the NMC and by you.

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

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

- Witness 2: General Practitioner and Senior Partner, North Camp Surgery

- Witness 3: Practice Nurse, North Camp Surgery.

The panel also heard evidence from you under oath.

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

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

Charge 1

1. On an unknown date did not follow safe procedure for administering medication in that you:

This charge is found proved.

In its consideration of charge 1, the panel noted that you admitted to the factual charges as set out in charges 1a(i), 1a(ii), 1a(iii), 1a(iv) and 1b. However, you contested that in taking those actions, you did not follow safe procedures for administering medication.

In reaching this decision, the panel took into account the evidence of Witnesses 2 and 3 as well as the hearsay evidence from Witness 1. It also took account of your evidence.

The panel had regard to the typed note exhibited by Witness 3 in which she detailed the incident. She stated:

> *"Another incident in 2022, was when Megan had used a medication for a patient, that was prescribed for another patient. From memory, Megan had scribbled out the patient's name on the label on the box. She added the new patient's name, who she was giving the medication to, and also wrote the dosage she had given as it was a different dose to the amount in the box. The medication was an inter muscular drug that we give to patients with mental health struggles, and it helps to calm them. I found this when I went to give some medication to a patient, and saw that a box of medication had been altered, I informed my Manager right away.*

This is absolutely not something that should happen. You should never use a medication prescribed for someone else, to give to another patient, and you certainly shouldn't ever alter the dose. An error could have happened, she could have given the wrong dose of medication. If a patient comes in to the surgery for their prescription medication and it is not available, we have to notify the pharmacy and ask the patient to come back in one hour to received their treatment. Megan knew this, this was our policy, and had been for years."

During her live evidence, Witness 3 maintained that in carrying out those actions that are set out in charges 1a(i), 1a(ii), 1a(iii), 1a(iv) and 1b, you failed to follow safe procedures for the administration of medication.

The panel also heard from Witness 2 on this matter whose evidence was that prescriptions should not be altered as it creates a risk of administering the incorrect dose to a patient. Her evidence was that such alterations increase the risk of drug errors, for example if the patient that the prescribed medication was intended for attended and the annotated label went unnoticed. Witness 2's evidence was clear in that a nurse should never in any circumstances administer a drug prescribed to one patient to another. Witness 2 further explained that if a patient's prescription was not available, you should have requested an urgent prescription from a doctor or arranged another appointment to administer the prescribed medication.

The panel also noted Witness 1's statement in which she said:

"When we asked Megan about [the admitted conduct], she said that she did not see the issue with what she had done as the patient still got the medication they required.
At the surgery, if a medication for a patient is missing then we notify the pharmacy and ask the patient to come back in an hour once the medication has been issued. Megan would have known this as this is routine practice at the surgery, although we

do not have a specific guideline for this, Megan would have been very use to the procedure and would have known not to give another person's prescription to a patient, and instead to ask the patient to return in one hour so that there own medication can be administered."

The panel bore in mind the evidence it heard from you. During your oral evidence you acknowledged that you had altered the medication box which was prescribed to Patient A and changed it to detail the name and dosage for Patient B and subsequently administered the medication to Patient B. However, you stated that at the time you did not consider this to be an 'unsafe procedure' as you were administering the correct medication and dosage for Patient B. The panel further noted that on reflection you acknowledged that the changing of the name and the dosage on the medication did introduce a risk of a drug error as described in evidence by Witness 2. You reflected that this was indeed "an error in judgement".

The panel concluded that, based on the evidence it has heard, altering prescribed medication is fundamentally improper as it heightens the likelihood of medication errors. It took into account that the NMC's witnesses were unequivocal that it would not be permissible for a nurse to administer medication prescribed for one patient to another. The panel recognised that you did not consider this to be unsafe as the dosage you administered to Patient B was correct. However, it determined that even in those circumstances it is not accepted practice nor is it a safe procedure when administering medication to carry out the actions as set out in charges 1a(i), 1a(ii), 1a(iii), 1a(iv) and 1b. The panel therefore finds this charge proved in its entirety.

Charge 2

2. On or around 26 November 2021 did not ensure Child A's immunisation record was updated.

This charge is found proved.

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

The panel noted Witness 3's written statement in which she stated:

> *"I recall an incident regarding the child immunisation records not being updated by the Registrant. […] I contacted [Witness 1] to let her know that the registrant said to have completed the child immunisation records on or around 26 November 2021, but there was no record showing."*

The panel had regard to an email addressed to Witness 1 from Witness 3 dated 17 December 2021. In that email Witness 3 stated:

> *"[Person 1] tasked me and Megan a note to enter 3 lots of child imms onto computer records – Megan completed task on the same day 26/11.21 but work was not done nil to be seen in childrens records – mum ringing re whether children are in date I have advised [Person 1] I will enter imms into records when I have time probably after xmas and let mum know if any outstanding vaccines required"*

During her live testimony, Witness 3 explained to the panel that when the task was assigned by Person 1, both she and you shared equal responsibility for ensuring that Child A's immunisation record was updated. However, she stated that since you were the one who marked the task as completed, effectively removing it from the system's visibility, you, at that point, were charged with full responsibility for carrying out the task. She explained that because you had removed it from visibility, you effectively deprived her of the opportunity to complete the task.

The panel took into account your evidence during which you informed the panel that you may have inadvertently marked the task as complete but that this was retrievable from the deleted folder.

After the panel retired to make its decision on facts, you requested to reopen the hearing and submit further evidence to the panel in relation to this charge. The panel accepted this request. You told the panel that your normal practice is to complete the electronic records for the patient before marking the task as completed. You told the panel that you did not have a clear memory of the event due to the passage of time but you believed that it was only the red book that you will have neglected to complete in this particular instance.

The panel referred you to the email addressed to Witness 1 from Witness 3 dated 17 December 2021 as detailed above and invited your comments on this. You responded:

> *"As I say, generally 99.9% of the time I would, we would both always make sure the the computer side of things were filled in correctly and the red book is done at a later date.*
> *But on this occasion it doesn't look like that happened. This was three years ago. As I say, I can't fully remember"*

The panel took your further evidence into consideration. It noted that the evidence from the NMC is firmly that the electronic record was not completed and that this suggests that you were not following your normal practice, but that as you confirmed in your evidence, you marked task as completed inadvertently. Therefore, it found that the further evidence does not avail you.

The panel considered the evidence before it and noted that, based on the evidence it has heard, when the task was assigned to both you and Witness 3 you had shared responsibility for it. However, although it may have been inadvertent, when you marked the task as completed, you assumed responsibility for it and would have been required to update Patient A's immunisation records. The panel heard in evidence that Patient A's immunisation records were not updated as they should have been before the task was closed and therefore concluded that you did not ensure that task was fully completed. The panel therefore finds this charge proved.

Charges 3 and 4

3. On 26 November 2021 administered Depo-Medrone to Patient C who was prescribed Depo-Provera.
4. On 30 November 2021 administered Depo-Medrone to Patient D who was prescribed Depo-Provera.

These charges are found proved.

In reaching this decision, the panel took into account the live evidence of Witnesses 2 and 3, the written statements, and the patient records for Patient C and D. It also took into account the written statement by Witness 1 as well as the note of the audit she had conducted. The panel also took into account your evidence.

Witness 3 informed the panel that, on reviewing Patient C's records when she arrived for her next dose of Depo-Provera, she identified that you may have administered Depo-Medrone instead of Depo-Provera. She told the panel that she would regularly administer Depo-Provera at that time and therefore was familiar with the batch numbers for this medication and noticed that the batch number documented on the patients' records was different.

The panel had regard to the significant event record completed by Witness 3 dated 22 February 2022 in which she recorded:

> *"A lady arrived for her depo provera she was on time for this 12 weeks +4 days. On discussion she said she had been bleeding for 3 weeks which had not happened before, she had been on depo provera for over 2 years.*
> *I was concerned as this seemed unusual I checked the batch number entered for last injection and realised this batch no. belongs to the drug depo medrone which is a drug not given by nurses generally I spoke to [Witness 2] and my practice manager [Witness 1]."*

During her evidence, Witness 2 informed the panel that she was made aware of the incident when she received the significant event record completed by Witness 3. Witness 3 had also completed a significant event record on 22 February 2022 having been made aware of the incident and it stated:

> *"Patient came for her regular depot contraceptive and reported abnormal bleeding for the last 3 weeks which she had never had despite being on injection for 2 years. When the notes of last injection in November were looked at the batch number for the depot [sic] provera given was different and was a batch number for a steroid injection."*

The panel had regard to the written statement by Witness 1 in which she stated:

> *"On 29th November 2021, Megan gave a patient the wrong medication. The patient had come into the surgery for their Depot Provera injection, which is a contraceptive, and Megan had documented that she had given Depot Provera but the batch number was that of the Depo Medrone which is a steroidal anti inflammatory injection used for joint injections. When Megan was asked about this she said it must have been an record keeping error as she was certain she had given the patient the correct medication. When we carried out an audit and review of the Depot Medrone there were 2 doses that weren't accounted for so it is likely that Megan has given the Depot Medrone in error, meaning that the patient may have experienced an unplanned pregnancy due to thinking she was protected, when she wasn't. There was also a 2nd lady picked up in the audit with the same issue and same incorrect batch number in her medical record whilst Megan had documented she had given her a depo provera."*

The panel had regard to the document detailing the audit carried out by Witness 1 in which it stated:

"Search run on EMIS to identify all patients that had a depo-provera coded in their record between 26.10.21 and 15.12.21.
17 patients were identified: of these 15 patients had the correct batch number associated with the depo-provera injection and 2 patients were identified with the incorrect batch number of DL17502 which is the batch number for the depo-medrone injection

Search also run on depo-medrone injections given between 26.10.21 and 28.2.2022.
This showed 2x depo-medrone injections were given by the GP in this period.
A batch of 10 depo-medrone injections were delivered to the surgery on 26.10.21
[…]
On checking we now have 6 depo-medrone injections with the batch number DL17502 left in the nurses cupboard.
2 depo-medrone injections are unaccounted for."

The panel had regard to the patient records for Patient C and Patient D. The local record for Patient C showed that on 26 November 2021, Patient C received an injection and the batch number for this medication was recorded as DL17502. Similarly, Patient D's local record showed that she received an injection on 30 November 2021 and the batch number for this medication was recorded as DL17502.

The panel had regard to the photographs of the medication boxes for Depo-Medrone which showed that the batch number on those boxes were, as recorded on the patient records, DL17502.

During your evidence you informed the panel that you could not say for certain whether it was Depo-Medrone you had administered instead of Depo-Provera given the passage of time since the incident. However, you suggested that there is a possible explanation; not that you had administered the incorrect medication, but that you recorded the wrong batch number on the patient records. You explained that you may have entered in the batch

number from a discarded box of Depo-Medrone. You stated that doctors administered Depo-Medrone and it was possible that a doctor may have left a box of Depo-Medrone on the nurses desk and you could have mistakenly recorded the incorrect batch number from that box.

The panel considered all of the evidence presented. It noted that the live evidence of Witnesses 2 and 3 was consistent with their documentary evidence and also with the hearsay evidence of Witness 1. It considered whether that these allegations could have been a record keeping error rather than a medication administration error as you suggested. The panel took into account that both Witness 2 and 3 stated that Depo-Medrone was only administered by a doctor. They further informed the panel that doctors at North Camp would administer drugs in their room and not in the nurses room. They considered the chances of a doctor leaving a box of Depo-Medrone in the nurses office highly unlikely. Therefore, the panel concluded that the evidence before it, including the record of the audit which showed that 2 boxes of Depo-Medrone were unaccounted for, the photographs of the boxes of Depo-Medrone and the local patient records corroborated the evidence of Witnesses 2 and 3. The evidence, including batch number discrepancies and the audit findings, supported the conclusion that the wrong medication was administered to both patients. The panel determined that, on the balance of probabilities, on 26 November 2021 and 30 November 2021, you administered Depo-Medrone to Patient C and Patient D, when both patients were prescribed Depo-Provera. The panel therefore finds charges 3 and 4 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

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

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

Mr McPhee identified the specific relevant standards where he submitted your actions amounted to misconduct. He submitted that your conduct in the admitted charges and the

charges found proved by the panel fell far short of what was proper in the circumstances and therefore amounted to serious misconduct.

Mr McPhee submitted that charges 2, 3, 4 and 5 all demonstrated a failure by you to keep clear and accurate records. He submitted that, in relation to charge 2, you assumed responsibility for updating the patient's record but failed to do so. In relation to charges 3 and 4, Mr McPhee submitted that this was a failure to keep clear and accurate records as the medication administered by you was not the one which you had recorded in the patient's notes. In relation to charge 5, he stated that you erroneously recorded that you had administered a Vitamin B12 injection when you had not.

In relation to charge 1, Mr McPhee submitted that the panel has found that you failed to follow a safe procedure in the administration of medication. He referred the panel to its decision that the conduct was "*fundamentally improper as it heightens the likelihood of medication errors."* He referred the panel to the evidence it has heard from Witnesses 2 and 3 that this was simply not accepted practice. He submitted that your conduct demonstrated a failure to administer medicines within the limits of policies, guidance, and widely accepted safe practice. He submitted that that it was also a failure to take all steps to keep medicines stored securely. He referred to the evidence of Witnesses 2 and 3 who said that the conduct had increased the risk of drug error and that the drug could have been picked up and used by someone else who was ignorant of your hand annotated label.

In relation to charges 3 and 4, he submitted that there was a failure by you to make sure the treatment administered was compatible with the care or treatment each patient was receiving. He submitted that as you were not aware that you had administered the wrong drug, you could not know of the consequences and risks associated with its administration, including its compatibility with other treatments being received by those patients.

Mr McPhee submitted that the charges found proved demonstrate a lack of awareness of or, at least, a failure to reduce as far as possible the potential for harm in your practice. He submitted that the unsafe administration of medication, the administration of the wrong medication to two patients and the failure to maintain accurate records of care and treatment provided increased significant potential for harm to patients.

For all of those reasons, he submitted that your conduct as set out in the charges, both admitted and found proved, amounted to misconduct and that you fell far short of what was proper in the circumstances and the standards reasonably expected of a registered nurse.

Submissions on impairment

Mr McPhee moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr McPhee submitted that the panel should ask itself if you are able to practise kindly, safely and professionally. In answering that question, he submitted that the panel will should have regard to the need to protect the public and the wider public interest, including the need to declare and maintain proper standards and maintain public confidence in the profession and the NMC as its regulator.

Mr McPhee submitted that, with those considerations in mind, the panel must find that you cannot practise kindly, safely or professionally. He submitted that your conduct poses a significant risk of harm to the public and breaches fundamental tenets of the nursing profession. He further submitted that your conduct is liable to undermine public confidence in the profession and the NMC as its regulator.

Mr McPhee stated that the duty to protect the public places nurses in positions of exceptional trust as they provide care for patients in their most vulnerable states. Mr McPhee submitted that your conduct fell short of that standard because you failed to follow safe procedures for the administration of medication; you administered the wrong medicine to two patients, putting them at risk of adverse reactions and unwanted pregnancies; you failed to maintain accurate records preventing others involved in the care of the two patients from having a full, accurate and up to date picture of the care provided to them.

Mr McPhee submitted that the panel should consider whether the concerns are remediable and whether they have in fact been remediated by you such that your fitness to practice is not currently impaired. He stated that these are principally concerns of clinical practice and accepted that the conduct found proved is amenable to remediation.

Mr McPhee recognised what he described as ‘an admirable degree of developing insight’. He submitted that that in the course of this hearing, you have properly recognised where errors have been made and invited the panel to take this into account.

However, Mr McPhee submitted that there is no evidence to suggest that you have remediated the misconduct. He submitted that the failures in this case are serious and if repeated would place patients at a real risk of harm. He submitted that the public interest requires your fitness to practise to be found impaired unless and until you can demonstrate remediation of the concerns.

Mr McPhee submitted that you acted in a way which put patients in your care and others at unwarranted risk of harm.

Mr McPhee invited the panel to make a finding of impairment on both public protection and public interest grounds in light of all the information before it. He submitted that this is a case where there had been repeated misconduct. He submitted that there is a risk of

repetition and with it, a real risk of significant harm to the public should you be permitted to return to unrestricted practice. He submitted that confidence in the nursing profession and the NMC as its regulator would be seriously undermined if you were permitted to return to unrestricted practice in light of the misconduct found proved.

You told the panel that you take your job very seriously and that your nursing career has previously been unblemished. You described yourself as a caring and patient-centred nurse, and you fully acknowledged the findings of the NMC, accepting that the errors made were entirely your responsibility.

However, you asked the panel to consider the circumstances under which these errors occurred, explaining that you were under extreme work pressure at the time. This pressure was not only due to your commitments at North Camp but also stemmed from additional work at mental health and learning disability nursing homes. Some of this work was ad hoc, and you often only found out about extra clinics after a busy shift which added to the strain.

You explained that the errors occurred over a two-to-three-week period, a time when your workload was especially demanding. While you stated that you did not use this as an excuse, you acknowledged that the pressure may have contributed to the mistakes you made during that time.

After resigning from North Camp, you told the panel that you continued working at Jenna House Surgery, where you felt there were no concerns or issues raised about your practice. You emphasised that, although the errors at North Camp were significant, you worked for an additional six months without incident.

You took full responsibility for the haloperidol error, describing it as a poor judgment on your part. You stated that the patient was very agitated, and you made a fundamental mistake in that situation. You further fully accepted the panels findings and understood the risk regarding the errors that you had made.

You informed the panel that over the past year, you have been proactive in completing online training and updates to keep your practice current. You provided evidence of completing courses in adult safeguarding (level 2), child safeguarding (level 2 or 3), conflict resolution, infection control, baby immunisation, and flu updates.

You expressed how devastated you were to be in front of this panel, but you fully accepted the errors you made. You asked the panel to consider the context in which they occurred and stated that you have taken steps to improve your practice. You reiterated your commitment to being a better nurse going forward.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that 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:

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.3 complete all records accurately […]

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

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

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

20 Uphold the reputation of your profession at all times

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether your actions as set out in each of the charges individually were so serious to amount to a finding of misconduct.

Regarding charge 1a, the panel determined that by altering Patient A's medication box to reflect the name and dosage for Patient B, you demonstrated a significant deviation from the professional standards expected of a registered nurse. The panel noted that your actions created a serious risk of harm—not only by introducing the potential for a medication administration error, but also by potentially jeopardising Patient A's access to their prescribed medications, which may not have been available when they returned from Hospital for their treatment. The panel concluded that your actions in charge 1a fell seriously short of the conduct and standards that would be proper in the circumstances and were sufficiently serious to amount to a finding of misconduct.

In relation to charge 1b, the panel carefully considered the contextual background you provided in explaining your actions. You indicated that you believed you were acting in the best interests of the patient, who was presenting as agitated. However, the panel concluded that, as a registered nurse, you were obligated to adhere to the proper procedures for safe medication administration. During evidence at the facts stage, the

panel heard that it is not accepted practice nor safe to administer medication intended for one patient to another. The panel also took into account that there was no suggestion that the circumstances at the material time amounted to an emergency. Consequently, the panel determined that your conduct in this instance fell far below the professional standards expected and was sufficiently serious to constitute misconduct.

In respect of charge 2, the panel considered that you explained that you had inadvertently marked the task as complete. It noted that, during your evidence, you stated that it was part of your usual practice to ensure that records were properly updated before marking the task as complete, but you acknowledged that, on this occasion, it appears that you failed to do so. The panel took into account that this appeared to be an administrative error and that there was minimal risk of harm to Child A. It determined that, whilst it falls short of the proper standards expected, it does not meet the threshold for misconduct. The panel therefore concluded that charge 2 does not warrant a finding of misconduct.

In relation to charges 3 and 4, the panel gave careful consideration to the fact that on two separate occasions, you administered the incorrect medication to two patients. Specifically, the panel noted that the medication the patients were meant to receive was a contraceptive injection but you administered a steroid, which is a medication that can only be administered by a qualified doctor. The panel further considered the gravity of the situation, acknowledging that the patients who received the steroid were unaware of the error at the time and would have reasonably believed that they had received the correct treatment, thereby being assured of pregnancy prevention. The panel considered that the patients, under the mistaken belief that they were receiving the intended contraceptive, were placed at significant risk of an unintended pregnancy. The physical consequences of this error could have been profound, but the emotional and psychological impact on the patients could have been equally severe. The panel concluded the severity of the error, particularly in light of its potential consequences for the patients' health and well-being, is sufficiently serious to constitute misconduct. It concluded that your actions fell seriously short of the conduct and standards that would be proper in the circumstances and were

sufficiently serious to amount to a finding of misconduct. As a result, the panel found that charges 3 and 4 amounted to misconduct.

In relation to charge 5, the panel carefully considered the circumstances surrounding your recording of Vitamin B12 administration for Patient E, despite that injection not having been given. The panel took into account the contextual factors you provided that led to this error. While acknowledging that your actions fell short of the expected professional standards, the panel determined that this was not a deliberate or reckless act and did not result in any direct harm to the patient's care or well-being. The panel concluded that, while the error was concerning, it did not meet the threshold for misconduct. It also noted that Witness 1, in her written statement said, "*This incident itself isn't so serious".* As such, the panel determined that charge 5 did not amount to misconduct, though it emphasized the importance of accurate record-keeping and professional vigilance in preventing such errors.

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 and to maintain professional boundaries. Patients and their families must

be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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 concluded that limbs a – c of the “test” are engaged in this case. The panel finds that patients A, C and D were put at risk of physical and emotional harm as a result of your misconduct. The panel concluded that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel noted that you made some initial admissions at the outset of the proceedings and, as the hearing progressed, it observed that you have further recognised the shortcomings in your nursing practice at the time. At the outset of the hearing, you focused on the cause of the allegations being the breakdown of your relationship with Witness 1. However, as the hearing has progressed, the panel noticed that you have shown some developing insight into the wrongfulness of your actions, particularly in terms of understanding of how your conduct did not align with proper and safe procedures. However, the panel found that there was insufficient evidence to demonstrate that you fully appreciate how your actions exposed patients to potential harm. Specifically, there was insufficient evidence to suggest that you fully recognised the physical and emotional risks your actions posed to the patients involved.

Additionally, the panel did not have evidence before it that you have understood the wider implications of your behaviour, particularly in terms of how your actions negatively affected the reputation of the nursing profession and the impact on your colleagues. The panel noted that you stated your errors were made whilst you were going through a stressful period at work. You reassured the panel of the steps that you would take if you found yourself in a similar situation, for example, reducing your workload and taking a step back etc. The panel, whilst acknowledging your developing insight, is not satisfied that you have developed the necessary full and comprehensive insight to demonstrate a clear understanding of the seriousness of your actions. The panel recognised that your insight is still in the early stages of development, and it appreciates that further time and reflection may be required for you to fully understand the full extent of the impact of your actions, both on patients and the wider nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed. In light of this, it carefully considered the evidence before it to determine whether you have taken appropriate steps to strengthen your practice. The panel acknowledged the numerous training certificates you have provided which it found demonstrated your commitment to maintaining your registration and to keeping your nursing practice current and up to date. However, the panel was not satisfied that the courses you have undertaken directly address the specific concerns raised in this case. While the training you have completed is valuable, it did not appear to focus on the particular areas of practice that the panel found proved namely medication administration and record keeping.

In light of all of the circumstances, the panel concluded that there is a risk of repetition of the conduct found proved given that your insight remains in its early development stage and the learning undertaken by you to date is not specifically relevant to the charges. The panel's consideration at the impairment stage is whether it is satisfied that you can practise kindly, safely and professionally. The panel had no evidence before it to suggest that you are not able to practise kindly or professionally. However, it could not conclude, at this time, that you are able to practise safely in relation to medications administration and record keeping. 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 determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of

impairment were not made in this case. It therefore also finds your fitness to practise impaired on public interest grounds.

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

Sanction

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

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

Submissions on sanction

The panel had regard to the Notice of Hearing, dated 2 October 2024, wherein the NMC had advised you that it would seek the imposition of a conditions of practice order if the panel found your fitness to practise currently impaired.

Mr McPhee invited the panel to impose a conditions of practice order for a period of one year with review. He submitted that this is a case where no lesser sanction would be sufficient to protect patients and the public and to maintain professional standards. He further submitted that any greater sanction would be inappropriate and would not be proportionate in the circumstances of this case.

Mr McPhee firstly highlighted the NMC guidance and identified what he deemed to be the relevant aggravating and mitigating factors. He referred the panel to the SG which sets out

that panel must start with the least severe sanction and work up until the appropriate outcome is identified.

In Mr McPhee's submission, aggravating factors in this case include repeated serious errors in a short space of time, with risk of serious harm to the public. The also invited the panel to consider mitigating factors. He outlined that the panel has heard and acknowledged, for example, your developing insight into your failures. He acknowledged your reflective accounts and evidence of training and submitted that some of that is relevant to the misconduct and impairment found by the panel, and some of it is not.

Mr McPhee submitted that the guidance makes clear that the panel here is concerned with risk, and harm need not have materialised. He submitted that in this case, there was a risk of harm, particularly in the administration of Depo-Medrone, in place of Depo-Provera, and the patients were without contraceptive protection. He submitted that those patients will have suffered the actual psychological and emotional harm of learning that they had been administered the wrong medication months prior. He submitted that those patients were under the misapprehension that they were protected by contraception when they were not. He further submitted that there was also a serious risk of physical harm, such as by way of adverse drug reactions, as a result of the administration of the wrong medication.

Mr McPhee highlighted that the SG makes clear that the panel may have regard to your fitness to practise history. He submitted that the panel has heard that you have been a nurse for around 40 years, with no previous fitness to practise history. The panel may consider that the failings in your case, confined to a relatively short period in November 2021, are one-offs during a long career and will consider that factor alongside the evidence of insight and reflection.

Mr McPhee addressed those sanctions, which he said are not appropriate in this case. He acknowledged that it is open to the panel to impose no sanction. However, he submitted that this is plainly inappropriate in the circumstances where the panel has found misconduct involving a risk of harm to patients and a finding of current impairment. He

submitted that the protection of the public and maintenance of professional standards requires some mark of sanction.

Mr McPhee submitted that a caution order is only appropriate where there is no risk to the patients or the public. He submitted that, again, the panel has found risk of harm in this case, so the imposition of a caution order is also inappropriate.

Mr McPhee submitted that the next available sanction is a conditions of practice order. He submitted that this is a case in which conditions could be formulated to adequately and fully protect the public. He submitted that the misconduct and impairment found by the panel arise from incidents relating only to your clinical practice, and even more specifically relating to medication administration and record keeping. He referred to the SG which sets out the factors in which a conditions of practice order may be appropriate and submitted that those factors do apply here.

Mr McPhee addressed the panels recognition of your developing insight. He submitted that the areas in need of assessment or retraining are clear and identifiable and submitted that there is no evidence in this case of general incompetence. He submitted that your errors are confined in type and time and that you have displayed potential and willingness to respond positively to retraining, having undertaken retraining of your own volition while you have not been employed pending these fitness to practise proceedings.

What conditions, if any, to impose is a matter for the panel, but Mr McPhee invited the panel to consider two conditions in particular. Firstly, that you be directly supervised when administering medication and secondly, that you be indirectly supervised in relation to record keeping.

Mr McPhee then moved on to the remaining sanctions, which he submitted are not appropriate in this case. The next available sanction is a suspension order. He submitted that the SG requires the panel to ask itself whether the seriousness of this case requires temporary removal from the register. He submitted that the concerns in this case are

plainly serious. However, he submitted that you could return to nursing practice safely with conditions, and so a suspension order would be inappropriate and disproportionate in the circumstances.

The ultimate sanction available to the panel is a striking off order. In Mr McPhee's submission, a striking off order would be grossly disproportionate, given that your misconduct is confined in time and character, you have displayed developing insight, and the concerns in this case are fully capable of remediation through training and reflection.

Mr McPhee submitted that the public interest in this case weighs in favour of sanction, but also in favour of you remaining on the register and providing vital healthcare to the public as you have done over a long career of nursing.

For all those reasons, Mr McPhee submitted that the panel should impose a conditions of practice order for a period of 12 months with a review.

You stated that, as identified by Mr McPhee in his submissions, these are isolated incidents over a 40-year career.

You stated that you do not think you are a risk to the public. You mentioned that you were not aware of any of these charges until after you were suspended, so you were unable to address them at an earlier stage.

You explained that the areas in which you made mistakes were due to the volume and range of nursing duties you were dealing with at the time.

You clarified that these are not ongoing issues within your practice.

You acknowledged that there were significant issues and recognised the potential impact of your errors on patients. You stated that if you or your family members were given the

wrong drug in error, you would be upset and would want the nurse involved to reflect, learn, and move on.

You reiterated that these were isolated incidents which occurred over a three-week period. You emphasized that these errors were not the result of a disagreement with your manager but due to you being extremely busy including having been allocated external clinics.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over short a period of time
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Some admissions made at the outset of the hearing, along with further acknowledgments made during the course of the hearing
- Continued development of your insight throughout the hearing process
- Voluntary training undertaken during periods of unemployment as a registered nurse, some of which was relevant to your earlier misconduct
- Reflections indicating recognition of past shortcomings

- Personal circumstances, including heightened stress levels due to workload pressures including the Covid-19 pandemic

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 address the risks identified and it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your 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;*

- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 concluded that appropriate and practical conditions can be formulated to address the concerns raised in this case. The panel noted that there was no evidence of any harmful, deep-seated personality or attitudinal issues that would suggest a fundamental risk to patient safety. Instead, the panel identified specific areas of your practice that would benefit from targeted assessment and retraining. Additionally, there was no indication of general incompetence that would necessitate more severe action. The panel concluded that it could formulate conditions that allows for ongoing monitoring and assessment. It was satisfied that conditions can be put in place that will safeguard patients during the period they are in force.

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

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. The panel concluded that, whilst there are identifiable failings in your practice, these appear to be isolated rather than reflective of a general incompetence or incapacity to meet professional standards. The panel also took into account the steps you

have already taken to improve, including voluntary retraining and demonstrated insight into the areas requiring improvement. The panel concluded that a suspension order or striking-off order would, therefore, be disproportionate, given the context of your case and the potential for remediation.

Having regard to the matters that the panel has identified, it 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 limit your nursing practice to one substantive employer which must not be via an agency.

2. You must be supervised whenever administering medication. The supervision requirements are as follows:
    a) For a minimum term of 4 weeks, you must be directly supervised by another registered nurse.
    b) After the initial 4-week period, and upon assessment of your medication administration practice, if deemed safe to do so by a registered nurse may transition to indirect supervision.

    You must provide a report from the assessing nurse summarising the assessment and decision to transition to indirect supervision which must be submitted to your case officer.

3. You must be indirectly supervised by another registered nurse in relation to your record keeping.

4. You must have monthly meetings with your line manager, supervisor or mentor to discuss your clinical workload specifically in relation to your:
   a) Record keeping
   b) Medication administration

Prior to any review of this case, you must send your case officer a report from your line manager, supervisor or mentor which outlines your discussions in relation to these areas.

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

6. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any 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.

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

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

The period of this order is for 12 months. The panel concluded that this period of time would allow you sufficient time to secure employment and support your return to nursing practice.

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 attendance at any future hearing;

- An up-to-date written reflective account addressing your insight into the matters found proved;
- Any up-to-date training undertaken relevant to the charges in this case; and
- Any recent references and testimonials.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr McPhee. He submitted that an interim order is necessary for public protection and is otherwise in the public interest. He submitted that the panel have found current impairment, which poses a risk to the public and that an interim order, in the same form as the substantive order, is necessary to safeguard the public against that risk.

You did not make any submissions to the panel with regards to the imposition of an interim order.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the 28-day appeal period, and the period during which an appeal may be lodged and considered.

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.