Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 11 November – Friday, 15 November 2024
Monday, 18 November – Thursday, 21 November 2024
Monday, 25 November – Wednesday, 27 November 2024

Virtual Hearing

Name of Registrant:	**Joyce Anna Walker-Vos**
NMC PIN:	08G0314E
Part(s) of the register:	Nurses Part of the Register-Sub Part 1 RNA: Adult nurse, level 1 (8 September 2008)
Relevant Location:	Hexham
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, Lay Member) Rashmika Shah (Registrant Member) David Newsham (Lay Member)
Legal Assessor:	Nina Ellin KC (11 – 15 November 2024) Fiona Barnett (18 - 21 November 2024) John Bassett (25 – 27 November 2024)
Hearings Coordinator:	Maya Khan (11 – 18 November 2024) Sharmilla Nanan (19 November 2024) Dilay Bekteshi (20 – 27 November 2024)
Nursing and Midwifery Council:	Represented by Aliyah Hussain, Case Presenter
Miss Walker-Vos:	Present and represented by Alex Lawson
Facts proved:	7c

Facts proved by admission: 1, 2, 3, 6a, 6b, 8, 9 and 11

Facts not proved: 4, 5, 7a, 7b and 10

Fitness to practise: Impaired

Sanction: Conditions of practice order (18 months)

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

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

Ms Hussain, on behalf of the Nursing and Midwifery Council (NMC), made a joint application that parts of this case be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 (2) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Lawson, on your behalf, supported this application.

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

Having heard that your case involves reference to [PRIVATE], the panel determined to hold those parts of the hearing in private.

Details of charge

That you, a registered nurse:

Demonstrated poor medication practice in that you:

1. On 23 December 2021 you discharged one or more unknown patients with the incorrect medication, namely, Metformin.

2. On 26 December 2021 you failed to give unknown Patient their insulin when it was due/in a timely manner.

3. On 6 February 2022 you, failed to administer Piperacillin/ Tazobactam to an unknown patient, when it was due/at all.

4. On 29 March 2022, you made an error with the administration of an IM drug injection

5. Between October 2021 to July 2022, on one or more occasions a drug round took you longer than was required.

6. On 25 March 2022, you failed to prioritise the following:
    a. The administration of an enema to an unknown patient prior to their discharge;
    b. A covid test for an unknown patient prior to their discharge.

Failed to treat a patient with dignity and respect in that:

7. On 29 March 2022 you:

    a. Left a patient in soiled clothing after their stoma bag and urostomy bag leaked;
    b. Failed to assist a Colleague B in providing care for the patient, following the burst/leaking stoma bag;
    c. Failed to clinically assess whether a new stoma/urostomy bag was required.

Failed to work contracted hours in that:

8. On 1 and/or 25 November 2021 you failed to attend a shift that you were due to work;

9. Between 25 October 2021 to 6 July 2022, on one or more occasions attended late for a shift you were due to work.

Failed treat a colleague with kindness, respect and compassion in that:

10. On 23 December 2021 you shouted at Colleague A.

Failed to appropriately respond to a patient's normal or worsening medical condition in that:

11. In January 2022 you did not repeat and/or report an unknown patient’s abnormal observations;

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

Background

You undertook nursing training in 2005 at Northumbria University and qualified as a nurse in 2008.

In July 2021, having been out of practice for some time, you successfully applied for a post at Northumbria Healthcare NHS Foundation Trust (the Trust). You were employed on a permanent basis as a staff nurse at Hexham General Hospital working 37 and a half hours a week. You worked on the General Medicine Ward with 25 beds for patients suffering with a variety of conditions. The majority of the patients on that ward are elderly and fragile. The aim of the ward was to treat and discharge patients either to their homes or to a care home facility. There was a minimum requirement for two trained nurses to be on the ward at any given time and for up to seven healthcare staff members to be on the ward at any given time.

When you began your employment at the Trust, you were on a probation period and subject to a conditions of practice order. Your first probation report in January 2022 highlighted a number of challenges and issues with your practice, including punctuality, medication errors, prioritising basic nursing care [PRIVATE].

In March 2022, the Senior Management Team on the ward, namely Ms 1 Ward Manager at Hexham General Hospital and Ms 3, the Modern Matron at Hexham General Hospital, had become extremely concerned about your conduct and decided that you required direct supervision by your line manager on each and every shift that you worked on the ward.

[PRIVATE]

A second probation report was produced and in May 2022 Ms 1 decided that she was unable to sign you off your probationary period. Ms 1 made a referral to a probation panel hearing. This hearing took place in July 2022 and the Trust decided that based on the accumulation of concerns which included [PRIVATE] and communication issues,

your employment was no longer tenable. Your employment was terminated, and you left the Trust on 11 July 2022.

The Trust then referred the matter to the NMC. The regulatory concerns focus on five specific areas where the NMC alleged that your practice fell below the standard reasonably expected of a nurse. The regulatory concerns are as follows:

1. Poor medication practice
2. Failure to treat a patient with dignity and respect
3. Failure to work contracted hours
4. Failure to treat colleagues with kindness, respect and compassion
5. Failure to appropriately respond to a patient's normal or worsening medical condition.

Decision and reasons on facts

Mr Lawson made a number of admissions on your behalf. He referred the panel to a document titled *'Admissions'* in which you made full admissions to charges 1, 2, 3, 6a, 6b, 8, 9 and 11.

The panel therefore finds charges 1, 2, 3, 6a, 6b, 8, 9 and 11 proved in their entirety, 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 Ms Hussain and Mr Lawson.

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 or is more likely than not to be true.

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

- Ms 1: Ward Manager at Hexham General Hospital

- Ms 2: Senior Nursing Assistant at Hexham General Hospital

- Ms 3: Modern Matron at Hexham General Hospital

- Ms 4: Ward Coordinator at Hexham General Hospital

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 the NMC, including the agreed statement of the ward sister, Ms 5.

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

Charge 4

4. On 29 March 2022, you made an error with the administration of an IM drug injection

This charge is found NOT proved.

The panel found that there was no dispute between the parties that you had made an unsuccessful attempt to administer intramuscular (IM) medication to a patient. The issue in dispute was whether this was due to an error or a faulty batch.

The panel considered the local statement of Ms 1, dated 29 March 2024, in which she stated: *"I later administered with JR with no problems and suspected it may have been a faulty batch*. [sic]*"*

The panel noted that this was echoed in Ms 1's oral evidence where she expressed that *"it may have been a faulty batch, I don't know"*

The panel considered your oral evidence, in which you stated: *"All I know is that when I injected the needle into the right thigh there was no drawback of blood but when I came to pushing I couldn't without using force."*

Additionally, the panel considered your written response to the allegation, in which you stated:

> *"I removed the IM needle from the patients thigh and attempted to discharge the medication from the needle and syringe over a sink and away from the patient and the result was the same, this re-confirmed to me that I made the best decision for the safety and wellbeing of the patient.*
>
> *I spoke with the pharmacy team immediately after (they were at the ward desk working on their laptop) whom had confirmed that it was likely a batch error with the medication and proceeded to order a replacement dose."*

The panel accepted both your oral and written accounts in that you followed the appropriate procedures but encountered a problem with the medication, which failed to deploy from the syringe both after the patient had been injected and during your subsequent test over the sink. You recounted speaking with the pharmacy team who indicated that a faulty batch was likely. You emphasised having taken great care in reading the instructions four times and had asked a student nurse to independently read and verify them. You provided evidence detailing how the medication was prepared and confirmed that there had been no issues with the syringe prior to this incident; it simply would not release into the muscle during the injection attempt. You made the decision to abort the procedure to avoid potential harm to the patient.

The NMC has not produced any evidence explaining why this attempt was unsuccessful or why your attempt to administer the drug constituted an error. A Datix report was not completed by anyone, and consequently, no investigation took place.

In the absence of any evidence to indicate why the syringe would not deploy the medication, the panel found charge 4 not proved.

Charge 5

5. Between October 2021 to July 2022, on one or more occasions a drug round took you longer than was required.

This charge is found NOT proved.

The panel considered Ms 1's evidence that a typical drug round might usually take about 45 to 60 minutes, with the understanding that issues can arise during this time which may cause the round to take longer. She also stated that the morning drug round is particularly extensive.

The panel took into account the probationary hearing report in April 2022, which stated: *"Jay is still spending over 90 minutes on Drug rounds when these normally take 20 – 30 minutes. Jay confirmed she likes to ensure everything is correct and would take her time rather than make a drug error."*

The panel noted that the probationary report did not include any suggestions for how they could have supported you in completing drug rounds more efficiently.

The panel took into account your written response to the allegation, in which you stated:

> *"I am returning to nursing after a significant time period for which the trust was wholly aware as was noted being confirmed within my appeal hearing regarding their understanding of reading my application form. I need to ensure my accuracy*

> *and refresh and learn of medications I had not been familiar with that I encountered throughout my experience. I am not the fastest reader and adjusting to giving between 1-20 morning medications, some requiring second checks for PRN pain relief.*
>
> *I cannot give medications ignorantly; I need to do referencing checks and read through their indications and contra-indications as I am duty bound to do. This takes a moment or two or three, if there are numerous."*

You acknowledged that there were occasions when you took longer than other nurses to complete a drugs round. You attributed this to your extended absence from practice, your need to check medications thoroughly and other things cropping up during the drug round such as patients needing to be taken to the toilet.

The panel determined that different individuals may require varying amounts of time to complete drug rounds based on level of skill, experience and unexpected factors occurring during the task. The panel found that you had only recently returned to practice and that you are relatively inexperienced compared to other practitioners.

The panel determined that it is not unreasonable to expect that a less experienced nurse recently returning to practice, [PRIVATE], to require additional time to safely complete a drug round.

The panel found that the NMC produced no clear and consistent evidence of exactly how long a nurse would require to complete a drug round as there were so many variations that could come into play.

While the panel acknowledged that it took you longer than it would for an experienced nurse familiar with the medications, it recognised that you took the amount of time that you required to complete drug rounds safely.

As a result, the panel found charge 5 not proved.

Charges 7a & 7b

Failed to treat a patient with dignity and respect in that:

7. On 29 March 2022 you:

a. Left a patient in soiled clothing after their stoma bag and urostomy bag leaked;
b. Failed to assist a Colleague B in providing care for the patient, following the burst/leaking stoma bag;

These charges are found NOT proved.

The panel heard from Ms 2, the senior nursing assistant, who stated that upon entering the bay, she immediately noticed that the patient in bed 22D was in soiled clothing due to stoma bag leakages. She said that she informed you, and her account was that you took no further action beyond closing the curtains for the patient.

The panel heard your evidence that while you were present in the four-bed bay, you were engaged in discussions with a patient in a different bed in 22C and had not seen or smelt the leaking stoma bags. You told the panel that you are unaware of the condition of the patient in 22D until informed by Ms 2. Both you and Ms 2 gave evidence that the patient's stoma bags would have been correctly checked within the preceding hour.

The panel determined that there was no evidence to suggest that it was more likely than not that you were aware of the leaking stoma bag as, although you were present in the bay, you were focused on other patients.

Whilst it is evident that the patient in 22D was soiled prior to Ms 2 entering the bay you stated that you were attending to the patient in bed 22C and had your back to patient in 22D. You stated that *"I did not have a clear view of the patient's stoma and urostomy bags from where I was positioned speaking with patient 22C, I was looking at patient 22C."* The panel accepted your evidence that you were unaware of the condition of patient 22D and, as such, without this knowledge, whilst it could be said that you left the patient in soiled clothing after their stoma bag leaked, the panel determined that you

could not be found to have failed to treat her with dignity and respect as you were unaware of the incident.

The panel therefore finds charge 7a not proved.

With regard to charge 7b, in your written response against this allegation, you stated:

> *"I disagree with the allegation.*
>
> *I had taken actions to address the issue as soon as I had been made aware of the stomas having leaked.*
>
> *[Ms 2] notified me as I was between nursing tasks regarding the patient in 22C with whom the trainee nurse associate was present as she was working directly with me that day.*
>
> *The patient in 22D had been attended to in regards to personal hygiene including change of stoma and urostomy bag less than an hour before and I had not seen any stoma leakage on times I had walked past.*
>
> *Upon being notified by [Ms 2] I enquired to know whether [Ms 2] had experience with stoma care. I asked her directly and she expressed she had. I then asked of her urostomy experience to which she confirmed she had. From the information ascertained on asking [Ms 2] it was my belief that it would not be unreasonable that she, alongside the trainee nurse associate whom I asked to help [Ms 2] as we had left patient 22C together when [Ms 2] and I spoke.*
>
> *Upon [Ms 2] confirming she was comfortable to attend to patient Xs hygiene needs I asked the TNA who was present during this interaction to help [Ms 2]."*

In your written and oral evidence, you stated that, after being notified, you established that Ms 2 was adequately equipped to manage the leakages and care for the patient in bed 22D; therefore, you prioritised other matters. The panel accepted your oral

evidence in that you were proactive in your conversation with Ms 2, asking clear and specific questions to assess her knowledge and skill set, as well as to determine the most effective allocation of resources.

Whilst the panel felt that Ms 2 gave an honest account as she had perceived and remembered the events, the panel nevertheless preferred your evidence over that of Ms 2, noting the direct conflict between the two accounts. Ms 2 told the panel that at the time she felt panicked due to the impending arrival of the patient's son. The panel found it unlikely that a qualified and experienced nurse would simply walk away from a patient with a stoma leak without any further action or inquiry. The panel deemed it inherently probable that the situation unfolded as you had described. The panel accepted that your decision to delegate the care to Ms 2 was based on your assessment of Ms 2's affirmation that she felt competent in handling the situation and you felt it better to prioritise resources accordingly.

The panel therefore found charge 7b not proved.

Charge 7c

Failed to treat a patient with dignity and respect in that:

7. On 29 March 2022 you:

    c. Failed to clinically assess whether a new stoma/urostomy bag was required.

This charge is found proved.

The panel considered the witness statement of Ms 3, which states:

> *"As such, [you] at the very minimum should have inspected the patient to see what the correct course of action was and instruct SNA [Ms 2] on what should be done, although I would still have expected [you] to assist. If [you] was concerned about the patient and she was attending on, she should have arranged for someone to watch over them quickly even if she was only in the next bed space, to enable her to assist SNA [Ms 2]."*

During her oral evidence, Ms 3 stated that it is the nurse's responsibility to assess whether the bags need changing.

Additionally, you acknowledged during cross-examination that you held "the final say" in the matter. You also admitted that you did not return to the patient to conduct a check yourself and instead relied on the description provided by the nursing assistant, Ms 2.

The panel therefore found that you held the responsibility to clinically assess whether a new stoma/urostomy bag was required and that you failed to do so. The panel determined that this amounted to a failure to treat the patient with dignity and respect.

As a result, the panel found charge 7c proved.

Charge 10

Failed treat a colleague with kindness, respect and compassion in that:

> 10. On 23 December 2021 you shouted at Colleague A.

This charge is found NOT proved.

The panel considered the evidence of Ms 4, who said she was seated just meters away and had a clear view of you. She stated that you were speaking in a raised voice, not shouting. Ms 4’s evidence was that you were frustrated due to the change to the care plan that had been requested by the patient’s relative and subsequent risk to the patient on discharge, rather than with Colleague A herself. While Ms 4 did mention shouting in her statement, she was clear in her oral evidence that you were using a raised voice, rather than shouting and that this was not directed at Colleague A, rather the situation.

In your written response, you stated:

> *“I do not admit this occurred in the manner described. I did not shout at the colleague.*

I have a loud voice normally [PRIVATE], I speak in a very direct manner. I was frustrated that the patient's family were not considering the best needs of the patient and I found that stressful.

I was advocating for the patients needs and felt frustrated given the risk of discharge without a care package in place. I understand from my manager that the patient was readmitted onto a neighbouring ward within a week after suffering from a fall at home.

I understand on reflection that I could have handled the situation with my colleague in a better manner and fully understand why they felt that I was speaking to them in a way that did not offer them kindness, respect and compassion.

In future, I would ensure that discussions with colleagues would take place in a private room away from patients and I am sorry for my conduct in respect of my emotive response"

You acknowledged feeling agitated and frustrated, which stemmed from potential issues related to the discharge of a patient, especially just before Christmas. You accepted that you raised your voice and were passionate about the situation, and you also recognised that these discussions should have occurred in a private location.

The panel did not receive any evidence from Colleague A. Additionally, there appears to be no consistent evidence supporting the allegation that you *"shouted"* at Colleague A and failed to treat Colleague A with kindness, respect and compassion.

Consequently, the panel found charge 10 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.

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, you can practise kindly, safely and professionally.

Your oral evidence

You gave evidence under affirmation.

In regard to charges 1, 2, 3, and 6 associated with poor medication practices, the panel had sight of the competency-based assessment for medicines administration signed by Ms 1 in April 2022, indicating that you were proficient in all the required areas.

You highlighted the potential dangers of administering incorrect medications, citing metformin as an example that could dangerously affect a patient's blood sugar levels. You said that these errors not only endanger patient safety but could also undermine public trust in healthcare professionals, and that people would be understandably upset if a loved one received the wrong medication. In discussing the broader impact on the nursing profession, you conveyed the sentiment that incidents like these could lead to a loss of confidence among the public. When asked what changed in your practice that led to you being signed off, you replied *“nothing I did all my medication checks the same as I would any other time…I don’t believe that I made any changes that I did before.”*

In regard to charge 7c, you were disappointed at your failure to check the patient personally and realised that they would have felt that they were not being prioritised and would have had an expectation that there would be a closer inspection of their condition.

In regard to charge 11, you recognised that if a patient's vital signs were not rechecked, they could have deteriorated further and need further support from the clinical team.

In regard to charges 8 and 9, you realised that if you were late or did not attend for your shift, the workload would have to be balanced out between two nurses rather than three. It would cause frustration for the nurses and the HCAs who would be concerned that you had not turned up. You wanted to apologise to your colleagues.

You expressed remorse for past mistakes and emphasised your desire to improve as a nurse, underlining the importance of support systems in your journey ahead.

[PRIVATE].

[PRIVATE].

Submissions on misconduct and impairment

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

Ms Hussain invited the panel to take the view that the facts found proved cumulatively amount to misconduct. The panel should have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision. She identified the specific, relevant standards where your actions amounted to misconduct.

Ms Hussain submitted that the repeated failures to administer medication promptly, coupled with poor medication practices, constitutes a breach of the NMC's Code, thereby amounting to misconduct. While it has been acknowledged that you have displayed honesty and transparency, Ms Hussain invited the panel to consider the numerous repeated errors that posed a risk of harm to patients over an extended period.

Ms Hussain submitted that medication administration is a fundamental competency of the nursing profession and is essential for providing safe and effective patient care. For this reason, the Trust determined that it was necessary for the ward manager to supervise your practice. She submitted that your performance in this area falls significantly below the expected reasonable standards for a nurse in your role, breaching parts of the Code, including 1.4 and 18.

Regarding charge 7c, Ms Hussain submitted that your actions breach part 1 of the Code, in that you acknowledged having the final say on the matter but failed to fulfil your responsibility to clinically assess whether new bags were necessary.

In relation to charges 8 and 9, Ms Hussain submitted that these breaches engage part 8 of the Code, which requires nurses to collaborate effectively with colleagues. The panel heard evidence that when you did not report for work in November 2021, [PRIVATE]. In your evidence, you admitted to being a weak link on the ward, which forced the ward manager to schedule an additional staff member to ensure that minimum staffing levels were maintained. This further strained the already limited resources available on the ward. Moreover, the probationary booklet indicates that punctuality was a persistent concern from the outset of your employment.

Concerning charge 11, Ms Hussain submitted that your failure to appropriately respond to a patient's deteriorating medical condition by not repeating or reporting abnormal observations breaches part 13 of the Code. Ms 2 provided oral evidence detailing the proper procedures, noting that it was evident the patient was unwell yet you failed to acknowledge the urgency of the situation. In her statement, Ms 1 said that ignoring a

high Early Warning Score (EWS) creates a potential risk of harm to patients, and had there been significant deterioration, urgent escalation would have been necessary

Ms Hussain 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Hussain highlighted that the NMC's guidance poses a question for assessing whether a registrant's fitness to practice is impaired: Can the nurse practice kindly, safely, and professionally? Based on the findings of facts, the answer to this question cannot be "yes." Despite your full engagement in these proceedings and your honesty, ongoing concerns remain. Ms Hussain submitted that there is no evidence to indicate that you can practise safely. It is clear that your conduct has placed patients at risk of harm multiple times, as evidenced by Ms 1 and Ms 3.

Looking towards the future, Ms Hussain submitted that concerns still exist. [PRIVATE]. Ms Hussain stated that your conduct brings disrepute to the profession and you have noted, in your own evidence, that this has harmed public trust and confidence.

Ms Hussain submitted that while you have reflected on your conduct, you have not yet had the opportunity to demonstrate your ability to practise safely or complete any Continuing Professional Development (CPD). Therefore, there is a high risk that you may repeat past mistakes. She invited the panel to remember that the Trust deemed it unsafe for you to practise unsupervised in March 2022. [PRIVATE].

Given all these factors, Ms Hussain submitted that as of today, your fitness to practise remains impaired.

[PRIVATE].

Mr Lawson submitted that the NMC's case relies on the cumulative nature of various issues, suggesting that while each may seem minor, together they create a larger picture that indicates misconduct. Nonetheless, he proposed that it may be more beneficial to look at the charges more granularly.

In relation to the medication charges, specifically charges 1, 2, 3, and 6, Mr Lawson told the panel that Ms 1 signed you off medicines administration practice in April 2022. In light of this evidence, he submitted that although there may have been a breach, whether this constitutes misconduct requires careful consideration, especially given that remediation has taken place. Ms 1 indicated as of April 2022 that you were fit to administer medication, which is crucial for assessing current impairment, as she is best placed to comment on your practice in this area.

Regarding charge 7c, Mr Lawson argued that whether this constitutes misconduct should be considered in the context of a busy ward environment where a senior care assistant can manage tasks independently. Ultimately, it is for the panel to determine if this meets the misconduct threshold. He said that you have taken time to reflect on this matter, and it appears the failure to closely oversee the senior care assistant's actions has been recognised, thereby reducing the risk of repetition.

For charge 8, Mr Lawson acknowledged the difficulty in arguing that a failure to attend work cannot be considered misconduct. Concerning charge 9, he noted that being late happens and it is up to the panel to decide if this alone warrants a finding of misconduct. He referred the panel to your statement, [PRIVATE].

In relation to charge 11, Mr Lawson said that, while the charge itself has not been thoroughly examined, it involves an unspecified date and time, relating to a failure to act in a situation that appears unclear. He submitted that there is no evidence of patient harm associated with this incident and that this matter has not been fully explored. He said that you have reflected on this incident.

With respect to current impairment, following your evidence and statement, as well as your early admissions during these proceedings, Mr Lawson submitted that these

admissions demonstrate your insight into your regulatory failings. He emphasised your openness and honesty throughout these hearings, along with the significant reflection you have shown on the charges.

[PRIVATE].

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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

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*
>
> ***3.1*** *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> ***8.2*** *maintain effective communication with colleagues*
>
> ***13.1*** *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

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*

***19.3** keep to and promote recommended practice in relation to controlling and preventing infection*

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

Charge 1 relates to the discharge of a patient with incorrect medication, specifically Metformin, which the panel determined amounts to serious misconduct. In your evidence, you described the potential consequences of discharging a patient with incorrect medication. The panel found that there was an inherent risk of harm to the patient. Although actual harm did not occur in this instance, you acknowledged that it could have led to significant patient harm.

Charge 2 concerns your failure to administer insulin to a patient on time, which the panel also found to amount to serious misconduct. The panel noted that this represents a fundamental aspect of nursing practice.

The panel considered Ms 3's statement, which states:

> "*There was a real risk of patient harm if Sister [Ms 5] had not been present to take over from [you], as the insulin dependent patient could have seen their condition deteriorate to the point they required treatment form the Intensive Care Unit. If the patient continued to not receive the insulin then it risked the patient*

suffering from diabetic keto-acidosis, which is an alteration of the blood pH level which would turn the blood acidic."

The panel also considered Ms 1's statement, which states:

"*Although in this instance there was no recorded patient harm, not providing the insulin when required puts the patient at serious risk of harm as the sugar in the blood will not break down causing hyperglycaemia."*

Furthermore, the panel considered Ms 5's witness statement, which states:

"On 26 December 2021, at around 7.30 or 7.45, [you] was sitting at the nurses station on the right hand side of the ward. I went around to ask her if she was OK. [you] did not look up at me, but simply said she was doing some e-learning… [you] told me that she had forgotten to give the patient in room 10…their insulin at 5pm.

…

It is not uncommon when the ward is quiet for a nurse to try and complete some e-learning but it cannot be done at the cost of patient care, particularly drug administration. [you] should have done the round herself instead of delegating it to someone else to enable her to continue to do online training."

Whilst the panel noted your written evidence that you and Ms 5 had not been available at the same time, the panel found that failing to administer insulin to a patient in a timely manner was serious misconduct, as it is a fundamental nursing duty and you should have escalated your efforts to find assistance if you required it. This delay could have led to severe patient harm, potentially requiring intensive care.

Charge 3 pertains to your failure to administer Piperacillin/Tazobactam to a patient as required, which the panel determined also amounts to serious misconduct. The panel considered Ms 1's evidence, which states:

"PipTaz is a combination of medications that is required to be dissolved from a powder and is used to treat bacterial infections. If Sister [Ms 5] had not identified

[your] error with this medication then the infection suffered by the patient would not have been treated leading to a serious risk of harm. The risk created was the potential for the patient to turn septic which in turn could risk tissue damage, organ failure or in extreme circumstances death.

…

[You] could not provide a reason as to why she would have taken the medication into the room to be administered and not attached it."

The panel noted that the medication was necessary for treating bacterial infections. This failure posed a risk of the patient becoming septic, leading to severe consequences. The panel noted that this represents a fundamental aspect of nursing practice.

Charge 6 involves your failure to prioritise administering an enema and a COVID test to a patient prior to their discharge. The panel determined that it does amount to serious misconduct. The panel took into account Ms 3's statement:

"There were tasks that needed to be completed on the morning of discharge, such as the patient requiring an enema and Covid test. This is needed as the patient would become constipated over a long period of time and toxins would build up. The patient would require relief from this. If this is not dealt with appropriately then it can cause problems in the long term for a patient."

The panel also considered Ms 1's statement, which states:

"Although the most pressing issue here was that [you were] unable to prioritise tasks correctly, there was also the potential for patient distress prior to the discharge. The reason for the enema was not to allow the patient to be discharged but so that the patient could be discharged without the discomfort of constipation. A delay in this procedure therefore meant that the patient would remain in discomfort for a longer period of time than needed."

The panel noted that in 2022, the country was in the midst of the global Covid-19 pandemic and the use of covid tests was an essential tool to prevent the spread of

infection. The failure to undertake a covid test of a patient being discharged to a care home carried significant risk at this time.

Given the potential for patient harm and the failures in such fundamental nursing duties, this amounts to serious misconduct.

Charge 7c relates to your failure to treat a patient with dignity and respect, specifically regarding the clinical assessment of whether a new stoma/urostomy bag was required, which the panel decided amounts to serious misconduct. The panel noted that this failure likely caused the patient discomfort and breaches the core tenets of nursing practices. The panel considered Ms 3's statement, which states:

> *"I do not believe that [you] showed respect of dignity to the patient in the situation and was unfair to other members of staff such as SNA [Ms 2] who was left without support. I would have expected [you] to assist SNA [Ms 2] in helping the patient, it may have been a simple case that a seal on the bag was broken which is an easy fix or that the bag had burst and needed replacing. However, the decision to replace a bag would not have been the decision of an SNA to make, even if they were able to replace it, an individual is[sic] [your] position would have been responsible.*
> *…*
> *As such, [you] at the very minimum should have inspected the patient to see what the correct course of action was and instruct SNA [Ms 2] on what should be done, although I would still have expected [you] to assist…"*

The panel noted that healthcare professionals have an obligation to provide care that is respectful, compassionate and attentive to the needs of patients. Failing to assess the patient can lead to emotional distress and a breakdown of trust in the healthcare provided. The panel determined that maintaining dignity and respect for patients is vital in healthcare, and lapses in these areas does amount to serious misconduct.

Charges 8 and 9 relate to your failure to attend a shift that you were due to work and numerous instances of attending late to your shift, which the panel decided amounted to

serious misconduct. The panel noted that not only did you fail to attend, but you also did not inform your employer of your absence. The panel took into account Ms 1's witness statement which highlighted the increased burden this placed on fellow staff members due to your repetitive absence: *"As time progressed, I was never sure if [you] would turn up to the shifts that she would be on rota for and this would increase the workload on the staff where she would not turn up. When this became repetitive behaviour I decided it would be appropriate to keep [you] as the additional member of staff so that we would never fall below minimum levels."* The panel noted the necessity of having to keep you as an additional staff member due to your unreliability to ensure adequate coverage.

During the Probationary Period Hearing on 8 July 2022, both Ms 1 and Ms 3 detailed the significant impact of your poor punctuality on the department, particularly concerning patient care. The panel concluded that while a single incident of lateness may not amount to misconduct, the cumulative nature of your repeated absence and lateness at work demonstrates a breach of the professional tenets of the nursing profession.

The panel concluded that the charges individually and collectively, fell significantly short of the standards expected of a nurse, constituting 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.

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. 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 considered that limbs a), b) and c) of Dame Janet Smith’s test as set out in the Fifth Shipman Report were engaged by your past actions. The panel determined your failure to prioritise and undertake fundamental nursing tasks put numerous patients

at unwarranted risk of serious harm. It also determined that your misconduct had breached the fundamental tenets of the nursing profession identified above, and therefore brought its reputation into disrepute

The panel went on to consider whether you are liable in the future to place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession. In doing so, the panel assessed the available evidence about your levels of insight, remorse and remediation. The panel had regard to the factors set out in the case of *Cohen.* The panel determined that the misconduct in this case is capable of remediation as it pertains to clinical practice and the prioritisation concerning both your [PRIVATE] and your nursing practice.

The panel acknowledged that Ms 1 signed you off as competent to administer medication in April 2022. However, the panel was concerned regarding the nature of your practice and the implications of prioritisation in your work which, whilst your skills in actual administration of medication have been found to be safe, without being able to structure and prioritise your work and patient needs, there remains a risk concerning timeliness and your recognition of risk around medication and other clinical issues. The panel had regard to your oral evidence where when asked what changed in your practice that led you to being signed off, you replied *"nothing I did all my medication checks the same as I would any other time…I don't believe I made any changes that I did before".* The panel noted that you lack sufficient insight around the reasons that led to the errors that you made and following on from this the ability to articulate your individual needs which is essential in helping you become adequately structured and safe in your practice.

[PRIVATE].

The panel found that you have displayed developing insight, having admitted to charges at the outset of the hearing, provided a written statement and given thorough and candid oral evidence under affirmation. However, it was not satisfied that you have demonstrated sufficient understanding of your own practice or identified the support you

need for further professional development and training to ensure you can be a safe practitioner.

[PRIVATE]. As a result, the panel concluded that you have not sufficiently remediated your practice and that you are not currently able to practise safely.

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

The panel considered that in the circumstances of this case, a finding of impairment was also required on wider public interest grounds. It noted that the proven charges and misconduct identified in this case are serious. It considered that a fully informed member of the public would be concerned by the panel's findings. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made.

Having regard to all of the above, the panel was satisfied on the grounds of public protection and in the wider public interest 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 eighteen 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.

Submissions on sanction

The panel had sight of an impairment bundle and the Substantive Order Review Hearing determination dated 15 May 2024 (Case reference: 054710/2016).

Ms Hussain invited the panel to impose a suspension order for a period of twelve months with a review. She submitted that, in light of the panel's findings that you have not demonstrated sufficient understanding of your practice, nor identified the support you would need for further professional development and training to ensure that you can practise safely. She submitted that the misconduct that the panel found proved strikes at the very heart of the nursing profession and, at present, you pose a real risk of harm to patients and the wider public.

Ms Hussain outlined the aggravating factors: Firstly, she submitted that it is evident that you placed vulnerable elderly patients at significant risk of harm. Secondly, your insight is still in its developmental stage. Thirdly, there was a pattern of behaviour over a period of time, specifically in relation to the medication errors. Fourthly, the matter of previous regulatory findings is also critical. You were made subject to a conditions of practice order on 23 June 2017, which was initially imposed for 18 months. It has since been reviewed and extended six times, with the last review taking place on 15 May 2024.

Ms Hussain submitted that the panel has found your insight is still developing, and therefore, it follows that there is currently a risk of repetition in this case. Balancing all of these factors, she submitted that a suspension order is not only the most appropriate sanction but also the most proportionate in all circumstances. She invited the panel to consider any hardship that such an order might cause you. However, she submitted that the impact is extremely limited, as you are currently employed elsewhere and not in the nursing profession. In any event, any hardship you may experience is far outweighed by the public interest in imposing a suspension order in this case.

Mr Lawson referred the panel to the NMC Guidance SAN-1 and invited it to impose a conditions of practice order. He submitted that this order is appropriate under the circumstances. He submitted that a suspension order is simply a step too far. He emphasised that the panel's purpose is not to punish you; rather, removing you from your profession would not aid your return to practice nor would it be the proper sanction. He submitted that there has been no actual patient harm and that your insight is developing.

Mr Lawson highlighted that you are already subject to a conditions of practice order arising from very different circumstances, and its existence does not necessitate escalating to a more severe sanction. He further submitted that there are significant mitigating factors in this case, including your early admissions, the ongoing development of your insight, [PRIVATE]. Mr Lawson made recommendations for conditions that the panel could impose to facilitate a supported and managed return to work, concluding that it is ultimately for the panel to determine what conditions would be appropriate.

The panel asked the legal assessor for guidance on how any conditions imposed on your practice since February 2022 would interact with any existing conditions. The legal assessor stated that this is primarily a matter of practicality. If the panel was to determine that a conditions of practice order is the appropriate sanction in this case, it must ensure that any conditions imposed do not conflict with the existing conditions of practice. He said that any conditions the panel implements must be workable in all circumstances, which would include considerations related to the existing order.

Decision and reasons on sanction

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

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 a period of time
- Vulnerable patients were put at risk of significant harm

The panel also took into account the following mitigating features:

- Early admissions at the outset of hearing
- Remorse and evidence of insight into your misconduct
- [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 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…;*

- *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 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 supervision. Additionally, there was no indication of general incompetence that would necessitate more severe action. [PRIVATE]. The panel noted that when you were under the direct supervision of Ms 1, no concerns were raised about your practice. The panel therefore 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 accepted that you would be willing to comply with conditions of practice. 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 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 was of the view that, while the charges found proved are serious, the risk of repetition and harm can be mitigated by putting appropriate conditions in place.

Having regard to the matters it has identified, the panel concluded that a conditions of practice order would protect the public and 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 [PRIVATE].
>
> 2. You may not work as a bank or agency nurse.
>
> 3. You must ensure that you are directly supervised by a registered nurse of at least band 6 or its equivalent anytime you are working.
>
> 4. You must work with your line manager to create a personal development plan (PDP). It must address concerns about how to structure your clinical practice and prioritise your work and detail the areas of support [PRIVATE]. You must:
>   - Meet with your line manager at least every two weeks for a minimum period of six months and thereafter at such frequency as your line manager considers to be appropriate.
>   - Send your NMC case officer a copy of your PDP within two months of commencing employment within a clinical setting
>   - Send your NMC case officer a report from your line manager every month for the first six months and then

bimonthly. This report must show your progress towards achieving the aims set out in your PDP.

5. You will send the NMC a report from your line manager seven days in advance of the next NMC hearing or meeting.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 eighteen 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.

[PRIVATE].

Any future panel reviewing this case would be assisted by:

- Your attendance at any future hearing;
- Any recent references and testimonials;
- Evidence of CPD; and
- Any up-to-date training undertaken relevant to the charges in this case.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is

necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Hussain. She invited the panel to impose an interim conditions of practice order. This would be to ensure that an interim conditions of practice order remains in place in the event that you lodge an appeal and remains in place until any such appeal has been determined.

Mr Lawson indicated that he takes a neutral stance on 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 allow for the possibility of an appeal to be made and determined.

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.