Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 9 October - Wednesday, 23 October 2024

Virtual Hearing

Name of Registrant:	**Egle Lukoseviciute**
NMC PIN	10J0022C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 05 October 2010
Relevant Location:	Derbyshire County
Type of case:	Misconduct
Panel members:	Catherine Devonport (Chair, Registrant Member) Timothy Kemp (Registrant Member) Keith Murray (Lay Member)
Legal Assessor:	Gillian Hawken Fiona Moore (22-23 October 2024)
Hearings Coordinator:	Angela Nkansa-Dwamena
Nursing and Midwifery Council:	Represented by Stephen Page, Case Presenter
Miss Lukoseviciute:	Present and represented by Stuart Brady, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved:	Charge 2b
Facts not proved:	Charges 1a, 1b,1c, 2a (i and ii) and 2c (i, ii, iii, iv and v)
Fitness to practise:	Not Misconduct
Sanction:	**N/A**

Interim order: **N/A**

Details of charge (as amended)

That you, a registered nurse:

1. On 6 September 2019:
    a. During the restraint of Resident A, you used an inappropriate restraint technique in that you moved/pulled Resident A's finger/s back;
    b. In the alternative, during the restraint of Resident A you instructed a colleague to move/pull Resident A's finger/s back;
    c. You knowingly led the restraint of Resident A with colleague/s who did not have the Non-Abusive Psychological and Physical Intervention ("NAPPI") training required.

2. On or about 18 September 2019:
    a. In regards to an incident between 2 service users, you failed to:
        i. Document the incident;
        ii. Sign the, Adverse Event Reporting Form ("AERF") completed by Colleague A in a reasonable time/at all;
    b. Whilst on the Robin Unit you left the clinic open and/or unlocked;
    c. Did not action Resident B's adverse reaction to a Hyoscine patch, in that you:
        i. Did not escalate this to the out of hours GP;
        ii. Did not document Resident B's adverse reaction in their notes 'A Day in My Life';
        iii. Did not create a body map;
        iv. Did not document the removal of the Hyoscine patch;
        v. Having removed the patch, did not take steps to document or manage the withdrawal of medication.

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

Decision and reasons on application to amend the charge

At the outset of the hearing, the panel heard an application made by Mr Page, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of Charge 1c.

The proposed amendment was to correct a typographical error as Charge 1c contained the word ‘lead’ as opposed to ‘led’. The proposed amendment would provide clarity and more accurately reflect the evidence and would not cause any injustice to you at this stage.

Original Charge

1. On 6 September 2019:

   …

   c. You knowingly lead the restraint of Resident A with colleague/s who did not have the Non-Abusive Psychological and Physical Intervention (“NAPPI”) training required.

Proposed Amendment

1. On 6 September 2019:

   …

   c. You knowingly ~~lead~~ **led** the restraint of Resident A with colleague/s who did not have the Non-Abusive Psychological and Physical Intervention (“NAPPI”) training required.

Mr Brady, on your behalf, indicated that he had no objections to the error being corrected.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

On 26 May 2020, the NMC received a referral from Exemplar Healthcare (Exemplar), raising concerns about you. The charges arose whilst you were employed as a registered nurse at the Yarningdale Care Home (the Home), one of the homes run by Exemplar.

On 6 September 2019, it is reported that you were the Nurse in Charge of a unit within the Home. Whilst in the common area of the unit, at approximately 11:00 hours, Resident A reportedly required assistance from the care team in meeting their personal care needs. It is further reported that you had led the care team in assisting Resident A to their bedroom, where restraint was required to assist Resident A in the shower room. It is alleged that you instructed staff members, who were not suitably trained in Non-Abusive Psychological and Physical Intervention (NAPPI) Training Level 2 or 3, to undertake restraint. It is further alleged that you used unapproved restraint techniques, involving bending back Resident A's fingers to release their grip on their clothing.

On 18 September 2019, it is reported that you were involved in three incidents during the shift. Firstly, you allegedly left the clinic unattended with the door open. In relation to the second incident, it is alleged that after being informed about an incident of verbal abuse between two service users, you did not document this incident as per the Home's policy. It is reported that you instructed a care assistant,

Colleague A, to complete an incident form. However, Colleague A had allegedly completed the wrong form, and you had left a note at handover for Colleague A to complete the form correctly upon their return. The Home reported that it was your responsibility to ensure that the documents were completed.

It is further alleged that after becoming aware that Resident B had experienced an adverse reaction to a Hyoscine patch, a medication used to treat excessive salivation, you did not take appropriate action. The Home reported that you should have called the out of hours GP service, documented physical or other observations/assessments and taken steps to document or manage the withdrawal of the medication.

In October 2019, you were invited to attend a disciplinary hearing, at which you were dismissed from your post.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Page and Mr Brady.

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

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

- Witness 1: A Peripatetic Home Manager at Exemplar, at the time of the alleged incidents.

- Witness 2: A Healthcare Support Worker at the Home, at the time of the alleged incidents.
- Witness 3: Head of Quality at Exemplar, at the time of the alleged incidents.
- Witness 4: Quality Manager at Exemplar, at the time of the alleged incidents.
- Witness 5: Clinical Nurse Manager at the Home, at the time of the alleged incidents.
- Witness 6: Head of Behavioural Support and Mental Health at Exemplar, at the time of the alleged incidents.

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 Mr Brady.

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

Charge 1a

That you, a registered nurse:

1. On 6 September 2019:
    a. During the restraint of Resident A, you used an inappropriate restraint technique in that you moved/pulled Resident A's finger/s back;

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2, Witness 4 and Witness 5, the documentary evidence of Colleague 1 and your oral and documentary evidence.

The panel had regard to the Adverse Event Reporting Form (AERF) completed by you on 6 September 2019, shortly after the incident. The panel noted that this established that the restraint of Resident A had taken place and that there is no dispute that this incident occurred.

The panel noted that the language used to describe the alleged contact with Resident A's fingers during the incident appeared to change between witnesses and across the time the local investigation was conducted. Words such as *'moved'*, *'pushed'*, *'pulled back'*, *'bent back'* and *'touched'* had been used to describe the inappropriate restraint technique used on Resident A at various stages of the investigation and during oral evidence.

The panel had regard to the local written witness statement of Witness 2, a direct witness to the incident, dated 6 September 2019. She initially described the motion as:

> *'I noticed that Egle pushed her finger through Resident A hand and pushed the fingers up to remove the clothing'*

However, within her written NMC statement, dated 11 November 2021, she described:

'The Registrant then pulled Resident A's fingers back to remove the nightgown from her grip.'

Notwithstanding this, during her oral evidence, Witness 2 explained that it was more of a movement that applied pressure on Resident A's joints. She also clarified that she could not remember saying Resident A's fingers had been *'bent back'* but she could recall saying that they had been *'moved back'*.

The panel noted that the phrase *'bent back'* had first been introduced within a *'Summary of debrief'* statement dated 6 September 2019, co-signed by Witness 4, Witness 5 and yourself, in which it was described that Colleague 1 had bent Resident A's fingers back:

'[Colleague 1] confirmed that she physically bent Resident A's fingers to release her clothing…'

During her oral evidence, Witness 5 confirmed that you had admitted to bending back Resident A's fingers during the restraint and that she had recalled Witness 2 stating that you had *'bent'* Resident A's fingers back. However, during cross-examination, Witness 5 accepted that the term *'bent back'* may have been changed from the original explanation and been adopted.

The panel noted that whilst you had signed the summary of the debrief, you annotated the documented stating that you did not agree with some of the statements made.

During her oral evidence, Witness 4 explained that she had asked you to demonstrate how you would release fabric from a firm grip. This was supported by a statement co-signed by Witness 4, Witness 5, Manager 1 and yourself:

'EL was asked by [Witness 4] to demonstrate the technique, [Witness 4] held her t-shirt loosely and asked EL to show her how she would have released her fingers, EL did show her the correct technique initially by pulling the

clothing, [Witness 4] held the t-shirt more firmly and asked EL what she would do at that point, EL started to pull 2 of [Witness 4] fingers. [Witness 4] explained at that point she should not touch the fingers.'

Following a demonstration by Mr Brady showing fingers being bent back, in response to a question, Witness 4 agreed that this was not the action demonstrated and responded in what the panel considered to be, an incredulous way:

'…we're not bending people's fingers back, Mr Brady. Egle absolutely did not pull my fingers back like you demonstrated…'

Within your written statement before the panel dated 17 October 2024, you explained:

'I tried to say that I did not bend Resident A fingers back [sic]. As always I used the material release technique. Then [Witness 4] asked me to demonstrate the technique on her and she held her own top. I demonstrated and she said the material was released correctly. Then [Witness 4] started asking what went wrong if I applied the correct technique. I remember saying to her that the resident kept constantly grabbing the clothes very hard and I found it very tricky to release the material. Then [Witness 4] said she would hold her T shirt firmly and asked me to demonstrate it again. She held her top very tight, I attempted to release, but was unable to do it. According to [Witness 4], because I touched her 2 fingers, it was unacceptable.'

During your oral evidence, you denied moving, pushing, pulling or bending back Resident A's fingers. You clarified that any movement of Resident A's fingers was as a result of you moving the fabric of Resident A's clothing and any contact with her fingers would have been an incidental *'touch'* during the material release technique.

The local witness statement of Colleague 1 dated 6 September 2019, also alluded to a gentler contact with Resident A's hands:

'…she was holding her under were [sic]. We just try smoothly to take off her hand.'

The panel considered the above evidence. It noted that there were a number of inconsistencies. Firstly, the panel noted that the way the movement of Resident A's fingers had been described varied depending on the time of report and the person asked and it was therefore difficult to ascertain what the actual movement of Resident A's fingers was. In addition, the panel had no evidence before it, such as a policy or training document to demonstrate what the correct material release technique would be and whether any movement of a service user's fingers was acceptable. Secondly, the panel was unable to ascertain who was directly involved in the restraint of Resident A and what their role was. Both you and Colleague 1 were alleged to have undertaken the incorrect restraint technique and both you and Witness 2 could not recall who was undertaking the restraint and who was holding Resident A's clean clothing.

The panel considered the oral evidence of Witness 4 in relation to what she recalled of your demonstration of the material release technique. It attached little weight to this demonstration as it considered that it was subjective and may not have accurately reflected the circumstances in which Resident A's restraint took place. Similarly, the panel attached little weight to the hearsay evidence of Colleague 1 as it could not be tested in cross examination.

In light of the above, the panel concluded that it was unable to determine whether the movement of Resident A's fingers during the restraint was an inappropriate restraint technique and that with respect to Charge 1a, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 1b

That you, a registered nurse:

1. On 6 September 2019:
    b. In the alternative, during the restraint of Resident A you instructed a colleague to move/pull Resident A's finger/s back;

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 2, the documentary evidence of Colleague 1 and your oral and documentary evidence.

The panel had regard to the *'Summary of debrief*' statement in which it outlined:

> *'[Colleague 1] confirmed that she physically bent Resident A's fingers to release her clothing, as advised by EG'*

However, this is not supported by Colleague 1's local witness statement, in which she made no reference to bending back Resident A's fingers.

During panel questioning, Witness 2 was asked whether she had been instructed by you to move or pull Resident A's fingers. She clearly stated:

> *'No, I wasn't touching her clothing so she wouldn't have asked me'*

Further, when Witness 2 was asked whether you had asked Colleague 1 to move or pull Resident A's fingers, she stated:

> *'I don't remember so.'*

You told the panel that you had not instructed anyone to move or pull Resident A's fingers. This was supported by your response during your local investigation meeting with Witness 1 on 26 September 2019:

> *'Why would I tell staff to do this?... it was said I bent fingers but then it was said that I told agency to do it. This is discrepancies in the story…[sic]'*

The panel accepted the above evidence and determined that it was unlikely that, during the restraint of Resident A, you had instructed a colleague to move or pull Resident A's finger(s) back during the restraint.

In light of this, the panel found Charge 1b not proved.

Charge 1c

That you, a registered nurse:

1. On 6 September 2019:
    c. You knowingly led the restraint of Resident A with colleague/s who did not have the Non-Abusive Psychological and Physical Intervention ("NAPPI") training required.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1 and Witness 2, the oral evidence of Witness 6 and your oral and documentary evidence.

The panel first considered the word *'knowingly'* within the charge and whether Witness 2 and Colleague 1 were trained in restraint.

The panel had regard to the local investigation meeting, noting from the meeting between you and Witness 1 on 26 September 2019 that:

‘[Witness 1]: Staff training was unknown and you was aware [Witness 2] wasn’t trained.

[You]: [Witness 2] was trained to level three 3 in previous jobs.

[Witness 1]: where is the evidence of this training, that is i.e. certificates.

[You]: I haven’t seen anything.

[Witness 1]: you were aware she wasn’t trained with Exemplar.

[You]: Yes.

The panel had regard to Witness 2’s local witness statement, in which she stated:

‘I said at this time that I was not trained to do this and I didn’t feel comfortable. Egle said that she would lead and show myself and [Colleague 1] what to do.’

This was supported by her written NMC statement:

‘It was decided that an intervention would be required to support Resident A’s personal care. At this point I stated that I did not feel comfortable being involved in an intervention that required any restraint. I had been trained previously in positive handling but this had been in a setting where I had been caring for children not adults. I was not comfortable applying that training in this environment.’

During her oral evidence, Witness 2 had stated that she felt uncomfortable undertaking the restraint on Resident A as she had not been trained at Exemplar and that although she had previously been trained in NAPPI, this was at her previous employer at a school for children.

The panel also had regard to the *'Summary of debrief'* statement in which it stated that Colleague 1 was in fact trained in restraint:

> *'[Witness 4] asked [Colleague 1] if she had received restraint training. She said she was fully trained with all areas required for the agency, and could restrain.'*

The panel heard contradictory evidence from witnesses with respect to the validity of restraint training undertaken outside of Exemplar Healthcare. The panel heard that a NAPPI restraint qualification not delivered by Exemplar could be accepted as valid training for agency workers and staff. However, the panel also heard that a member of staff would only be considered competent and trained to undertake restraint if they had received training from Exemplar. The panel heard from Witness 6, a former NAPPI trainer in the Home, who stated that NAPPI restraint training was standardised across most healthcare settings. He said that if a staff member had a valid certificate in NAPPI Level 2 or Level 3, there is no reason why they would not be deemed competent to undertake NAPPI restraint techniques.

The panel also heard from Witness 1 who confirmed this and stated that in the Home, a NAPPI restraint qualification would need to be updated annually.

You informed the panel that you had previously worked with Witness 2 at a different care home, five to six years prior to the incident, and that you had both been trained in restraint. You told the panel that you were under the impression that Witness 2 had training in restraint, even though she had not yet been trained by Exemplar:

> *'I explained that I would lead the intervention and this is how other support workers would get a support from me as I knew the resident. When I said this, [Witness 2] appeared ok and did not disagree to participate. I used to work with [Witness 2] in challenging behaviour dementia nursing home under other healthcare provider about 5 - 6 years ago, therefore I knew she was not new in care sector and she knew the restraint techniques used by Exemplar as the*

same techniques I was taught in my previous employment and [Witness 2] had received the same training there as well).'

This was confirmed by Witness 2 however, she stated:

'Yeah, Egle would have known my training at [Home 1]. It wasn't formalised training, so I can't say it was NAPPI 3 for example. It was basic principles. I was taught NAPPI 2, not 3. When I was at special school, not [Home 1]. I don't remember if I was taught that I could use the restraint at [Home 1]. Either way, I didn't do any restraint at the special school.'

The panel considered the above evidence, and it was satisfied that Colleague 1 did have some form of restraint training. However, it was unable to determine Witness 2's training status and in light of this, the panel determined that you had knowingly led the restraint of Resident A with a member of staff whose training status was unknown.

Notwithstanding this, the panel also considered the word *'required'* within the charge. It noted that the NMC had not adduced evidence to show which staff members were appropriately trained in NAPPI restraint at the Home, despite several witnesses saying that records would have been held by Exemplar. The panel had regard to a training timetable which indicated that Witness 2 was due to undertake NAPPI Level 2 training with Exemplar on 12 September 2019 however, the panel had no information with regards to her previous training status outside of Exemplar. Witness 2 could not recall whether she had attended the training on 12 September. In addition, the panel had no evidence before it, such as a policy document to suggest that staff had to be trained by Exemplar to be deemed competent to undertake restraint.

In light of this, on the balance of probabilities, the panel was not satisfied that it could determine that Witness 2 did not have the NAPPI training that was required and that with respect to Charge 1c, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 2a (i and ii)

2. On or about 18 September 2019:
    a. In regards to an incident between 2 service users, you failed to:
        i. Document the incident;
        ii. Sign the, Adverse Event Reporting Form (“AERF”) completed by Colleague A in a reasonable time/at all;

This charge is found NOT proved in its entirety.

In reaching this decision, the panel took into account the documentary evidence of Colleague A and Witness 5, the oral evidence of Witness 1 and Witness 6 and your oral and documentary evidence.

The panel first considered whether you had a duty to document the incident between the two service users and sign the AERF completed by Colleague A.

The panel noted that you were the Nurse in Charge of the shift and that you would have been responsible for completing documentation and overseeing the work of care staff. This was confirmed by the oral evidence of Witness 1, who stated that as the Nurse in Charge, you should have ensured that the AERF was completed with details of the incident even if you had not witnessed the incident:

> *‘…the AERF needs to be signed off by the nurse… if I was it responsible and an incident occurred, then it's my responsibility to read and to sign and to check that form before it is actually submitted [sic].*

...if that was myself, I would complete the form and make it clear on there that I'm repeating the information as given to me before I left shift.'

However, the panel took into account that you were not a direct witness to the incident and that Colleague A was the one who reported it to you, this is not a disputed fact.

The panel had regard to Colleague A's local written statement written on 20 September 2019:

'A service user [Service User A] approached me and stated that [Service User B] had been seen going into [Service User C] room telling her to shut 'the fuck up', then slammed the door and went into his own room.

I approached EL and explained the situation and she said she would speak to [Service User B], and I said I would AERF it, if she could sign it. (The AERF still hadn't been signed, it was found 2 days later in the nurses station unsigned)'

This was mostly supported by the local written statement of Witness 5, dated 20 September 2019:

'… [Home Manager 1] informed me that another resident [Service User A] had spoken to her about an incident with another service user…I then asked Colleague A if she was aware of this and she said she was and had informed Egle earlier in the day and asked her to do an AERF form. I then asked Egle to complete the AERF and document it in her file…'

You explained in your witness statement that:

'I was doing tea time medication when team leader [Colleague A] came to tell me that she was approached by service user [Service User A]. [Service User A] explained that she witnessed a service user [Service User B] walking in the corridor. Service user [Service User C] was in bed and was constantly shouting the word 'help'. [Service User B] came to her bedroom doorway, shouted 'shut up', then closed [Service User C]'s bedroom door and walked away.

…

From what I was told I believed that it was a minor incident…([Service User C] was known for repeated shouting and even if asked what she wanted, she would continue shouting the same word). [Service User B] used to isolate himself from others a lot as he disliked noisy environment… It was just his shouting of 'shut up' that was not acceptable towards [Service User C]. I said to team leader [Colleague A] that ABC (Antecedent, Behaviour, Consequence) form would need to be completed for this.'

You further stated in your witness statement:

'I came back to nurses station just after 7 pm and learned that team leader [Colleague A] was gone (carers worked from 7am till 7pm, nurses from 8am till 8pm). She never brought me an incident form to look at and countersign. I saw an incident form left on nurses desk, but it was not a proper incident form, just it's supplementary form. A proper incident form needed to be completed first and a supplementary form then had to be added with other people's involved names and with a reference number from the original incident form). The supplementary form is designed in a such way that there is no space to explain the incident itself. [Colleague A] filled just a supplementary form with resident's full name and date of birth, that's it. She has not written anywhere of what actually had happened.'

During your oral evidence, you clarified that you were unaware that the exchange between Service User B and Service User C involved a swear word and had you

been made aware of this, you would have advised Colleague A to complete an AERF instead, as suggested by Home Manager 1 and Witness 5, in accordance with the Home's aggression policy. You further stated that since you were not a direct witness to the incident, you would not have been able to document the incident or fill in the AERF accurately, so you had handed over the incomplete form to Colleague 2 at handover for Colleague A to complete on her return the next day.

This was supported by Colleague 2's email dated 22 October 2019:

> *'During handover Egle had reported that there had been and incident involving two service user [sic], Egle informed me that an AERF had been completed by care staff on the wrong form therefore she had not signed it, Egle requested that this be passed onto staff the following morning.'*

The panel had regard to a blank AERF, which included the supplementary form. Despite minor differences, Witness 6 confirmed that this would have been the form used at the time of the incident. During cross examination, Witness 1 accepted that a completed supplementary form alone would not have been a sufficient record of the incident.

The panel considered the above evidence and decided to accept your evidence. It noted that Colleague A had taken responsibility for completing an AERF but, had only completed a supplementary form on the AERF. The panel acknowledged that although you were the Nurse in Charge, you had not been a direct witness of the incident and the information relayed to you by Colleague A did not accurately reflect the incident, namely the involvement of a swear word. The panel took into account the fact that you had raised this issue during your handover to the Nurse in Charge of the night shift, Colleague 2, by asking for the correct AERF document to be completed by Colleague A the next day so that the 48-hour time limit for completion could be met.

In light of the above, the panel considered that it would have been unreasonable for you to document or to complete an AERF about an incident you had not witnessed,

when you had not been appraised of all the facts and to sign an account of an incident that had been recorded on incorrect documentation would not have been appropriate. The panel considered there to be no failure on your part.

Accordingly, the panel found Charge 2a not proved in its entirety.

Charge 2b

2. On or about 18 September 2019:
    b. Whilst on the Robin Unit you left the clinic open and/or unlocked;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 3 and Witness 5 and your documentary evidence.

The panel had regard to Witness 5's local witness statement, which stated:

> *'I attempted to open the clinic door to check if Egle was in there. The clinic door opened and was unlocked but Egle was not inside the clinic. The team leader Colleague A informed me that Egle had left the unit and gone to the One Care [a separate unit attached to Yarningdale]. When Egle returned to the unit, I informed her she cannot leave the clinic room door unlocked to which she just huffed at me.'*

Witness 3 confirmed in her NMC written statement dated 5 October 2021, that:

> *'The clinic door is not allowed to be left open because it is the area where medicines are stored. This included controlled drugs and overflow stock that would not be in a medication trolley. The risk of this would be that a resident could get hold of medication and accidently or intentionally take the drugs that could cause harm. Company policy is that medication is kept in a locked trolley in a locked room…'*

In your written statement, you stated:

> *'I admit that I accidently left clinic room door unlocked and I apologised for it, but there were a lot of contributing factors that led this mistake to happen.*
>
> *Firstly, a phone call was received when I was dispensing medication in the clinic room. There was a printed note on clinic room door saying, that the nurse should not be disturbed during medication round except in emergency situation. However, as nobody from carers picked up the phone, I had to answer it.*
>
> *As there was no one else around, the social worker approached me and asked to be given resident's care plan. I had two distractions within a minute.'*

This was supported by your investigation meeting notes with Witness 1:

> *'Social Worker asked for care plan, health professionals were there, one care called as [Service User D] had seizure or because he needed medication. I was distracted, gave the folder to the social worker and thought I locked the door. Went to one care, came back and [Home Manager 1] and [Witness 5] in the nurse station. [Home Manager 1] walked away and [Witness 5] said I had not locked the door. I didn't lock it and appologise for this [sic].'*

The panel considered the above evidence. The panel heard that the clinic door was within the nurses' station, which had a keypad access to it. The panel noted that although the clinic door had been left open and unattended, the medications were locked away and service users would not have been able to access the clinic room due to access to the nurses' station being restricted. However, in light of the above evidence, the panel determined that you had left the clinic door open/unlocked on the Robin Unit.

Accordingly, the panel found this charge proved.

Charge 2c (i, ii, iii, iv and v)

2. On or about 18 September 2019:
    c. Did not action Resident B's adverse reaction to a Hyoscine patch, in that you:
        i. Did not escalate this to the out of hours GP;
        ii. Did not document Resident B's adverse reaction in their notes 'A Day in My Life';
        iii. Did not create a body map;
        iv. Did not document the removal of the Hyoscine patch;
        v. Having removed the patch, did not take steps to document or manage the withdrawal of medication.

This charge is found NOT proved in its entirety.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 3, including Resident B's records, the oral and documentary evidence of Witness 5 and the oral evidence of Witness 1 and Witness 4. The panel also took into account the documentary evidence of Colleague 2 and your oral evidence. In relation to this charge, you produced additional documentation from the Home.

The panel considered each of the sub-charges in relation to the stem of the charge, whether you did not action Resident B's adverse reaction to the Hyoscine patch.

The panel had regard to Resident B's *'A Day in My Life'* record (nursing notes for a service user) for 18 September 2019. It noted that at 15:45, Colleague A had documented Resident B's adverse reaction and had stated that a body map had been completed. This entry had been countersigned by you.

The panel also had regard to Resident B's Medication Administration Record (MAR Chart), on which you had input the letter 'G' on 18 September 2019 against the

Hyoscine patch. This letter indicated ‘see note overleaf’ on the MAR chart. The panel noted that you had recorded overleaf that you had not applied the Hyoscine patch as a *‘rash developed’*.

The panel also noted the diary entry for 19 September 2019, where you had documented on 18 September 2019 for staff to chase Resident B’s GP as you were unable to make contact on 18 September at 16:35 hours. The diary was used by nurses to handover additional information between shifts.

You told the panel that when Colleague A had informed you of Resident B’s adverse reaction, you had taken off the patch to prevent further irritation. You said you had attempted to contact Resident B’s GP, but the surgery was closed and had documented this in the staff diary. You told the panel that you did not call the out of hours GP service as you had assessed Resident B and he had informed you that he felt fine. You said that you had made a clinical judgement and determined that Resident B was well, and that the reaction was not so serious for it to be urgently reported to the GP. You therefore made a professional judgement not to escalate to the GP out of hours service. You said that Colleague A had documented the reaction and that you would not have countersigned her entry if you had not seen the body map that had been completed. You then handed over to Colleague 2 that Resident B should be monitored overnight. The panel considered this to be reasonable steps to take in the circumstances and therefore could not find fault in your clinical practice in this regard.

This was supported by Colleague 2’s email:

> *‘Egle informed me at handover that a service user had skin reaction caused by patches, Egle reported that she had attempted to call the GP surgery however was not able to speak to them, Egle had forwarded this task in the diary for the following day and advised the service user be monitored.’*

When this evidence was put before Witness 3 during cross examination, she responded:

'Yes, having seen this, I've changed my opinion.'

Witness 1, Witness 4 and Witness 5 also agreed that in light of the evidence above, you had made reasonable efforts to document and action Resident B's adverse reaction to the Hyoscine patch.

The panel considered the above evidence. The panel was satisfied that you had taken sufficient steps to action Resident B's adverse reaction. It noted that you had made an attempt to contact Resident B's GP and when this was unsuccessful, you had made a reasoned clinical decision in relation to the severity of Resident B's reaction and ensured that it was handed over that he required further monitoring, and you had followed this up with a note in the staff diary. The panel determined that there was documentation of Resident B's adverse reaction in the form of his *'Day in My Life'* record and MAR Chart and, despite the body map not being adduced by the NMC, the panel accepted your evidence that you would not have countersigned Colleague A's entry, had you not seen the body map Colleague A had documented she had completed. The panel considered that the fact that a Hyoscine patch had not been applied by you on 18 September 2019 and was subsequently discontinued by Resident B's GP on 19 September 2019, indicated that you had removed the Hyoscine patch. The panel was of the view that although this was not documented, it would be reasonable to conclude that you had removed the patch, considering it had caused an adverse reaction.

In light of the above, the panel determined that you did action Resident B's adverse reaction to the Hyoscine patch and that, in the circumstances, your actions were considered to have been reasonable.

Accordingly, the panel found this charge not proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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 Page invited the panel to consider NMC guidance (reference FTP-2a) entitled *'Misconduct'* and *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates' (2018)* (the Code) in determining whether your actions in Charge 2b amount to misconduct. He reminded the panel that the Code sets out professional standards of practice and behaviour for nurses and midwives.

Mr Page referred the panel to Section 13 of the Code in relation to preserving safety, namely Section 13.4:

> *'13.4 take account of your own personal safety as well as the safety of people in your care'*

Mr Page recognised that not all breaches of the Code amount to misconduct however, he submitted that the panel should consider whether there was a risk of harm to patients in your care at the time of the incident.

Mr Page acknowledged that your alleged misconduct was as a result of a one-off clinical incident that would not usually come before the regulator. He submitted that if there is evidence that a registrant has reflected and learned from their mistake, there may be a low risk of repetition. He further submitted that the main issue for the panel to consider is whether the act of you leaving the clinic door open was serious, which may have led to a risk of harm to service users in your care.

Mr Page referred to the panel's conclusion with respect to Charge 2b and the evidence of Witness 3, namely:

> *'The clinic door is not allowed to be left open because it is the area where medicines are stored. This included controlled drugs and overflow stock that would not be in a medication trolley. The risk of this would be that a resident could get hold of medication and accidently or intentionally take the drugs that could cause harm. Company policy is that medication is kept in a locked trolley in a locked room…'*

He submitted that it appeared that to a limited extent, that the panel had rejected the risks identified by Witness 3 since access to the clinic room was restricted, as it was within the secured nurses' station. Mr Page submitted that leaving the clinic door open did present a risk, albeit a low risk. He further submitted that the panel may take into account the fact that you had apologised for leaving the clinic door open and that there were a number of contributing factors which led to this mistake being made.

Mr Page invited the panel to take a holistic approach to the circumstances, inclusive of the contributing factors, when considering whether your action in Charge 2b constitutes misconduct. He submitted that the panel should consider whether leaving the clinic door open, on a single occasion, amounted to serious misconduct and

presents a risk of harm. He further submitted that it has to be acknowledged that there is no evidence that the NMC has put before the panel to demonstrate that you have a habit of leaving clinic doors open. Furthermore, the NMC did not put any evidence before the panel to suggest that there has been a repeat of this conduct.

Mr Page submitted that the panel should be mindful that by providing direct care to service users, no matter how low the risk may be, there is still a risk of harm arising from not keeping the clinic door locked, in breach of the Home's policy.

Mr Brady also referred to NMC guidance (*reference FTP-2a*) which sets out:

> *'…one-off clinical incidents won't usually require regulatory action if there is evidence that the professional has reflected and learned from their mistake and we consider that the risk of repetition is low.'*

He submitted that the panel may fairly consider that this is a paradigm example of a one-off clinical incident. He submitted that there were certain circumstances and pressures that led to this incident happening, namely that you had to answer a phone call whilst you were undertaking your medication round, and you were informed that another resident needed painkillers. At the same time, a social worker also required your attention.

Mr Brady submitted that you were only gone for approximately 10 minutes. He reminded the panel of its findings of fact that although the clinic door had been left open and unattended, the medications were locked away and service users would not have been able to access the clinic room due to access to the nurses' station being restricted. He further submitted that this meant that the risk of harm was very low, considering the controlled drugs cupboard and drugs trolley were locked, further minimising any arising risks.

Submissions on impairment

Mr Page then moved on to the issue of impairment. He referred the panel to NMC guidance (*reference DMA-1*) and invited the panel to consider whether your fitness to practise is impaired as of today. He reminded the panel that the NMC defines fitness to practise as a registrant's ability to practise kindly, safely and professionally.

Mr Page submitted that a decision of impairment will rarely be based on one factor alone and invited the panel to take a holistic approach, taking into account all of the circumstances you were faced with at the time. He submitted that there are two factors to consider; firstly, the nature of the concern and secondly, the context of the conduct involved in the concern.

Mr Page submitted that the panel should consider whether you have in the past acted or are liable to act in the future in a way that would put people receiving care from you at an unwarranted risk of harm. He submitted that the panel should be mindful regarding managing the risk that a registrant poses to people receiving care and to members of the public, and that this is a risk management exercise.

Mr Page submitted that given the panel's conclusion with respect to Charge 2b, it may conclude that there is no risk, or in the alternative, that there is a low risk of harm. Mr Page submitted that in its consideration of whether your fitness to practise is impaired, the panel should be mindful of the context in which your error occurred, the working environment and culture at the time and whether there has been any learning, insight and steps you have taken to strengthen your practice, with respect to Charge 2b, taking into account whether there is likely to be any repetition of the conduct and what reflection and insight has been demonstrated.

Mr Page referred the panel to documents adduced by Mr Brady on your behalf, namely a *'Twice daily clinic security checks'* document for the dates between 18 June 2020 and 27 June 2020 and a Risk Assessment document dated 12 June 2020. Both documents were from your employment at Home 2, shortly after your departure from the Home. He submitted that the documents demonstrate that you

were open and transparent with your new employer, informing them of the concerns raised about your practice and the ongoing NMC investigation. However, Mr Page submitted that the documents date back to 2020 and the panel should consider if there are any current documents with respect to current risk.

Mr Brady submitted that this was a one-off clinical incident and referred to the documents from your former employer in 2020. He submitted that Home 2 was the care home you worked for after you left the Home, and you were clear about the allegations made against you and your referral to the NMC, which is reflected within the risk assessment.

Mr Brady outlined the document and submitted that spot checks had been implemented with respect to the incident involving leaving the clinic door open and you had passed. He submitted that you approached your new employer and were honest and transparent about the concerns raised about your practice and both you and your employer put steps in place to enable you to practise safely. He further submitted that your employer justifiably implemented spot checks to ensure that clinic doors had been locked, and this regime that was put in place just to ensure you were safely securing the clinical areas.

Mr Brady submitted that you have demonstrated your learning on a narrow clinical failing, and this goes beyond what is proportionate to address impairment. He submitted that this shows that you are not impaired and that your action in leaving the medication room door unlocked was influenced by extenuating circumstances.

Mr Brady submitted that this is a paradigm case of a one-off incident which does not amount to misconduct. He submitted that the bar for misconduct and impairment has not been met and considering the approach Home 2 took to mitigate the risks, the risk of repetition is low. He further submitted that the risk of repetition is a material factor in the panel's consideration and that this matter does not meet the bar for misconduct, nor does it display any impairment of your ability to practise as a registered nurse.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

The legal assessor reminded the panel of the definition of misconduct in the case of *Roylance (supra)* and in particular, that in the regulatory context, misconduct has to be serious. With reference to the aforementioned judgements, the legal assessor advised that this has been held to include conduct which would be considered deplorable by fellow practitioners; conduct falling seriously short of the standards the public has the right to expect from a registered nurse or midwife; and conduct which is sufficiently serious that it can properly be described as misconduct going to fitness to practice. The legal assessor reminded the panel that it should consider the issue of misconduct first, and only if the panel finds misconduct established should it then go on to consider impairment of fitness to practice.

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, specifically:

> *'**Preserve safety***
> *You make sure that patient and public safety is not affected…*
>
> ***13 Recognise and work within the limits of your competence***
> *To achieve this, you must, as appropriate:*
> *…*
> ***13.4** take account of your own personal safety as well as the safety of people in your 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*

…

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel determined that your actions were not sufficiently serious to amount to misconduct in the regulatory context. The panel noted that this was an isolated, one-off incident which occurred within an extremely busy work environment where there were a number of situations that simultaneously required your attention, whilst you were completing a lengthy medication round.

The panel took into account that the clinic room was described by witnesses to have been inside the nurses' station. Access to the nurses' station was restricted by way of keypad entry therefore, no service users had access to the clinic room whilst it was unattended, and no actual harm was reported.

The panel noted that when you were challenged by Witness 5 and Home Manager 1, you immediately recognised your mistake, admitted to it and apologised. The panel considered the documents you provided from your employer in 2020, Home 2, post Yarningdale, and determined that you have demonstrated that you would not repeat your actions in the future therefore, there is a low risk of repetition. The panel recognised that the incident was an isolated lapse of professional standards, which was immediately recognised and admitted. The panel was of the view that this was a narrow clinical failing.

The panel noted that the NMC conceded that there is a low risk of repetition, and it is mindful of the need for proportionality and right touch regulation. The panel referred to NMC guidance (*reference FTP-2a*) and acknowledged that the purpose of fitness to practise proceedings is not to punish registrants but to keep the public safe. The panel drew on the advice from the legal assessor and concluded that a fully informed fellow practitioner would not consider your conduct deplorable and likewise, a fully informed member of the public would not find your conduct to fall seriously short of the standards rightfully expected of registered nurses.

The panel noted that you were open and transparent with Home 2 from the outset, and you had asked for support through a risk assessment to enable you and your employer to support and monitor your practice, thereby demonstrating safe practice. It is acknowledged that you have engaged and cooperated fully in these proceedings and the panel has not been made aware of any subsequent regulatory concerns.

The panel found that your actions, taken in context, did not fall seriously short of the conduct and standards expected of a registered nurse and therefore did not amount to serious professional misconduct.

This will be confirmed to you in writing.

That concludes this determination.