Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 2 September 2024 – Monday, 9 September 2024

Virtual Hearing

Name of Registrant:	Ejiro Efe Bourdillon
NMC PIN	13E2939E
Part(s) of the register:	Registered Nurse – Mental Health RNMH – 18 January 2014
Relevant Location:	Redcar and Cleveland
Type of case:	Misconduct
Panel members:	Rachel Cook (Chair, Lay member) Carole McCann (Registrant member) Anne Phillimore (Lay member)
Legal Assessor:	Fiona Barnett (2 September – 7 September 2024) Nigel Ingram (9 September 2024)
Hearings Coordinator:	Hamizah Sukiman
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mr Bourdillon:	Present and represented by Silas Lee, instructed by Royal College of Nursing (RCN)
Facts proved by admission:	Charges 2a, 2b, 7a and 7b
Facts proved:	Charges 2c, 2d, 3, 5, 6a, 6b, 8a and 8b
Facts not proved:	Charges 1a, 1b, 1c, 4a and 4b
Fitness to practise:	**Impaired**

Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

Before the charges are read, the panel heard an application made by Mr Kabasinskas, on behalf of the Nursing and Midwifery Council ('NMC'), to amend the wording of charge 2d. The proposed amendment was to replace the sub-charge referred to in this charge from '2d' to '2c', to correct the typographical error in the Notice of Hearing. He told the panel that it was your representatives at the Royal College of Nursing ('RCN') who drew the NMC's attention to this typographical error. He submitted that this amendment would not be prejudicial to your case, as your representatives were aware of this error.

The proposed amendment is as follows:

> "That you, a registered nurse:
>
> 2) On 30 September 2022, following Resident A having suffered an unwitnessed fall:
>
> d) failed to provide junior colleagues with any moving and handling advice and/or assistance beyond the instruction referred to at charge ~~2d~~ **2c**.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

Mr Lee, on your behalf, submitted that he does not oppose the application.

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

The panel was of the view that this amendment, as applied for, was in the interest of justice. The panel noted that this is an agreed application between you and the NMC. It was satisfied that, as this amendment is sought to correct a typographical error, no prejudice or injustice would be caused to either party by the proposed amendment being

allowed. The panel determined that it was appropriate to allow the amendment, as applied for, to correct the typographical error.

Details of charge (as amended)

That you, a registered nurse:

1) On 10 September 2022:
   a) failed to check in medication for Resident D.
   b) failed to administer medication to Resident D.
   c) failed to store Resident D's medication in the fridge.

2) On 30 September 2022, following Resident A having suffered an unwitnessed fall:
   a) failed to conduct a physical examination of Resident A.
   b) failed to take observations for Resident A.
   c) instructed junior colleagues to 'just pick her up' or gave instructions to that effect referring to Resident A when it was not safe to pick Resident A up without a physical examination having been conducted and/or observations having been taken.
   d) failed to provide junior colleagues with any moving and handling advice and/or assistance beyond the instruction referred to at charge 2c.

3) On 04 November 2022, failed to administer eyedrops to Resident E in line with their treatment plan.

4) On 02 December 2022:
   a) failed to check in Analgesia patches prescribed to Resident C.
   b) failed to store the Analgesia patches prescribed to Resident C appropriately in that you left them on the medication trolley when they should have been store in the controlled drug cupboard.

5) On 04 January 2023, administered discontinued medication to Resident B.

6) Your actions at charge 5 were undertaken despite:
   a) you having been given oral and written handover that the medication was discontinued due to Resident B's swallowing difficulties.
   b) your knowledge that Resident B had swallowing difficulties which render administration of a large tablet unsafe.

7) On 24 February 2023:
   a) failed to accurately check in Buprenorphine patches prescribed to Resident A.
   b) failed to accurately record in the controlled drug book that you had administer one Buprenorphine patch to Resident A.

8) On 25 February 2023:
   a) Shouted at a colleague who was providing feedback on your clinical practice.
   b) Told a colleague who was providing feedback on your clinical practice that she was 'stupid' or said words to that effect.

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

Background

The charges arose whilst you were employed as a Band 5 registered nurse at Shoreline Care Home ('the Home'). You commenced employment at the Home on 5 August 2022, and, at the relevant time, you were subject to a six-month probationary period.

It is alleged that, within your first few weeks at the Home, concerns were raised regarding your poor nursing practices. The Clinical Lead at the Home, who was also your supervisor, alleged that on 10 September 2022, you failed to administer medication to Resident D, and you had instead left the medication on the side "*all night*".

The Home also alleged that, on 30 September 2022, Resident A suffered an unwitnessed fall, and you allegedly did not appropriately assess the resident for potential injuries. It is further alleged that there were concerns raised concerning your decisions on the moving and handling of Resident A from the floor.

Further concerns were also raised regarding your medication practice. It is alleged that you failed to appropriately document the delivery of medication patches into the Home in the controlled drugs book, and you did not document that a dose of the patch which was applied to a resident. It is also alleged that you administered a tablet medication to Resident B, who was at high risk of choking, despite you being told that the medication no longer being prescribed to Resident B. The Home also alleged that, on a different occasion, you failed to administer eyedrops to Resident E, despite it being outlined in Resident E's treatment plan.

On 25 February 2022, you allegedly became aggressive to the Clinical Lead after she attempted to complete further supervision with you due to an alleged error made in the controlled drugs book. You resigned from your position on the same day.

Decision and reasons on application to admit an additional email as hearsay evidence on Day 2

On the second day of proceedings, amidst Witness 2's live evidence, the panel heard an application made by Mr Kabasinskas to admit an email from the referrer, dated 2 July 2023, into evidence pursuant to Rule 31. The email appears to be correspondence between a member of staff of Hornby Healthcare and member of staff at an NHS pharmacy regarding the delivery of prescription medication. He submitted that this email is an additional piece of information regarding the delivery of the prescription to the Home, and it relates to Charge 3.

Mr Kabasinskas informed the panel that the NMC was supplied with this email by the referrer, and the attachment referred to in the email has not been provided to the NMC. He accepted that the email does not make specific reference to the prescribed eyedrops as outlined in Charge 3. However, he submitted that the referrer would have no reason to send any other documents in relation to the delivery of a prescription on the same date, and that the panel can be satisfied that, through the date referred to in the email, that this concerns the same prescription.

Mr Kabasinskas submitted that this email is relevant to these proceedings, as it provides the panel with an indication of the extent of the information provided by the pharmacy in relation to their delivery of the prescription on 4 November 2022, which supports Witness 2's live evidence.

He acknowledged that this email is hearsay evidence, as the author of the email is not giving evidence in these proceedings. However, he submitted that the panel can be satisfied that this email thread is not the sole and decisive evidence in relation to Charge 3. He further submitted that it would be disproportionate to obtain a witness statement or to call the author of this email as a witness in these proceedings to be cross-examined.

Mr Kabasinskas reminded the panel of the principles outlined in the case of *R (on the application of Bonhoeffer) v General Medical Council* [2011] EWHC 1585 (Admin), namely there is no automatic right to cross-examine the maker of a statement in regulatory proceedings.

With regard to fairness, Mr Kabasinskas submitted that the panel would have the opportunity to test this evidence by further questioning Witness 2 on the timeline of the prescription delivery at this stage, as she remains under affirmation. He invited the panel to admit the email into evidence.

Mr Lee submitted that he opposed the application. He submitted that the email is not exhibited by any witness which are part of these proceedings, and there is no indication

that Witness 2 has seen the email or can comment on the email. He further submitted that, whilst he appreciated that the email has arrived to the NMC from the Home, there is no indication that the email speaks towards matters in dispute in this case.

On the relevance of this email, Mr Lee submitted that there is no subject title on the email thread, and it appears to be a thread between staff of Hornby Healthcare and a member of staff at a pharmacy, none of whom are involved in these proceedings. He further submitted that the email referred to an attachment, which is not available in these proceedings, and consequently, the panel cannot examine. He also submitted that the email referred to a prescription, but there is no further indication that this relates to the specific eyedrops outlined in Charge 3.

With regard to fairness, Mr Lee submitted that neither he nor the panel would have the opportunity to question the author of this email regarding any additional circumstances which may be relevant to these proceedings. He further submitted that there is nothing in this email which is demonstrably reliable for the panel to rely upon. He reminded the panel that there is little dispute between the NMC and you regarding prescription being delivered on 4 November 2022, and that the dispute centres around whether it was delivered in the day shift or the night shift, which the email does not comment on. He invited the panel to refuse the NMC's application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, irrespective of its admissibility in civil proceedings. She distinguished the case of *Bonhoeffer* from this matter, and she outlined for the panel that the case of *Bonhoeffer* involved a witness statement, rather than a piece of document such as an email. She invited the panel to consider the relevance of the email first, before moving on to consider the fairness of admitting the email into evidence.

In reaching its decision, the panel considered submissions from both Mr Kabasinskas and Mr Lee, as well as the legal advice it received on Rule 31.

The panel noted that the email appears to be between two members of staff, one of Hornby Healthcare and another of an NHS pharmacy, neither of whom are party to these proceedings. The panel considered that the email confirmed that a prescription was delivered to the Home on 4 November 2022, but it does not refer to any specific time in which it was delivered nor a specific resident.

The panel was of the view that there is no information indicating that this email relates to the matters in dispute in Charge 3. The panel considered that the email does not specifically refer to the eyedrops, instead referring more generally to "*the prescription*". The panel noted that the date referred to in the email appears to be the same date as outlined in Charge 3, but it was not satisfied that this sufficiently connects the email to the charge. The panel considered that as both the sender and recipient of the email are not identified as a party to these proceedings, it would be unable to question them on their role and relationship to the Home to ascertain the email's connection to Charge 3.

Notwithstanding its inability to connect the email to Charge 3 above, the panel also considered that you do not dispute that the prescription was delivered, but rather the time in which it was delivered. The panel determined that the email does not confirm a specific time, and reconfirmed a point broadly agreed upon between you and the NMC, namely that the prescription was delivered, at some point, on 4 November 2022. Accordingly, the panel was satisfied that it has other information before it to decide on whether Charge 3 is found proved, and that this email is not materially relevant to either party's case on this charge.

The panel was not satisfied that this email is of sufficient relevance to these proceedings to be admitted as hearsay evidence. In these circumstances, the panel refused the NMC's application.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Lee, who informed the panel that you made full admissions to charges 2a, 2b, 7a and 7b.

The panel therefore finds charges 2a, 2b, 7a and 7b 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 Mr Kabasinskas and Mr Lee.

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: Healthcare Assistant at the Home
- Witness 2: Referrer and Clinical Lead Nurse at the Home

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who reminded it that the burden of proof lies with the NMC, and she outlined the principles derived from the case of *Pope v General Dental Council* [2015] EWHC 278 (Admin). She reminded the panel to not make general assessments on the credibility of a witness solely based on their demeanour when giving evidence. With

regard to the charges alleging failure, she reminded the panel to first establish whether there was an obligation upon you to fulfil that act, before deciding on whether you have failed to fulfil that obligation. She reminded the panel that its reasons do not need to summarise all the evidence and submissions, but it should be sufficiently clear to a reader.

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

Charge 1a)

"That you, a registered nurse:

1) On 10 September 2022:

a) *failed to check in medication for Resident D.*"

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's witness statement to the NMC, which stated:

"*Following the arrival of the medication into Shoreline the expectation would be for Jiro, as the nurse, to immediately check in the medication and administer the antibiotic medication for Resident D following the instructions on the prescription. Jiro did not administer the medication when it arrived at Shoreline leaving resident D with an untreated infection for over 12 hours. In addition to this, Jiro had left the antibiotic medication out all night and should have been in the refrigerator …"*

…

I spoke to Jiro regarding my concerns regarding resident medication and …"

The panel considered Witness 2's description of the delivery of prescribed medication, which stated:

> *"When medication arrives at Shoreline the expectation is that the nurse in charge of the shift will 'check in' the medication and ensure this is administered, in line with the prescription. Often the medication is delivered late in the evening from the pharmacy, so the night nurse is responsible for checking in the medication and commencing it as per prescription instructions."*

The panel considered the Staff Supervision Record, dated 10 September 2022, which outlined that Witness 2 discussed with you the following:

> "*Discussed that this is a 24hr service and that night staff are expected to complete what day staff have not had the opportunity to complete*."

The panel had sight of the care notes for Resident D, confirming the diagnosis and prescribed medication. The panel heard from Witness 2 that the medication was left "*on the side*" and had not been properly checked-in.

The panel considered your written response, namely that the medication was contained within an unmarked, sealed box which was in the nurses' station containing a number of unmarked, sealed boxes.

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to check in the medication for Resident D, were under an obligation to do so.

The panel considered Witness 2's live evidence, which confirmed that the induction process at the Home consisted of the completion of an induction booklet – which has not been made available before this panel – as well as a period of time working supernumerary alongside another qualified member of Home staff. Witness 2 stated that

she did not undertake your induction. You told the panel that you worked two nights a week at the Home, and your induction period lasted for one week, and would therefore have consisted of two night shifts.

The panel was of the view that, as you would have commenced your employment a few weeks prior to 10 September 2022 (namely on 5 August 2022), you would not necessarily have been aware of how to handle the check in of medication on the night shift if you had not witnessed it before. The panel accepted Witness 2's live evidence that medication, in general, is delivered from the pharmacy to the Home sometime between 18:00 and 19:00. The panel heard from Witness 2 that the day shift ended at 19:00 and the night shift began at 19:00. The panel was of the view that the medication is delivered to the Home primarily during the day shift, and you may not have witnessed this during your supernumerary period.

The panel considered your live evidence, where you told the panel that you were not aware that the medication had been delivered to the Home, and that you needed to check-in the medication. You told the panel that you do not deny that there were sealed, unmarked boxes in the nurses' station, but you were not aware at the time of the contents of the boxes. The panel did not have sight of any handover notes which would indicate that another member of staff brought the medication to your attention. Consequently, the panel was not satisfied that you were aware that Resident D's medication was contained within one of the sealed, unmarked boxes.

The panel was not satisfied that the NMC has proven that you were under an obligation to check in Resident D's medication, given that you were not aware that the medication was within the Home in the first place.

The panel noted that, following this incident, Witness 2 discussed with you the duties of a night shift nurse to check-in medication, as outlined in the Staff Supervision Record, dated 10 September 2022, above. The panel was satisfied that this was consistent with your

written statement confirming you changed your practice following this incident, which stated:

> *"During my supervision session, the issue of parcels was discussed, and I was advised to inspect any parcels in the office or clinic at the beginning of my shift to determine the contents. Since receiving this guidance, I have followed the instructions."*

The panel also heard live evidence from you, where you confirmed that since the incident, you check every box to ensure that medication is checked-in appropriately.

Based on the above, this charge is found not proved on the balance of probabilities.

Charge 1b)

"*That you, a registered nurse:*

1) *On 10 September 2022:*
   b) *failed to administer medication to Resident D*."

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings in Charge 1a above.

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to administer medication to Resident D, were under an obligation to do so.

The panel considered that, based on its findings in Charge 1a above, you were not aware that the medication for Resident D had arrived in the Home. Consequently, you would not be aware of an obligation for you to administer the medication to Resident D.

Accordingly, this charge is found not proved on the balance of probabilities.

Charge 1c)

"That you, a registered nurse:

1) *On 10 September 2022:*
   c) *failed to store Resident D's medication in the fridge*."

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings in Charges 1a and 1b above.

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to store Resident D's medication in the fridge, were under an obligation to do so.

The panel considered that, based on its findings in Charges 1a and 1b above, you were not aware that the medication for Resident D had arrived in the Home. Consequently, you would not be aware of an obligation for you to store the medication in the fridge.

Accordingly, this charge is found not proved on the balance of probabilities.

Charge 2c)

"That you, a registered nurse:

2) *On 30 September 2022, following Resident A having suffered an unwitnessed fall:*

c) *instructed junior colleagues to 'just pick her up' or gave instructions to that effect referring to Resident A when it was not safe to pick Resident A up without a physical examination having been conducted and/or observations having been taken."*

This charge is found proved.

In reaching this decision, the panel took into account your admissions to Charges 2a and 2b, as well as Witness 1's witness statement to the NMC outlining the incident, which stated:

> *"My HCA colleague went to get Jiro, when Jiro came into the lounge he immediately told us both to pick resident A up from the floor. I asked Jira* [sic] *if he would want to check resident A before we picked her up, but he said, "just pick her up". I know this is not what should have happened, and I am aware, from my knowledge of other resident falls that a nurse is required to assess a resident whilst they are on the floor.*
>
> *As Jiro was a more senior member of the care team, the other HCA and I went ahead and picked resident A from the floor and placed her back in her chair. At the time Jiro did not do anything, he did not assist us to pick up resident A, He just stood over us while myself and my colleague picked resident A up…"*

The panel also considered Witness 2's witness statement on the incident:

> *"… Resident A did have frequent falls; however, this is no reason not to properly assess her and seek other medical attention from paramedics. Jiro made no assessment at all of resident A. On the CCTV I witnessed care staff immediately picking up Resident A from the floor without any assessment completed by Jiro."*

The panel also considered the Staff Supervision Record, dated 8 October 2022, which outlined your discussions with Witness 2 about the appropriate steps to take following an unwitnessed fall.

The panel considered that you denied this allegation, and stated that:

> "*I did not use this language. I did not instruct my colleagues to pick Resident A up. [Witness 1], Health Care Assistant and I and Resident A up from the floor, and they confirmed they were not in any pain or distress*."

The panel determined that Witness 1 was consistent in both her witness statement to the NMC as well as her live evidence under oath. The panel considered Witness 1 to be clear that you instructed both her and another HCA to "*just pick [Resident A] up*", despite no physical examination or observation. The panel considered that Witness 1's evidence was tested under cross-examination and remained consistent.

The panel accepted that Witness 2 referred to CCTV footage which has not been made part of the proceedings, and it noted that Witness 2 did not observe this incident directly. However, it was satisfied that the evidence is clear and Witness 2's report of what she saw on the CCTV footage was consistent with Witness 1's evidence.

The panel was of the view that your written statement and your live evidence was inconsistent. It considered that, given your admission to Charges 2a and 2b, your live evidence in relation to how you and another HCA assisted Resident A to be implausible in that you believed Resident A may have injured her hand when she fell but that you also used the same potentially-injured hand to assist Resident A from the floor. The panel noted that you did not offer this account in your written statement.

The panel considered that your live evidence indicated that you and Witness 1 lifted Resident A, and that the other HCA who came to inform you about the unwitnessed fall was not present and had left to get on with other work. However, the panel preferred the

evidence of Witness 1, which confirmed that two HCAs were involved in lifting Resident A, and you were not involved in lifting her. The panel was satisfied that Witness 1's evidence remains consistent both in her written and oral accounts in respect of this event. In contrast, the panel considered your account to be both implausible and inconsistent.

Furthermore, the panel was satisfied that you gave these instructions when it was not safe to do so without a physical examination being conducted and/or observations having been taken. The panel noted your admission to Charges 2a and 2b, and that you accepted in your live evidence that you did not conduct a physical examination or an observation on Resident A before she was picked up. The panel considered Witness 2's witness statement, which stated:

> *"Following Jiro being made aware of resident A's unwitnessed fall he should have visually assess resident A whilst she was on the floor as there may have been potential injuries such as fractured bones that would have contraindicated moving her from the floor. The resident was prescribed anticoagulant medication placing them at high risk of intercranial bleeding following head injury, Jiro did not assess for a potential head injury. It would be unknown to Jiro what fractures may have been present and therefore instructing care staff to pick resident A up from the floor was not the correct process. Resident A should have been kept on the floor until they had been thoroughly assessed and it had been established that it was safe to do so. Jiro should have called Paramedics for assistance if he had identified any concerns."*

The panel was satisfied that Witness 2's evidence indicated that it would not be safe to pick up Resident A until she had been properly physically examined and observations have been taken.

Therefore, the panel was satisfied that this element of the charge is also proved.

Charge 2d)

"That you, a registered nurse:

2) *On 30 September 2022, following Resident A having suffered an unwitnessed fall:*
   d) *failed to provide junior colleagues with any moving and handling advice and/or assistance beyond the instruction referred to at charge 2c."*

This charge is found proved.

In reaching this decision, the panel took into account its findings in Charge 2c above.

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to provide junior colleagues with advice, were under an obligation to do so. The panel determined that, based on your live evidence as well as the written and live evidence from Witness 1, you were the nurse in charge.

The panel had regard to your job description:

- *"To positively support the Deputy Manager in providing leadership to the care staff within Shoreline Nursing Home.*
  ….
- *Be responsible for promoting and safeguarding the welfare of those individuals they support."*

The panel was satisfied that, as the nurse in charge, you were under an obligation to provide junior colleagues with moving or handling advice and/or assistance.

The panel considered Witness 1's witness statement to the NMC, which stated:

"At the time Jiro did not do anything, he did not assist us to pick up resident A, He

just stood over us while myself and my colleague picked resident A up."

The panel had regard to its findings on your inconsistencies regarding this incident as outlined in Charge 2c. Accordingly, it was of the view that Witness 1 provided a clear, consistent account – both in her witness statement and her live evidence – of your involvement in picking up Resident A. The panel was satisfied that you did not provide Witness 1 or the other HCA with any moving or handling advice, nor did you assist them, beyond your remarks in Charge 2c.

Accordingly, the panel was satisfied that this charge is found proved on the balance of probabilities.

Charge 3

"That you, a registered nurse:

3) *On 04 November 2022, failed to administer eyedrops to Resident E in line with their treatment plan."*

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement to the NMC, which stated:

"Resident E was prescribed eye drops … These eye drops needed to be administered every two hours to resident E … The eye drops arrived at Shoreline on the evening of the 4 November and should have been commenced immediately and given every two hours. However, it is clear from the MAR chart for resident E that Jiro did not commence the medication."

The panel considered Resident E's Medication Administration Record ('MAR') Chart, dated 4 November 2022, from which it could be seen that no eye drops were administered on 4 November 2022, as the relevant box on the MAR Chart was blank/empty.

The panel considered your statement, which stated:

> "*I did not receive any clear communication about Resident E's medication or its location. The parcel containing the eyedrops was left among the item left in a box on the floor and it was not handed over to me. I address the issue with Heather Keld during the morning handover. I could not find the eyedrops as they were misplaced. I reported the issue during the handover to [Witness 2]. This was the standard procedure for reporting missing medication*."

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to administer eyedrops to Resident E, were under an obligation to do so.

The panel determined that, based on the live evidence you provided under affirmation, that you were the nurse in charge of that shift, and consequently, you were responsible for the administration of medication on the night shift.

Additionally, the panel considered that you signed Resident E's MAR Chart, indicating that you were aware that Resident E had been prescribed the eyedrops. The panel noted that, in both your written statement and your live evidence, you told the panel that you signed and completed the MAR Chart, which confirmed that the medication had been "received" but you were not able to locate the eyedrops. The panel considered it significant that although you signed and dated the MAR Chart to confirm receipt of the medication, you subsequently stated that you did not receive it. The panel considered this to be improbable.

The panel took into account that this incident occurred following the discussion with Witness 2 outlined in the Staff Supervision Record, dated 10 September 2022. You told the panel that, following the Staff Supervision Record, your practice changed, and you were more diligent with checking the parcels in the Home. The panel heard in live evidence that you felt that as you were in a new job, that Witness 2 was your "*boss*", and you had to just listen and accept what she said.

Accordingly, the panel was of the view that it was improbable, on the balance of probabilities, that you signed the MAR Chart when you had not received the eyedrops, particularly after having been told by Witness 2 the importance of receiving and documenting medication which is delivered to the Home.

The panel determined that if you were not able to locate the eyedrops, you could have indicated as such in the relevant MAR Chart box by writing "O" (meaning "omitted") or "Ot" (meaning "other") to indicate to the next registered nurse on shift that the eyedrops had not been administered to Resident E.

The panel determined that it preferred Witness 2's evidence for this charge as it is clear and consistent with documentary evidence, namely the MAR Chart. The panel was of the view that your account is improbable, for the above reasons.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 4a)

"That you, a registered nurse:

4) *On 02 December 2022:*
    a) *failed to check in Analgesia patches prescribed to Resident C."*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's witness statement to the NMC, which stated:

> *"Resident C was prescribed an Analgesia patch, these are controlled drugs and as such should not be placed on the medication trolley as they should be kept and locked in the controlled drug cupboard. The medication should also be logged in the controlled drug book when it arrived at Shoreline.*
>
> *On 2 December 2022 on the day shift, there had been a delivery of the analgesia patches for resident C. When the analgesia patched arrived at Shoreline it was a busy day, and the day nurse did not have time to log the medication and left these in the treatment room for Jiro to ensure that they were booked into the controlled drug register and lock them safely in the controlled drug cupboard."*

The panel also considered your written statement on this incident, which stated:

> *"The previous day shift nurse, whose name I cannot recall, failed to properly check the analgesia patch into the system. Because of their oversight, the patch was neither delivered during the night shift nor was it due to be administered, and it was not my responsibility to check in the patches. As no one had told me about the patches, and nothing had been communicated to me, I had no caused to look for medication in order to check it in. As before, parcels are not delivered during the night shift."*

You told the panel that you were not aware that the patches had been delivered to the Home, as the registered nurse on the previous shift did not inform you that the patches needed to be checked-in and stored. You informed the panel that, as these patches were not due to be administered to Resident C during your night shift, you had no reason to look for these patches.

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to check in the Analgesia patches, were under an obligation to do so.

The panel considered that Witness 2 confirmed that the Analgesia patches were delivered during the day shift, but checking the patches in was a task that the day shift nurse had not undertaken. The panel did not have sight of any evidence suggesting that it was made clear to you that this was an outstanding task from the day shift.

The panel noted that, based on live evidence from both you and Witness 2, there appeared to be a lack of a formal, structured handover system at the Home between the day and night shifts. As stated, the panel heard from Witness 2 that the day shift ended at 19:00, and the night shift began at 19:00, and consequently, staff handovers were conducted either after the day shift ended, or before the night shift began. The panel took into account Witness 2's evidence that she has, in the past, stayed late beyond her shift to complete a handover. The panel also took into account your evidence, where you confirmed that, occasionally, you have received phone calls from day shift nurses passing on information overlooked during handovers.

The panel accepted your account that Resident C did not require the patches to be administered during your night shift. The panel saw no evidence to the contrary from the NMC. Consequently, the panel was of the view that you had no reason to locate the patches during your night shift. Witness 2 confirmed that the Analgesia patches arrived at the Home during the day shift and asserted that you left the medication on the trolley. However, the panel was not presented with any corroborating evidence to support this.

The panel was satisfied that there is no supporting evidence indicating that information regarding the patches were handed over to you verbally or in a written format before you began your shift. The panel accepted your account that you were unaware that the Analgesia patches – which were delivered during the day shift – needed to be checked-in.

Accordingly, the panel was satisfied that you could not fail to conduct a task that you could not have reasonably been aware of.

This charge is found not proved on the balance of probabilities.

Charge 4b)

"That you, a registered nurse:

4) On 02 December 2022:

b) failed to store the Analgesia patches prescribed to Resident C appropriately in that you left them on the medication trolley when they should have been store in the controlled drug cupboard."

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings in Charge 4a above.

The panel considered Witness 2's witness statement:

"When the analgesia patched arrived at Shoreline it was a busy day, and the day nurse did not have time to log the medication and left these in the treatment room for Jiro to ensure that they were booked into the controlled drug register and lock them safely in the controlled drug cupboard.

Jiro did not place the medication in the controlled drug Cupboard nor record this in the controlled drug book. Jiro left the medication on the trolley."

In determining this charge, the panel first considered whether the NMC has sufficiently proven that you, in failing to store the Analgesia patches appropriately, were under an obligation to do so.

The panel noted that Witness 2's evidence clearly indicated that you failed to store the medication appropriately. However, the panel was not satisfied that there is sufficient evidence linking the information that the Analgesia patches was delivered and not checked-in by the day nurse, with your alleged failure to store the medication correctly.

Based on its findings in Charge 4a, the panel was satisfied that there is no evidence indicating that this information had been handed over verbally or in a written format, which would enable you to be informed. Accordingly, the panel was satisfied that you could not fail to conduct a task that you could not have reasonably been aware of.

The panel found this charge not proved on the balance of probabilities.

Charge 5

"That you, a registered nurse:

5) *On 04 January 2023, administered discontinued medication to Resident B."*

This charge is found proved.

In reaching its decision, the panel considered Witness 2's witness statement, which stated:

> *"Resident B has been discharged from hospital back to Shoreline during the day on 4 January 2023 following admission due to a chest infection … Unfortunately, the antibiotic medication prescribed to resident B from the hospital were large oval tablets. Due to resident B being a high risk of choking this was not appropriate medication to be administered. Luckily, we had a GP on site, and I approached the GP who advised that there was a shortage of liquid antibiotic medication, but the antibiotic could be prescribed as capsules that could be opened mixing the contents*

with water to enable safe administration to resident B. Unfortunately, we would not be able to obtain this until the following day. At the evening handover with Jiro, I advised him of this change, and the plan for resident B's antibiotic medication moving forward."

The panel had sight of Resident B's MAR Chart, in particular the entries or markings which Witness 2 confirmed were made by her. The MAR Chart had both a vertical line on the boxes marked "4" – indicating 4 January 2023 – as well as a large, diagonal line across. The MAR Chart had a handwritten commentary, which read:

"Discontinued. To Be Commenced on Amoxycillin due To Swallow Problems By Dr Hood"

The panel also considered the Patient-Centred Notes ('PCN'), which is undated, which stated:

"[REDACTED] *has been bright and alert throughout the day. Co-amoxyclav withheld due to high risk of choking and discussed with Dr Hood this afternoon. Dr Hood will e* [sic] *prescribe amoxycillin capsules to be opened and mixed with water due to national shortage of suspension due to high demand for patients with strep throat.*

Included reason: Is a shift handover note"

The panel had sight of the Staff Supervision Record, dated 5 January 2023, which stated:

"Despite verbal and written handover of this Ejiro recommenced the medication on the resident's mar and administered it to her."

The panel also considered that your written statement in response to Charge 6a, which stated:

"I deny this charge. I accept that I gave Resident B the medication. I did not have any of the information handed over to me that it had been discontinued."

The panel noted that you accepted, both in your written statement and your oral evidence, that you administered medication to Resident B. The panel considered the key issue to be whether the medication had been discontinued.

You told the panel that you were unable to read Witness 2's handwriting on the MAR Chart; the electronic PCN was not available to you when you administered the medication; you were not informed of Resident B's discontinued medication in the handover and that you tried to contact Witness 2 on the telephone to obtain clarification but Witness 2 did not answer.

However, the panel was satisfied that the medication was discontinued for the following reasons:

- The panel accepted Witness 2's live evidence, where she told the panel that a large, diagonal line across a MAR Chart was a "*universal*" sign that a medication has been discontinued;
- The word "*discontinued*" was written on the MAR Chart;
- This information is supported by Resident B's PCN and the Staff Supervision Record, dated 5 January 2023.

Accordingly, the panel was satisfied that this charge is proved on the balance of probabilities.

Charge 6a)

"That you, a registered nurse:

6) Your actions at charge 5 were undertaken despite:

a) *you having been given oral and written handover that the medication was discontinued due to Resident B's swallowing difficulties."*

This charge is found proved.

In reaching this decision, the panel took into account its findings in Charge 5 above.

The panel considered Witness 2's witness statement on the incident, as outlined in Charge 5 above. The panel also considered Resident B's MAR Chart and the PCN as detailed above. The panel noted that the PCN is not dated, timed and does not specify an author; however, it noted that the PCN text refers to the withholding of medication due to high risk of choking. The panel took into account Witness 2's live evidence, where she confirmed that she had informed you in a handover of the changes to Resident B's care.

The panel also considered Witness 2's notes from the Staff Supervision Record, dated 5 January 2023, which stated:

> "*During the shift handover for 04/01.2023 Ejiro was advised that a resident in the home had been discharged back to the home on an antibiotic that due to the size and shape of the tablet placed her at risk of choking. He was further advised that due to her high risk of choking the medication had been discussed with her GP discontinued and an alternative safer antibiotic had been prescribed.*
> *…*
> *Despite verbal and written handover of this Ejiro recommenced the medication on the resident's mar and administered it to her.*
> *…*
> *Ejiro appeared to have not listened to the verbal handover or read the written handover from his colleague."*

The panel considered your evidence, where you told it that you were not told about the discontinuation of the medication in your handover, and that the PCN was not available to you when you began your shift.

The panel noted that, as this is an "*and*" charge, it must find both limbs – namely you were given an oral and written handover – proved for this charge to be proved. The panel considered each limb in turn, before reaching a decision on the charge as a whole.

With regard to an oral handover, the panel determined that both you and Witness 2 accepted that there should be a verbal handover given at the start and end of every shift. The panel considered that Witness 2, in both her written and live evidence, informed the panel that a verbal handover was given to you regarding Resident B's swallowing difficulties, and the change in her medication. The panel determined that this has been corroborated by the Staff Supervision Record completed the following day, which indicated twice that a verbal handover was given to you. The panel noted that this Staff Supervision Record was signed by you.

The panel was satisfied that, on the balance of probabilities, an oral handover was given to you regarding the discontinuation of medication to Resident B, due to her swallowing difficulties.

With regard to a written handover, the panel noted that your evidence stated that you did not see the PCN. The panel accepted that the PCN lacks information regarding the time, date and author, but it was noted that there is a specific reference in the PCN that it is *"a shift handover note"*, and the information contained within it is consistent with the information outlined in the MAR Chart. Furthermore, the panel was of the view that the MAR Chart – which contained a large diagonal line across it as well as the word "*discontinued*" and "*swallow problems*" – formed another part of a written handover. The panel accepted, even if some of the handwritten commentary on the MAR Chart was not clearly legible, it was satisfied that the words "*discontinued*" and "*swallow problems*" were sufficiently legible. The panel determined that, on the balance of probabilities, a written

handover was given to you regarding the discontinuation of medication to Resident B, due to her swallowing difficulties via both the PCN and the MAR Chart.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 6b)

"That you, a registered nurse:

6) Your actions at charge 5 were undertaken despite:
b) your knowledge that Resident B had swallowing difficulties which render administration of a large tablet unsafe."

This charge is found proved.

In reaching this decision, the panel took into account its findings in Charges 5 and 6a above.

The panel considered Witness 2's witness statement on the incident, as outlined in Charges 5 and 6a above. The panel also considered Resident B's MAR Chart and the PCN as detailed above. The panel noted that the PCN is not dated, timed and does not specify an author; however, it was satisfied that the PCN comments on Resident B's discontinued medication. The panel also took into account Witness 2's live evidence under affirmation.

The panel also considered your written statement responding to this charge, which stated:

"*I was unaware of Resident B's swallowing difficulties as this information had not been handed over to me. Resident B took the medication with no difficulty at all."*

The panel considered that, in your live evidence you told the panel that, whilst you were aware that Resident B suffered from some swallowing difficulties, you had no knowledge of Resident B's swallowing difficulties which would render the administration of the tablet unsafe, as you were not told so during the handover.

In reaching its decision on this charge, the panel considered its findings on Charge 6a above, namely that an oral and written handover was given to you on Resident B's discontinued medication.

The panel considered that, in the Staff Supervision Record detailed above, Witness 2 indicated that:

> "*Ejiro was advised that a resident in the home had been discharged back to the home on an antibiotic that due to the size and shape of the tablet placed her at risk of choking. He was further advised that due to her high risk of choking the medication had been discussed with her GP discontinued ….*"

The panel noted that you signed this Staff Supervision Record. The panel further determined that, in light of receiving both an oral and written handover, it is more likely than not that you had sufficient knowledge of Resident B's swallowing difficulties which would render the administration of the tablet unsafe.

The panel was satisfied that you received both an oral and written handover, which informed you that Resident B's swallowing difficulties rendered it unsafe for the continued administration of the medication.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 8a)

> *"That you, a registered nurse:*

8) *On 25 February 2023:*

a) Shouted at a colleague who was providing feedback on your clinical practice.*”*

This charge is found proved.

In reaching its decision, the panel considered Witness 2’s witness statement on the incident, which stated:

> *“I addressed my concern with Jiro following his failure to record medication into the controlled drug book correctly, he appeared to have difficulty in understanding what I was trying to say, and therefore I took Jiro into the treatment room to show him the entry in the controlled drug book. Whilst in the treatment room Jiro’s conduct became extremely intimidating and aggressive towards me, he exploded with anger shouting and becoming verbally abusive towards me which was quite intimidating.”*

The panel also considered Witness 2’s local statement, dated 25 February 2023, which stated:

> *“As we were looking in the CD book at the above-mentioned entry EB became very angry and verbally aggressive shouting at me that there was nothing wrong with his entry in the book, and that I was just being stupid. He then stated that he had worked for the NHS so how dare I question his clinical skills. He went on to shout that if I didn't want him to work here all I had to do was say so and he would leave.*
>
> *Despite attempts to explain to EB that this was not personal and all I was doing was my Job as his clinical Manager he continued to shout at me and refused to listen to anything that I was attempting to say. As he was making me feel very intimidated, I decided that it was better for both of us if I discontinued the*

conversation and left."

The panel considered that Witness 2's local statement appeared to be signed and contemporaneous, as it was dated the same day, namely 25 February 2023, and followed on from the incident on 24 February 2023, as outlined in Charges 7a and 7b, which you have admitted. Within her local statement, Witness 2 referred to your "*verbally aggressive shouting*", and that you made her "*feel very intimidated*". The panel noted that, following this incident, Witness 2 referred you to the NMC on 2 March 2023. The panel also considered her live evidence, where she described you shouting at her and the ongoing impact that the incident has had on her.

The panel also considered your written statement on the incident, where you stated:

> "*I did not shout at any of my colleagues. [Witness 2] did become very emotional and raised her voice to me. She demanded that I admit to her accusations without giving me any opportunity to explain*."

In reaching its decision, the panel considered the nature of your working relationship with Witness 2 throughout your time in the Home. The panel noted that both you and Witness 2 admitted that there were some communication difficulties between the two of you, and Witness 2 described your working relationship as "*tense*".

The panel took into account that, when asked to give examples of your good practice in the Home, Witness 2 was unable to do so.

The panel also took into account that you told the panel that your experience with communication with Witness 2 was difficult from the start, and that you perceived Witness 2 as not listening to you, irrespective of what you said. You told the panel that you had sought advice on how you could improve the communication between you. Specifically, you told the panel that, as she was your boss, you felt like you had to agree to what she said. Mr Lee referred the panel to the Staff Supervision Record, dated 5 January 2023,

and the panel heard from you that Witness 2 had pre-written all the information within the document, and you felt like you had to agree.

The panel heard from Witness 2 that she did prepare some elements of the Staff Supervision Record ahead of time, and that it was her normal practice to type the agenda, have the discussion with the member of staff concerned, and type the remainder of the document up following the discussions, before asking the member of staff to inspect and sign it on the same day. She told the panel that this was her practice with the exception of the Staff Supervision Record, dated 5 January 2023, where there are elements which have been handwritten as she spoke to her manager regarding your continued employment at the Home. The panel noted that, in the section headed "*Discussion*" in the Staff Supervision Records, does not on any occasion, contain your account of your version of events.

Accordingly, the panel acknowledged that this incident occurred in a context of an increasingly difficult and tense working relationship between you and Witness 2.

The panel was of the view that Witness 2's witness statement, signed local statement, consistent and clear live evidence, combined with her referral to the NMC approximately one week later, indicated that, it was more likely than not, that this incident had occurred between the two of you.

Accordingly, this charge was found proved on the balance of probabilities.

Charge 8b)

"That you, a registered nurse:

8) On 25 February 2023:

b) Told a colleague who was providing feedback on your clinical practice that she was 'stupid' or said words to that effect.*"*

This charge is found proved.

In reaching this decision, the panel took into account its findings in Charge 8a above, as well as its findings on the nature of the working relationship between you and Witness 2.

The panel considered Witness 2's witness statement to the NMC as well as her local statement, dated 25 January 2023, which stated:

> *"As we were looking in the CD book at the above-mentioned entry EB became very angry and verbally aggressive shouting at me that there was nothing wrong with his entry in the book, and that I was just being stupid…"*

The panel also considered your response to this charge in your written statement, which stated:

> *"I deny this charge. I did not use this language."*

Based on its findings in Charge 8a above, the panel noted that this incident occurred in a context of a tense working relationship between you and Witness 2.

The panel was satisfied that Witness 2's live evidence was consistent with both her witness statement to the NMC as well as her signed local statement regarding you calling her "*stupid*" or words to that effect when she was attempting to give feedback on your clinical practice.

Accordingly, this charge is found proved on the balance of probabilities.

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.

At this stage, the panel received the following additional documentation:

1. NMC's Stage 2 Bundle of 49 pages;
2. Registrant's bundle of 65 pages which included a reflection, your CV and training certificates for 2022, 2023 and 2024;
3. Registrant's additional bundle of 23 pages which included a testimonial from a colleague.

The 49-page NMC bundle included a letter from the Case Examiners, dated 25 June 2019, and contained the following information:

> *"On 15 May 201 7, the NMC received a referral about your fitness to practise from SP, Manager at A24 Group ('the Agency'). Concerns arose when you were working as an agency nurse at HC One, Defoe Court Care Home ('Defoe Court') and working as a band 5 nurse at Roseberry Park ('Roseberry Park') at Tees Esk and Wear Valley NHS Trust ('the Trust').*
>
> ***The regulatory concerns:***
> *The NMC has identified and investigated the following regulatory concerns:*
> *While working at Defoe Court:*
>
> 1. *Failure to take appropriate action on signs of a head injury*
> 2. *Failure to escalate a deteriorating patient/call emergency services*
> 3. *Poor record keeping*

[REDACTED]

Background to the regulatory concerns:
The concerns in this case relate to two dates in 2017.

On 25 February 2017, you were working a night shift at Defoe Court. Resident JW fell during the shift and suffered a head injury. Concerns were raised that you did not ensure that proper observations were taken or seek medical assistance by calling 999. At around 07:00 Resident JW began vomiting and an ambulance was called and she was admitted to hospital. Ambulance staff raised a safeguarding concern.

[…]

You have told us that you accept regulatory concern 1. You have said in your statement to us that you should have called the ambulance straight away, but that you relied on the information provided by the healthcare assistant, who knew the patient better."

The panel noted, from the NMC letter to you, dated 25 June 2019, your response at the time, which stated:

"Your statement to us says that you recognise you should have called an ambulance for Resident JW straight away, but that you say you relied on information from healthcare assistants who knew the patient better.

Your reflective accounts form says that as a result of the incident, you have learned how to initiate four hourly observations, the need to inform medical staff if the score remains high after four hours, and the importance of using your client's intervention plan to check whether the score is usual. You say you have also learnt that you

need to follow Trust policy. You have told us that you have repeated online training and that you have regular clinical supervision."

The 49-page bundle also included a complete copy of a Fitness to Practise Committee panel's written determination following a Substantive Hearing between 8 and 12 April 2024. This April 2024 panel found the following charges proved and, as a result, imposed a 12-month Conditions of Practice order:

That you, a registered nurse:

1) *On 5 July 2021:*
   a) *…*
   b) *Grabbed Colleague A by the top of their shirt.* ***[PROVED]***
   c) *…*
   d) *Said:*
      i) *'What would you do if you were a man?'*
      ii) *'You would fuck everyone, won't you?'*
      iii) *'Answer me'*

      or said words to that effect to Colleague A. ***[PROVED]***

   e) *When Colleague A attempted to leave the conversation, physically prevented them from doing so.* ***[PROVED]***
   f) *Said, 'Don't walk past. Don't leave me like this' or said words to that effect to Colleague A.* ***[PROVED]***
   g) *Looked Colleague A up and down.* ***[PROVED]***
   h) *After you had been escorted from the Hospital following Colleague A's complaint, screamed and/or shouted Colleague A's name as they were leaving the Hospital carpark.* ***[PROVED BY WAY OF ADMISSION]***
2) *…*

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

In particular, the panel noted the following from the April 2024 determination:

"You said, in the future, you will strive at all costs to make sure that you maintain professional boundaries."

This 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

Prior to submissions from Mr Kabasinskas and Mr Lee, the panel heard further evidence from you under affirmation. You told the panel that you worked on an agency basis for Priory Group from November 2023 to June or July 2024. You informed the panel that, at this time, you worked four or five nights a week. You confirmed to the panel that you are currently not working, but you remain registered with the agency. You told the panel that nursing is your passion, and you remain committed to continuing with your nursing practice.

The panel had sight of your CV. In response to the panel's questions, you explained that your CV contains an error, in that it states that you were employed at the Home between August 2017 and February 2023. You confirmed that "August 2017" should read "August

2021” instead, and that you were directly employed by the Home at the same time as continuing your agency contract with MedSolve Medical Recruitment Agency. You were asked why your CV does not contain any reference to Tees Esk and Wear Valley NHS Trust, who you were working for. You initially told the panel that your CV was prepared at the request of the recruitment agency, who asked for your experience in the last five years. The panel noted that this would include the time period relating to April 2024 findings and Tees Esk and Wear Valley NHS Trust. You then stated that your CV has been prepared at the request of the RCN in preparation for these proceedings. The panel was concerned that your CV lacked clarity.

Mr Kabasinskas reminded the panel of its powers in the two-stage process in determining misconduct, and if relevant, impairment. He 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”*. He also invited the panel to consider the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Schodlok v General Medical Council* [2015] EWCA Civ 769 when reaching its decision on misconduct.

He invited the panel to take the view that the facts found proved fell short of the standards expected of a registered nurse within their professional practice, and consequently, amount to misconduct. He referred the panel to the terms of ’The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (‘the Code’), and drew specific reference to paragraphs 1.1, 1.2, 1.3, 1.4, 2.5, 8.1, 8.2, 8.4, 8.5, 8.6, 9.2, 9.3, 10.1, 10.2. 18.3 (only in relation to dispensing and administering medication); 19.1, 19.4, 20.1, 20.2.

Taking each charge found proved in turn, Mr Kabasinskas submitted that charge 2, taken together, amount to serious misconduct. He further submitted that charge 3, in all the circumstances found proved by the panel, amount to serious misconduct. He submitted that if the panel were not minded to agree with the NMC on charge 3 alone, it should consider charge 3 alongside charges 5, 6 and 7, as it all related to the administration of

medication. He submitted that charges 5, 6 and 7 – both individually and collectively with charge 3 – amount to serious misconduct. He submitted that charge 8 amounted to very serious misconduct.

Mr Lee submitted that you acknowledge that the panel is likely to find serious professional misconduct in relation to some or all of the charges. He invited the panel to consider the seriousness of the misconduct in its decision. In relation to the fall, he submitted that this change concerned a single incident at the Home in a setting where multiple falls would have occurred over the months you were employed. He told the panel that you accept the 2017 matters share some similarities; however, he invited the panel to consider that these are two incidents which occurred five years apart.

In relation to the medication error involving the eyedrops, Mr Lee submitted that you acknowledged that your conduct delayed the administration of the eyedrops for one shift, and there is a potential to cause harm to Resident E. He invited the panel to assess the seriousness of this misconduct, in relation to the potential harm suffered by Resident E. With regard to Resident B's tablet, Mr Lee accepted that the panel may find this charge more serious, in light of the risk to Patient B given her swallowing difficulties. In relation to the charges concerning controlled drugs (Buprenorphine), Mr Lee submitted that, in determining the seriousness of the misconduct, the panel should consider that it had been simple for the mistake to be spotted and followed up.

With regard to your conduct towards Witness 2, Mr Lee submitted that there is no doubt that the words you used and your manner was inappropriate and distressing to her. However, he told the panel that the conduct was in a certain context. He accepted that this does not absolve you of your conduct, but invited the panel to consider that there is some level of frustration that you were experiencing with Witness 2 at the time. In response to Mr Kabasinskas' submissions on impairment, he reminded the panel that this was not charged as harassment, and consequently, he submitted that it would not be appropriate for the panel to make a factual finding on harassment at this stage in the proceedings.

Submissions on impairment

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

Mr Kabasinskas outlined the four limbs in the Dame Janet Smith 'test', as outlined in *Grant*. He submitted that the fourth limb, on dishonesty, does not apply in this case.

With regard to the first limb, Mr Kabasinskas submitted that failures in medication administration have the ability to put patients at risk of suffering side-effects, thus placing patients at risk of harm. He further submitted that the failure to assess a patient following a fall clearly put patients at risk of harm, and the failure to ensure that patients are moved in the correct manner, following a fall, exposes them to risk of harm.

With regard to charge 8, Mr Kabasinskas accepted that the NMC has not pleaded this charge as harassment, but he submitted that it amounted to intimidating behaviour, as should be considered within harassment perimeters. He outlined the NMC Guidance on harassment, and reminded the panel that harassment is unwanted conduct which can make someone feel intimidated or humiliated. He submitted that your colleagues have a right to attend workplace free from this behaviour, and that you have a professional duty to treat your colleagues with kindness and respect.

With regard to the second and third limb, Mr Kabasinskas submitted that your misconduct has brought the nursing profession into disrepute, and that the Code is a tenet of the profession, which you have breached.

He invited the panel to consider the decisions, and principles derived from, the cases of *Nicholas-Pillai v GMC* [2015] EWHC 305 (Admin) as well as *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Looking to the future and whether your conduct is easily remediable, Mr Kabasinskas submitted that the concerns surrounding patient falls and medication can be remediable through training. However, he submitted that Witness 2 attempted to provide you with feedback on your medication practice, and you attempted to justify your shortcomings at all times. He invited the panel to assess the attitudinal issues as to whether you can accept and rectify your medication practices.

With regard to your aggressive behaviour, he drew the panel's attention to the NMC Guidance on whether a concern can be addressed (FTP-15a). He submitted that your conduct towards colleagues indicate an attitudinal concern, given the previous Fitness to Practise Committee findings on your conduct of a similar nature. He submitted that conduct of this nature is less likely to be remedied, particularly when it involves harassment.

On whether it has been remedied, Mr Kabasinskas invited the panel to consider the NMC guidance on whether a concern has been addressed (FTP-15b). He submitted that, with regard to patient care, there has been a previous referral to the NMC, in 2017, involving your inappropriate response to a fall, similar to charge 2 in these proceedings. He further submitted that you completed falls training following that incident in 2017, but this incident still occurred in 2022. He submitted that, on both the 2017 regulatory incidents and today, you told the NMC that you relied on HCAs. Mr Kabasinskas submitted that there is nothing to suggest that this area of your clinical practice has been adequately addressed following the incident outlined in charge 2.

With regard to your medication errors, Mr Kabasinskas submitted that, despite the numerous certificates suggesting you had undergone training and some of the training was completed as part of your role in the Home, the medication errors still occurred. He

submitted that the NMC is not satisfied that training, in itself, is sufficient, in light of the attitudinal concerns you demonstrate regarding your ability to take on feedback from colleagues.

With regard to your behaviour towards colleagues, Mr Kabasinskas submitted that it is not possible to address these concerns with training courses, given the findings of a similar nature made against you in April 2024. He submitted that there is very limited evidence before the panel indicating that your attitude has changed since that finding, and the panel could not be satisfied that you would not repeat this conduct.

Mr Kabasinskas submitted that the testimonials you have provided were produced in compliance with the Conditions of Practice order imposed in April 2024 and does not fully address all the areas of concerns outlined in these proceedings. He further submitted that the panel could not be satisfied that the authors of the testimonials were fully appraised of the allegations in these proceedings. He submitted that the panel has no information before it from you to indicate a change in your level of insight in April 2024 – which that Fitness to Practise panel determined was limited – to now.

On repetition, Mr Kabasinskas submitted that there is a repeated history of patients falling and your failure to act appropriately, despite training. He acknowledged your reflection related to patient observation and reporting, but he submitted that there is no evidence of you addressing the full concern, as your reflections do not relate to advising other staff members and handling a patient following a fall.

With regard to your medication error, Mr Kabasinskas submitted that the errors occurred despite training on medication. He further submitted that your poor reaction to Witness 2 attempting to give you feedback on your medication practice may be indicative of attitudinal issues surrounding your ability to accept your shortcomings in your practice in relation to medication.

With regard to your communication with colleagues, Mr Kabasinskas submitted that there have been two incidents of your poor and inappropriate behaviour towards colleagues, one of which resulted in a Fitness to Practise Committee finding against you.

Accordingly, Mr Kabasinskas submitted that there is a real risk of repetition and a finding of impairment on public protection grounds is necessary.

Mr Kabasinskas reminded the panel of the overarching objective of the NMC, namely to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He submitted that, in relation to charge 8 specifically, a finding of impairment on public interest grounds is necessary as the finding raises concerns about your attitude as a professional. He invited the panel to find your fitness to practise impaired on both public protection and public interest grounds.

Mr Lee told the panel that this has been a difficult and challenging process for you, and you have not submitted a written reflection in response to the panel's findings on facts as there has been no time to do so within these proceedings.

Mr Lee invited the panel to consider that some of these incidents occurred soon after you commenced your employment at the Home, having received minimal training specific to that clinical setting. He submitted that your medication failings were partly due to contextual factors, such as the lack of robust procedures on checking-in medication and handing over information to the next nurse on shift, and your poor working relationship with Witness 2, your line manager. He submitted that you accept responsibility for your failings, but he invited the panel to consider that your circumstances at the Home could have been better.

With regard to falls, Mr Lee submitted that you have demonstrably improved your practice. He submitted that, following the fall outlined in Charge 2, the Home did not take further issue with your practice in this respect, and no concerns were raised despite you working in an environment where falls would be relatively common.

Mr Lee invited the panel to consider that, since the imposition of the Conditions of Practice order in 2024, you have shown good compliance and have broadly reflected on professional boundaries with colleagues. He submitted that you have shown developing insight in this aspect of your professional conduct.

On medication, he invited the panel to consider the medicines training you have completed. He submitted that concerns can be addressed through further reflection, training, supervision and the strengthening of your practice. He submitted that there is no evidence of deep-seated attitudinal issues, and you have shown your capability of addressing the matters objectively and recognise where you have gone wrong. He further submitted that, through your oral evidence and written reflection, you have shown an understanding on how to act differently in future. He invited the panel to conclude that, in light of your insight, it could conclude that you are unlikely to repeat this conduct in the future, and no longer presents a risk to the public. Accordingly, a finding of impairment on public interest grounds is not necessary.

Mr Lee submitted that the nature of these concerns is such that, if the panel finds that there is no risk to the public, any public interest concerns fall. He accepted that public interest concerns follow from that of public protection.

The panel accepted the advice of the legal assessor. She reminded the panel that, when deciding misconduct, it may consider the charges individually, in groups or globally. She referred the panel to the decisions in, and the principles derived from, the cases of *Roylance*, *Nandi* and *Schodlok.* She reminded the panel that, where there are a large number of non-serious misconduct, it could be collectively regarded as serious misconduct. However, she invited the panel to exercise caution.

With regard to impairment, the legal assessor drew the panel's attention to the Dame Janet Smith 'test' and advised against the applicability of the dishonesty limb in this case. She reminded the panel that the consideration of impairment involves both past conduct

as well as an assessment of the likelihood of the conduct repeating in the future, in light of the consideration of any remorse, insight and the strengthening of practice.

She reminded the panel that it must exercise its own judgment in reaching its decision.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of Roylance, and its definition of misconduct, as well as the terms of the Code.

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

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

To achieve this, you must:

1.2 only act in an emergency within the limits of your knowledge and competence.

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

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues.

8.4 work with colleagues to evaluate the quality of your work and that of the team.

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

8.6 share information to identify and reduce risk.

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance.

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs.

18.3 make sure that the care or treatment you […] dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.

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

To achieve this, you must:

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

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.

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.

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

In relation to charge 2, taken as a whole, the panel considered that this charge was related to your clinical practice, in that you did not conduct the appropriate examination and observations following an unwitnessed fall of Resident A, a vulnerable adult with advanced dementia. The panel noted that you did not cause Resident A any harm, but it was of the view that serious physical harm could have come to her as a result of your failure. The panel also determined that you put your colleagues at risk of harm, by asking them to move Resident A without proper instruction. The panel was satisfied that your conduct fell seriously below what is expected of a registered nurse and amounts to serious misconduct.

With regard to charge 3, the panel took into account Witness 2's description of Resident E's eye infection, which stated:

"… his eye infection was very bad both eyes were reddened inflamed and discharging."

The panel considered that the eyedrops needed to be administered every two hours, and your conduct led to a delay in treatment to Resident E of at least 12 hours. Consequently, the panel was satisfied that Resident E missed several doses of the eyedrops. The panel

further considered that you signed to indicate that you received the eyedrops but did not document why they had not been administered to Resident E. Accordingly, the panel was satisfied that your conduct fell seriously below that expected of a registered nurse, and amounts to serious misconduct.

The panel considered charges 5 and 6 together, as they arose from the same set of facts. The panel was of the view that there was a potential for serious risk of harm to Resident B, given her swallowing difficulties. The panel considered that Witness 2 described Resident B not choking as "*just lucky*", given the high risk of choking. The panel was satisfied that your conduct fell seriously below the conduct expected of a registered nurse and amounts to serious misconduct.

With regard to charge 7, the panel considered that this involved controlled drugs and that, consequently, that makes this charge serious. The panel was of the view that another practitioner at the Home would not be able to confirm that the right amount of medication was documented in the controlled drugs book, and consequently, whether it is stored correctly. The panel determined that your actions were misrepresentations to your colleagues regarding the controlled drug stock. The panel was satisfied that your conduct fell seriously short of that expected of a registered nurse and amounts to serious misconduct.

In relation to charge 8, the panel took into account its findings on facts above. Notwithstanding the context and your working relationship with Witness 2, the panel determined that shouting and calling Witness 2 "*stupid*" fell beyond the confines of appropriate and professional communication with your line manager. At the time of the incident, you were receiving feedback regarding your practice from Witness 2, who was a senior colleague, regarding your failure to record medication in the controlled drugs book the day before, which you admitted to this panel (charge 7). The panel was satisfied that your conduct fell seriously short of that expected of a registered nurse and amounts to serious misconduct.

The panel found that your actions, collectively, did fall seriously short of the conduct and standards expected of a nurse and amounts to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

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

The panel considered that nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses 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 *Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered each of the limbs outlined above in turn.

With regard to your past misconduct, the panel was satisfied that your misconduct put Residents A, E and B at risk of harm. The panel was of the view that, in light of your misconduct, you have brought the nursing profession to disrepute and that you have breached the fundamental tenets of the nursing profession, given your significant breaches of parts of the Code.

The panel was satisfied that, as none of the charges relate to dishonesty, the fourth limb of the Dame Janet Smith "test" does not apply.

The panel then considered a future risk assessment, and it had regard to the considerations outlined in *Cohen.*

On whether your conduct is remediable, the panel took into account that some of the charges found proved relate to your clinical practice, which can be remedied with adequate reflection, retraining and supervision. However, the panel considered that there are previous incidents, which are similar in nature. The panel noted that the NMC received an earlier referral concerning your failure to take appropriate action on signs of a head injury in 2017 (Case Examiner's letter dated 25 June 2019), which you admitted to. Further, the panel noted that, in April 2024, a Fitness to Practise Committee found your fitness to practise impaired following the use of inappropriate language with a colleague in July 2021. The panel noted that the charges outlined within these proceedings arose subsequent to the 2017 referral (contained within the Case Examiner's letter dated 25 June 2019) and the July 2021 incidents (as decided upon by a Fitness to Practise Committee in its April 2024 findings).

The panel noted the following chronology:

- 2017: the NMC received a referral outlining a regulatory concern relating to failure to take appropriate action on signs of a head injury (with the Case Examiner's letter dated 25 June 2019);
- 5 July 2021: incident involving inappropriate behaviour with a colleague (a Fitness to Practise Committee's determination produced on 12 April 2024);
- These charges cover the period between 10 September 2022 to 25 February 2023.

The panel was of the view that there are some deep-seated attitudinal concerns – particularly in relation to charge 8 – which are more difficult to remedy, though not impossible.

The panel then considered whether these concerns have been remedied. The panel took into account the training certificates you have provided. The panel was of the view many of these related to mandatory training completed whilst you were employed at the Home, and the topics included areas of clinical practice identified in these proceedings. The panel determined that, despite this, the errors still occurred. By way of an example, the panel considered that you completed training in relation to controlled drugs on 22 October 2022 but charge 7 arose from circumstances occurring in February 2023.

On remediation and reflection, the panel considered that you largely attributed responsibility to Witness 2:

> *"The difficulties in my working relationship with [Witness 2] contributed significantly to this situation, as I felt as if she had a large amount of distrust towards me for a reason unbeknownst to me. This caused our communication to be less cohesive and as result incidents occurred that could have been easily mitigated if communication with one another in the workplace was more professional."*

The panel further considered that your reflection does not address aspects of your clinical practice which relate to charges you have admitted to. The panel was of the view that your Personal Development Plan ('PDP') addresses a very narrow aspect of your practice which was identified in the April 2024 Fitness to Practise hearing and does not address the areas of your clinical practice which needs remediation, as identified in these proceedings.

On whether your conduct is highly likely to be repeated, the panel considered the 2017 regulatory concern, part of which you admitted. The panel noted that this involved your lack of appropriate action "*despite [the patient] having blood at the back of his head … with mucus coming from his mouth and retching*". The panel considered that this admitted regulatory concern had a worrying similarity to charge 2. Furthermore, the panel considered the findings made against you in the Fitness to Practise Committee hearing in

April 2024, which concerned your treatment of a colleague also bore worrying similarities to your inappropriate interaction with Witness 2, as outlined in charge 8.

The panel further considered that the charges themselves, namely charges 3, 5, 6 and 7 all concern medication errors at different times and are therefore also worryingly repetitive in themselves.

With regard to your insight, the panel was of the view that you have demonstrated very limited meaningful insight and remorse. The panel considered that, in 2017, you provided a written reflective piece to the NMC, within which you outlined all the lessons you have learnt at that stage. Within the April 2024 Fitness to Practise Committee panel determination, that panel noted:

"… the panel considered the insight you have demonstrated to be limited…"

This panel was of the view that the reflection you have provided it for these proceedings makes reference to things you could have done differently but taking into account the earlier regulatory concern and the April 2024 findings, your subsequent actions do not demonstrate significant, sustained improvements to your clinical practice. It is for this reason that the panel determined that your recent expressed insight may not be meaningful.

Further, the panel considered that, in your live evidence following the panel's findings on facts, you told the panel that you believe that you are "*very skilled*", which is why you work for an agency, as you can "*fit into any setting*". The panel was satisfied that your meaningful insight into your wrongdoing is very limited at this stage.

The panel then considered that your last substantive working period ended in June or July 2024, and there is nothing before it from a manager confirming your recent practice, particularly in relation to your conduct with colleagues as well as the aspects of your clinical practice identified in the charges. The panel placed limited weight on the

testimonial you have provided which does not confirm that the author is aware of these proceedings.

Taken together, the panel was satisfied that, in light of your very limited meaningful insight, lack of remorse, lack of remediation and limited information from a recent employer regarding your clinical practice, it is highly likely that your conduct would be repeated.

Accordingly, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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 determined that a finding of impairment on public interest grounds is required. The panel was of the view that a well-informed member of the public would be extremely concerned if you were allowed to practise without restriction, particularly in light of the findings against you. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Accordingly, it finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Mr Kabasinskas drew the panel's attention to the NMC's SG (SAN-1) and reminded the panel to consider proportionality and the NMC's overarching objective.

Mr Kabasinskas submitted that the following aggravating factors apply:

- There is a regulatory history for the same or of similar concerns;
- Lack of insight into failings;
- Conduct which put residents at the Home at risk of suffering harm; and
- With regard to the medication errors specifically, there is a pattern of misconduct over a period of time.

He submitted that there are no mitigating factors in this case.

Mr Kabasinskas addressed each of the sanctions available before the panel. He submitted that it would not be appropriate to either take no action or to impose a caution order, given the seriousness of this case and the public protection concerns which the panel identified in its decision on misconduct and impairment.

He referred the panel to the NMC Guidance on the imposition of a conditions of practice order (SAN-3c), and he submitted that a conditions of practice order would not address the public confidence in the profession, as it would not be possible to impose conditions which adequately addresses the identified attitudinal concerns.

Mr Kabasinskas drew the panel's attention to the decision in, and the principles derived from, the case of *Sawati v GMC* [2022] EWHC 283 (Admin) and the case of *Sawati* does not apply to this case.

Mr Kabasinskas submitted that this case is serious. He further submitted that whilst your misconduct in charge 8 may be indicative of a concern which is more difficult to put right, this case broadly falls within the category of concerns which could result in harm if not put right, pursuant to the NMC guidance on seriousness (FTP-3, FTP-3b).

Mr Kabasinskas outlined the two remaining available sanctions, namely a suspension order and a striking-off order. With regard to the former, he invited the panel to consider the NMC guidance on suspension orders (SAN-3d). He invited the panel to consider the following factors, as outlined in the guidance:

- whether the seriousness of the case require temporary removal from the register?
- will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?

He submitted that the case is of adequate seriousness to require a temporary removal from the register. He further submitted that a period of suspension would be sufficient to address all the concerns listed above. He submitted that, in light of the deep-seated attitudinal concerns identified, a period of 12 months would be sufficient to protect patients and the public confidence in nurses.

Mr Kabasinskas then invited the panel to consider the following factors when considering the implementation of a suspension order:

- a single instance of misconduct but where a lesser sanction is not sufficient
- no evidence of harmful deep-seated personality or attitudinal problems
- no evidence of repetition of behaviour since the incident
- the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour

He submitted that, in relation to charge 8 specifically, the NMC accepts that it is not a single instance of misconduct. However, he submitted that it was not sufficiently serious to necessitate a striking-off order. He further submitted that the panel has found evidence of deep-seated attitudinal issues, but it has also found that these issues are remediable. He submitted that there is no evidence of repetition of behaviour since the incident in February 2023. He further submitted that, as the panel found that you demonstrated some insight at this stage, a striking-off order would be disproportionate.

On a striking-off order, he submitted that the case, whilst it is serious, is sufficiently low enough on the spectrum to not necessitate such an order. He submitted that the factors outlined in the NMC guidance on striking-off orders are not applicable in this case, and consequently, it would be disproportionate to impose it.

Mr Kabasinskas invited the panel to impose a suspension order with a review for a period of 12 months.

Mr Lee invited the panel to consider whether some stringent conditions could sufficiently address the public protection concerns. He submitted that, pursuant to the NMC guidance on Conditions of Practice orders (SAN-3c), such an order may be appropriate where there are identifiable areas of practice in need of assessment and retraining. He further submitted that the panel has identified specific areas, and these areas could be addressed through conditions.

Mr Lee submitted that there is no evidence of general incompetence, and there is a willingness to respond to any requirement that you have to retrain. Mr Lee reiterated your intention to commit yourself to your nursing practice, and you will comply with conditions imposed upon you by this panel. He drew the panel's attention to the conditions of practice order imposed by the Fitness to Practise Committee in the April 2024 substantive hearing, and he submitted that you have been complying with the conditions outlined in that order. He submitted that with the appropriate conditions, the panel can be satisfied that patients would not be put in danger or at risk of harm.

Mr Lee suggested some conditions for the panel's considerations. He submitted that, with regard to medication failings, the panel could require another registered nurse to supervise you at any time you are administering, receiving or handling medications, either indefinitely or until you are signed off as competent by an employer. He further submitted that, if the panel was of the view that this was insufficient, it may impose a condition requiring you to not to handle medications unless directly supervised. Mr Lee acknowledged that it follows, if a supervision requirement was imposed, that could be a condition that you would not be the only nurse on the shift, or to not be the nurse in charge.

In respect of falls management, Mr Lee submitted that the panel may wish to require you to complete an in-person further training course on falls, or to be signed off as competent in falls management before practising without supervision. He further submitted that, if the panel was of the view that this was insufficient, it could require you to keep a log for every fall you manage, so a future panel at a review hearing may be appraised of all the documentary evidence on your progress and remediation. Mr Lee further submitted that, if this panel found it necessary, and as an alternative, it could restrict you from working in an elderly-care setting, which would minimise the need for you to manage any falls.

With regard to your behaviour and communication with colleagues, Mr Lee submitted that your current Conditions of Practice order sufficiently addresses the issues of professional

boundaries, and this panel may wish to make minor amendments to the wording of the existing conditions to mirror the concerns identified in this case.

Mr Lee submitted that, given your failings that the panel has found proved, this is not a case in which the public interest would demand the panel to impose a more restrictive order than a conditions of practice order.

Mr Lee further submitted that a suspension order is not necessary to mark the seriousness of your misconduct, and that the panel's decision on your current impairment, that your limited insight and level of understanding of your wrongdoing at this stage has been made clear to you.

On a striking-off order, Mr Lee submitted that you agree with the NMC that such an order would be a step too far. He submitted that you accept the mistakes are serious and regrettable but are mistakes nonetheless which can be put right with sufficient commitment on your part. He submitted that the public confidence does not require a striking-off order, and that it would be upheld by any measure that protects public.

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 noted that in the Notice of Hearing, dated 29 July 2024, the NMC had advised you that it would seek the imposition of a 12-month suspension order if the panel found your fitness to practise currently impaired.

The panel took into account the following aggravating features:

- There is a regulatory history for the same or of similar concerns;
- Lack of meaningful insight into failings and reflection on the impact of your actions on patients and colleagues;
- Conduct which put residents at risk of suffering harm; and
- There are wide-ranging concerns – namely on medication errors, falls management as well as communication with colleagues – over a period of time between 2017 and 2023.

The panel also took into account the following mitigating features:

- Early admissions to some of the charges; and
- You appeared to have a tense working relationship with Witness 2, in context of charge 8 specifically.

The panel noted Mr Kabasinskas' submissions on seriousness, and it had regard to the NMC Guidance on seriousness (SAN-2). The panel was satisfied that this is not engaged in this case, as this case does not relate to dishonesty, sexual misconduct, abuse or neglect of children or vulnerable people, discrimination or criminal convictions or cautions.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the wide-ranging concerns arising from this 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 wide-ranging concerns arising from this case, and the risk to patients and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

When considering the above factors, the panel noted its findings on your current impaired fitness to practise and concluded that it was satisfied there is sufficient evidence of some deep-seated attitudinal concerns which could not be addressed through a conditions of practice order. Furthermore, whilst it acknowledged that there are some identifiable areas of your practice which needs retraining, it was of the view that it could not formulate

conditions addressing your behaviour and communication with colleagues, as identified in charge 8. Further, the panel was of the view that some areas of your shortcomings – such as medication management – indicate some concerns over your general competence.

The panel addressed the final three factors above together, and it was of the view that conditions could not be formulated in this case which would adequately address the attitudinal concerns identified.

On whether you have the potential and willingness to respond positively to retraining, it considered that charge 8 arose in the context of Witness 2 attempting to provide feedback to you, following an error which you admit (charge 7), which occurred the previous day. The panel was mindful that conditions need to be workable and was concerned that you have been found to shout at Witness 2 and tell her that she was "*stupid*", whilst she was, as your supervisor, providing you feedback on your clinical practice. The panel was satisfied that a conditions of practice order would not be workable or appropriate in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

When considering the above factors, the panel was of the view that there is a pattern of misconduct over a wide range of clinical concerns. The panel also considered its findings on your current impairment, and it determined that there is evidence of harmful, deep-

seated attitudinal concerns, albeit it noted that it determined that this could be remediable. The panel was satisfied that there has been no evidence of repetition of behaviour since the incident. The panel considered that, at this stage, you demonstrated very limited meaningful insight, and consequently, there is a significant risk of repeating behaviour.

The panel went on to consider whether a striking-off order would be proportionate. The panel considered the NMC Guidance on striking-off order (SAN-3e), which asked the panel to consider the following factors:

- Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?
- Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not struck off from the register?
- Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

In considering the above factors, the panel was satisfied that your misconduct, whilst it is serious, does not raise fundamental questions about your professionalism. It was of the view that public confidence in nurses could be maintained with a period of suspension, and the public confidence does not necessitate you being struck off from the register. Accordingly, the panel was satisfied that a suspension order could adequately protect patients, members of the public and maintain professional standards, and a striking-off order is not the only sanction which could address these concerns identified.

The panel was satisfied that the misconduct was not fundamentally incompatible with remaining on the register, and the case, in all its circumstances, did not meet the high threshold for a striking-off order for the following reasons:

- The panel has identified some insight, albeit very limited;
- The failings are remediable;
- The NMC guidance on seriousness is not engaged; and

- A suspension order could adequately protect patients, members of the public and maintain professional standards.

As a result, the panel determined that the imposition of a striking-off order would be disproportionate in this case.

Accordingly, the panel was satisfied that a suspension order is the appropriate and proportionate sanction.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel noted the hardship such a suspension order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and allow you adequate time to fully reflect and gain significant meaningful insight into your wrongdoing.

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

Any future panel reviewing this case would be assisted by:

- A written reflective piece setting out your learning following the panel's findings and how you have applied that in any role you are undertaking;

- Up-to-date written testimonials from work colleagues, your current employer or in any voluntary work you have undertaken;
- Evidence of any retraining you have completed; and
- Any further steps you have taken to strengthen your practice.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Mr Kabasinskas reminded the panel of the 28-day appeal period in which the substantive suspension order cannot take effect. He submitted that, in light of the panel's substantive decision on sanction, it should impose an 18-month interim suspension order. He acknowledged that an interim suspension order would restrict your nursing practice, which is currently subject to a conditions of practice order. He further submitted that this would be on both public protection and public interest grounds.

Mr Kabasinskas submitted that an interim order should be made for a period of 18 months to provide adequate time for your appeal to be addressed at the High Court, if you choose to appeal the decision.

Mr Lee offered no submissions.

Decision and reasons on interim order

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

The panel determined that not to impose an interim suspension order would be incompatible with its earlier findings.

The panel considered the guidance on interim orders (INT-1). 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 did not hear, and was consequently not satisfied, that an interim order would be in your own interests. The panel had regard to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel concluded that an interim suspension order is consistent with its findings on impairment and sanction. The panel therefore imposed an interim suspension order for a period of 18 months, to cover any relevant appeal period.

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

That concludes this determination.