Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Wednesday, 4 September 2024 – Friday, 6 September 2024

Virtual Meeting

Name of Registrant:	Andrea Dani
NMC PIN:	85I1609E
Part(s) of the register:	Registered Nurse - Adult nurse, level 2 (12 November 1990)
Relevant Location:	Hertfordshire
Type of case:	Lack of competence
Panel members:	Richard Youds (Chair, Lay member) Allwin Mercer (Registrant member) Colin Sturgeon (Lay member)
Legal Assessor:	Ruth Mann
Hearings Coordinator:	Eyram Anka
Facts proved:	Charges 1, 2a, 2b, 2h, 3a, 3b, 3c, 3d, 3e, 3g, 3h, 4, 5, 6
Facts not proved:	Charges 2c, 2d, 2e, 2f, 2g, 3f
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Dani's registered email address by secure email on 12 July 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting will be heard virtually.

In the light of all of the information available, the panel was satisfied that Mrs Dani has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you a registered nurse, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5 nurse, in that you;

1) Between 2018 – 2019 failed to complete triage for one or more patients in a timely manner.

2) On 14 October 2019;

    a) Asked Colleague Z to prescribe codeine for Patient C who had suffered a fall/head injury.

    b) After checking the codeine out of the controlled drug cupboard failed to ensure that a second registered nurse accompanied you to the patient.

    c) After dropping the codeine, failed to record the disposal with a second registered nurse, in the controlled drug book

    d) Asked Colleague Y to re-prescribe codeine for Patient C, as you did not want to admit dropping the codeine to Colleague Z.

e) Failed to ascertain/disclose Patient D's allergy to penicillin.

f) Failed to complete a Cas Card for Patient D.

g) Asked Colleague Y to prescribe Oramorph for Patient E;

   i. Without conducting the appropriate assessment;
   ii. Without checking what medication Patient E was on.

h) Did not escalate that triage times had reached over 45 minutes/2.5 hours 1

3) On 8 November 2019;

a) At around 7p.m. incorrectly administered Oxycodone 2.5mg/ml to Patient B, instead of Patient A.

b) Failed to ensure that a second registered nurse checked/witnessed the administration of Oxycodone 2.5mg/ml to Patient B, in that you did not ensure that a second registered nurse checked Patient B's;
   i. Name;
   ii. Date of Birth;
   iii. Potential allergies

c) failed to check Patient B's wristband before administering the Oxycodone 2.5mg/ml.

d) Failed to immediately call a doctor to attend Patient B after the incorrect administration of Oxycodone.

e) Failed to immediately escalate the medication administration error to the Nurse In Charge.

f) Failed to record the medication administration error in Patient B's drug chart

g) At around 8p.m. checked out Oxycodone 2.5mg/ml from the Controlled Drug

Cupboard without;

i. A second registered nurse.
ii. Recording the relevant entry in the Controlled Drug Book

h) At around 8 p.m. administered Oxycodone 2.5mg/ml to Patient A;

i. Without ensuring that the administration was checked/signed by second registered nurse.
ii. Failed to record/document the correct time the Oxycodone was administered to Patient A.

4) Around January 2019, acted outside the scope of your practice, in that you wrote a prescription for diclofenac for an unknown patient.

5) Failed to complete an informal capability/improvement plan which commenced on 12 July 2019.

6) Between July-November 2019 failed to complete your triage competency book.

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

Background

'2. Mrs Dani came onto the NMC register on 12 November 1990 as a Registered Nurse – Adults. She started working at East [and] North Hertfordshire Trust ('the Trust') in 2006 as a Band 5 nurse in the Emergency Department at Lister Hospital. She would also complete shifts in the Urgent Care Centre ('the Centre') at the New Queen Elizabeth II Hospital, which is part of the Trust, conducting triage assessments.

Charge 1

3. Concerns about Mrs Dani's triage assessment times were first raised in 2018. In May 2018 it was raised that Mrs Dani was not inputting observations onto the system, and when she was it was taking over an hour for each set to be completed. On one occasion it had also taken Mrs Dani over 45 minutes from handover and being booked in for the triage to be inputted on the system.

4. On 09 August 2018 the Matron, [Witness 4], spoke with Mrs Dani about how her triages were still taking over an hour. Despite assuring [Witness 4] that they would be completed, two hours later they were still incomplete. Mrs Dani's triage assessments continued to consistently exceed the expected 15 minutes, which was having a knock-on effect on overall triage waiting times. On 23 November 2018 an informal capability meeting was held with Mrs Dani, and she was set clear objectives with reference to triage and controlled drugs ('CD') management. The issues continued into 2019, ultimately resulting in Mrs Dani being placed on informal capability management.

<u>Charge 2(a)-(d)</u>

5. On 14 October 2019 Mrs Dani was working in the Centre and asked Emergency Nurse Practitioner ('ENP'), ('Colleague Z') to prescribe Codeine for a patient ('Patient C'). Patient C was elderly and had banged their head. Mrs Dani told Colleague Z that Patient C had suffered a fall and had back pain. Codeine can reduce consciousness in patients that have suffered from a head injury and is inappropriate for elderly patients due to their slower metabolism rate. It was thus inappropriate for Patient C.

6. The Codeine was prescribed, and Mrs Dani checked it out of the CD cupboard with another nurse. She however proceeded to take it to Patient C on her own. The Trust's Standard Operating Procedure ('SOP') for CDs provided that after being taken out of the CD cupboard by two medical practitioners, those practitioners must be present for the CD administration to mitigate the risk of error.

7. Whilst attempting to administer the Codeine to Patient C, Mrs Dani dropped it on the floor. She did not record the disposal of the dropped Codeine in the CD book, contrary to the SOP for CDs. This was required to ensure accurate records, as if not

recorded it would have appeared that Patient C had received double the amount should the Codeine have been re-prescribed. Mrs Dani then approached another ENP, ('[Witness 6]') and asked [Witness 6] to re-prescribe the Codeine. It would have been more appropriate for Mrs Dani to have asked Colleague Z, who should have already been provided details in relation to Patient C. In an informal performance management meeting on 21 October 2019 with [Witness 4], Mrs Dani advised that she had approached [Witness 6] because she did not want to admit to Colleague Z that she had dropped the Codeine.

Charges 2(e) and (f)

8. On the same date, Mrs Dani asked AH [the Doctor], a GP at the Centre, to prescribe a nebuliser for a patient ('Patient D') who was short of breath. AH asked Mrs Dani if Patient D had any allergies and Mrs Dani said they did not. Mrs Dani had not recorded any allergies in Patient D's 'cas card', which is used to highlight any allergies and provided to the GP when the patient is handed over. The Trust has a two-step check for allergies to reduce the risk of patients not remembering their allergies and being given harmful medication. Nurses should check at least two of the following sources to obtain a patient's allergy information: summary care record, nerve centre (patient documentation system, GP, relative/carer, the patient, or Lorenzo (registration system). Information obtained from the two-step check should be recorded in the cas card.

9. AH assessed Patient D, during which Patient D advised that they were allergic to Penicillin. Had AH prescribed the nebuliser without double checking the information provided by Mrs Dani, Patient D could have suffered an allergic reaction and possibly even gone into anaphylactic shock. Mrs Dani should have provided AH with Patient D's correct history and any information in relation to their allergies, should have been recorded in the cas card. She should have known to do this because it was part of her triage training.

Charge 2(g)

10. Also on 14 October 2019, Mrs Dani asked [Witness 6] to prescribe Oramorph for a patient ('Patient E'), who had attended the Centre for repacking of an abscess wound. Mrs Dani had not checked the medication that Patient E was already on,

nor conducted an appropriate assessment. [Witness 6] reviewed Patient E's notes and discovered that they would usually attend their GP practice for repacking but had needed to attend the Centre because the GP practice did not have capacity. There was no prescription for Oramorph. Practice Nurses are unable to prescribe Oramorph because it is a Schedule 4 drug. Since Patient E had not been receiving Oramorph previously as part of their post-operative care, it was inappropriate for it to be prescribed in the Centre. Mrs Dani told [Witness 6] that she thought Patient E would benefit from receiving Oramorph.

Charge 2(h)

11. On the same date, triage waiting times had risen to over 2.5 hours. It is important for triage to happen in a timely manner to ensure timely treatment and avoid harm. If triage waiting times reach over 45 minutes, the Band 5 Nurse conducting triage is required to notify the ENP. The ENP should then stop seeing patients and assist with triage to reduce the waiting times.

12. Mrs Dani was the Band 5 Nurse in charge of triage, but she did not inform [Witness 6], the ENP, that the triage times had exceeded 45 minutes, nor that the triage time had risen to over 2.5 hours.

Charges 3(a)-(c)

13. On 08 November 2019 Mrs Dani was working in the Clinical Decision Unit of the Emergency Department at Lister Hospital. At approximately 19.00 hours, she informed fellow Band 5 Nurse, [Witness 1], that she needed to re-dispense 2.5mg/ml of Oxycodone to a patient because the tablet had fallen on the floor. [Witness 1] witnessed Mrs Dani dispose of the tablet. Mrs Dani and [Witness 1] then signed out another dose of Oxycodone for Patient A. Mrs Dani recorded in the CD book that the discarded and re-dispensed tablets were meant for Patient A, and this was witnessed by [Witness 1].

14. Whilst Mrs Dani and [Witness 1] were walking to the resuscitation room, Patient B began to call out for help sitting up. Mrs Dani and [Witness 1] went to assist. They found the room was too congested to perform manual handling safely, so [Witness 1] removed a table. When [Witness 1] returned to the room, she and Mrs Dani

helped Patient B sit up. Patient B requested the table be returned so [Witness 1] went to retrieve it. When she returned to the room, Mrs Dani informed [Witness 1] that she had she had administered the Oxycodone to Patient B whilst [Witness 1] had been outside.

15. The Trust's SOP for CDs provides that the administration of CDs must be administered by the medical professionals who signed it out. It further provides that one of the medical professionals must witness the other perform safety checks prior to administration i.e., confirmation of the patient's name, date of birth, and potential allergies. If the patient does not have capacity to provide those details, then they must be obtained from the patient's wristband. Had Mrs Dani properly performed, or witnessed the safety checks, she would have realised that the Oxycodone had not been meant for Patient B.

16. Mrs Dani later informed [Witness 4] that whilst she had been with Patient B, the family had been extremely loud and asking her lots of questions. She stated that whilst she had asked Patient B to confirm their name and date of birth, she had been interrupted by the relatives and she therefore could not be completely focused. She stated that she thought she had heard Patient A's name. Mrs Dani acknowledged that she had not checked Patient B's wristband.

<u>Charges 3(d)-(h)</u>
17. At approximately 20.00 hours that day, Patient A informed Mrs Dani that they had not received their pain medication i.e., the 2.5mg/ml of Oxycodone. Mrs Dani then realised that she had administered it to the incorrect patient i.e., Patient B instead.

18. After realising that she had administered the Oxycodone to the incorrect patient, Mrs Dani went to the CD cupboard, removed another dose of 2.5mg/ml Oxycodone, and administered it to Patient A. She completed all these actions independently and without a second checker, contrary to the Trust's SOP for CDs. Mrs Dani did not record this further dose in the CD book, which meant that the remaining quantity listed was incorrect. She also did not amend Patient A's drug chart to reflect the

error, leaving it to appear that at around 19.00 hours she had correctly administered the tablet to Patient A.

19. Before administering the missed medication to Patient A, Mrs Dani should have tended to Patient B. She did not immediately call a doctor or escalate the error to the nurse in charge, nor did she record the error in Patient B's drug chart.

20. Once Mrs Dani had administered the medication to Patient A she informed the nurse in charge of the error and they, arranged for a doctor to attend completed an ABCDE assessment of Patient B, and arranged for 15-minute observations.

Charge 4

21. In January 2019, a retrospective audit of documentation revealed that Mrs Dani had written a prescription for Diclofenac PR for a patient. Mrs Dani was not an authorised prescriber. Only authorised prescribers may write on prescriptions. Mrs Dani's actions increased the potential for error as the doctor could have signed the prescription without reading it fully. She should have provided the doctor with a blank prescription and asked them to write any drugs they wanted on it. The Diclofenac PR was not administered to the patient as the prescription was not signed by a doctor. In a meeting on 22 January 2019, Mrs Dani stated that she had thought the doctor would have given the patient Diclofenac PR. She said she had been trying to help the doctor by speeding up the process and was planning to consult the doctor before giving the prescription to the patient. She acknowledged that she knew doctors should complete prescriptions in full.

Charges 5 and 6

22. In July 2019 Mrs Dani was placed on an informal capability plan due to concerns about her clinical performance, specifically triage competence and documentation, which was overseen by [Witness 4]. The plan included the following five objectives:

a) *Ability to document in a timely manner;*
b) *Improvement in keyboard skills;*
c) *Ability to manage time effectively;*
d) *Ability to be efficient in triaging patients; and*

e) Controlled drug management.

23. Mrs Dani was provided with a range of support measures e.g., she was given additional computer system training, allocated shorter and specific triage shifts, given a reduced number of patients, and allocated a Practice Development Nurse who could provide guidance. Some improvement was seen by August 2019 and therefore the Practice Development Nurse support was removed. However, Mrs Dani's progress regressed. Feedback was received that she was struggling with managing a single patient and her documentation remained unclear. She often forgot to save her triage, which made the records appear as though patients had not been seen. Her triage times were consistently exceeding the expected 15 minutes.

24. As part of the informal performance capability plan, Mrs Dani was required to complete the triage competency book by November 2019. This is often given to member of staff who have worked for around 18 months to two years to ascertain whether they can complete triage. The individuals would then be signed off and moved into the Senior Band 5 nurse block and able to complete triage at the QEII.

25. There was no evidence that Mrs Dani completed the requested competency triage book as requested, which was needed to demonstrate her competency. It would normally be expected that the triage competency booklet would be signed off within two or three months. Due to Mrs Dani's senior position, it was expected that she would have had all, if not the vast majority, of the booklet signed off significantly quicker.

26. There were no CD errors between July and September 2019; the errors as set out in charges 2 and 3 occurred in October 2019. Consequent to those errors, Mrs Dani was moved into an emergency technician role and did not function as a registered nurse. The role did not allow her to undertake any drug management.

27. The capability management was moved to a formal stage and an investigation was commissioned. On 17 February 2021, the Trust submitted a referral to the NMC with concerns about Mrs Dani's practice.'

On 3 January 2023, undertakings were imposed by the NMC Case Examiners, with regard to Mrs Dani's nursing practise to which she agreed. However, on 15 January 2024 the NMC Case Examiners were of the view that Mrs Dani had failed to engage meaningfully, or otherwise provide any information in relation to her progress in working within the undertakings. The NMC Case Examiners concluded that Mrs Dani was in breach of the undertakings and revoked the same.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the Royal College of Nursing (RCN) from 2021 in relation to the regulatory concerns.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Band 5 Registered Nurse at Lister Hospital, at the relevant time
- Witness 2: Band 7 Shift Leader and Coordinator in the Emergency Department (ED) at Lister Hospital, at the relevant time
- Witness 3: Practice Development Sister in the ED at Lister Hospital, at the relevant time
- Witness 4: Matron of ED at Lister Hospital, at the relevant time

- Witness 5: Deputy Manager for Gastroenterology and Acute Medicine at Lister Hospital, at the relevant time
- Witness 6: Emergency Nurse Practitioner at Lister Hospital, at the relevant time

The panel also had regard to written representations the RCN provided in relation to the regulatory concerns in 2021.

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

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

Charge 1

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> Between 2018 – 2019 failed to complete triage for one or more patients in a timely manner."

This charge is found proved.

In reaching this decision, the panel took into account the written statements and documentary evidence from Witness 4 and Witness 6.

The panel had regard to the direct evidence from Witness 6 who was the Emergency Nurse Practitioner (ENP) at the time. Witness 6's statement states,

'Another concern I had with the Registrant's performance was that during the same shift on 14 October 2019, triage times had risen to over 2.5 hours.

…Triage was taking a lot longer than it was supposed to because the triage process was not being followed hence the delays.'

The panel gave significant weight to this evidence as Witness 6 worked with Mrs Dani in the Emergency Department and had raised concerns about this issue at the time. Witness 6's concerns were corroborated by Witness 4's note of a discussion with Mrs Dani to review her performance objectives on 21 October 2019. The note states,

'I had received two emails regarding her triage and a drug error at the QEII. …and be able to triage patients within the 15 KPI. The feedback I had received from the QEII ENPs who had been on duty over two days she had worked at the QEII was that the triage was consistently over 30 mins and that she was taking much to(sic) detailed assessment and not getting the concise information that was required in order to get the right information and make a decision of priority as well as keep to the expected triage times.'

The panel noted that in Mrs Dani's Informal Capability Plan from July 2019, Witness 4 raised concerns about the length of time Mrs Dani was taking to complete triages. It also considered Witness 4's email dated 13 December 2021 providing an overview of concerns relating to Mrs Dani's practice. It was of note to the panel that one of the points in the email relates to a conversation Witness 4 had with Mrs Dani on 9 August 2018 about her triage completion times. Witness 4 states,

'… I had a conversation with Andrea regarding her triage (this is documented in a file note) I had noted that eth(sic) triage was over 1 hours(sic) and I had spoken to Andrea and she advised she would complete the triage. However 2 hours later I had noted that the triage was still not complete and had to speak to her again.'

The panel determined that there is evidence of concerns being raised about the length of time Mrs Dani took to complete triages, including a number of specific patient examples.

The panel bore in mind that Mrs Dani did not deny this allegation in her written representations.

Based on the evidence before it, the panel found charge 1 proved.

Charge 2a)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 14 October 2019;
>
> a) Asked Colleague Z to prescribe codeine for Patient C who had suffered a fall/head injury."

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement, an email from Witness 6 to Witnesses 3 and 4 dated 17 October 2019 and Mrs Dani's employee personal file note dated 21 October 2019.

The panel determined that there is no direct evidence from Colleague Z in relation to this charge. It noted that this charge is based on hearsay evidence from Witness 6's witness statement which states, *'…the Registrant approached me at an unknown time and explained that codeine had been prescribed by ENP Colleague Z.'*

The panel determined that Witness 6's hearsay evidence is not the sole evidence for this charge. It took into account the email from Witness 6 to Witnesses 3 and 4 on 17 October 2019 outlining concerns about Mrs Dani's practice. The second concern states, *'Andrea asked [Colleague Z] to write up some Codeine for her patient, which he did, he was aware that the patient had a fall and back pain…'*

The panel found that Witness 6's account of this event is corroborated by Mrs Dani's employee personal file note from a discussion with Witness 4 on 21 October 2024. During the discussion Mrs Dani informed Witness 4 that *'she had had a patient who presented with a fall and head injury and she had asked one of the ENPs to prescribe codeine. She had then gone to the CD cupboard with a nurse to check this CD out but after checking the nurse did not accompany her to the patient.'*

The panel took the view that although Witness 6's evidence is hearsay, Mrs Dani's account to Witness 4 on 21 October echoes Witness 6's witness statement and email. Further, Mrs Dani does not deny this charge in her reflective statement or representations from the RCN.

Accordingly, the panel found charge 2a is proved on the balance of probabilities.

Charge 2b)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 14 October 2019;
>
> b) After checking the codeine out of the controlled drug cupboard failed to ensure that a second registered nurse accompanied you to the patient."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement, Witness 6's witness statement, the Trust's Standard Operating Procedure (SOPs) for Controlled Drugs (CDs) and Mrs Dani's employee personal file note dated 21 October 2019.

The panel had regard to the SOPs for CDs, particularly Policy 9.6 which states that *'…CDs may only be administered by a registered practitioner with a second practitioner.'*

It also considered Policy 9.9 which states,

> *'Both practitioners must be present during the whole of the preparation and administration procedure.'*

The panel determined that Mrs Dani would have been aware of the policy and therefore had a duty to ensure that a second practitioner accompanied her to the patient. The panel considered that during Mrs Dani's review of her informal performance objectives on 21 October 2019 she informed Witness 4 *'that she had had a patient who presented with a fall and head injury and she had asked one of the ENPs to prescribe codeine. She had then gone to the CD cupboard with a nurse to check this CD out but after checking the nurse did not accompany her to the patient.'*

Witness 4 confirmed that Mrs Dani breached the Trust's policy in her witness statement, stating,

> *'The Registrant had not followed the process or policy of how to correctly administer a controlled drug…Whilst the Registrant had gone to the CD cupboard with a nurse, she had then independently gone to a patient.'*

Witness 6 also confirmed that Mrs Dani had gone to administer the codeine without another nurse in her witness statement, which states,

> *'…the Registrant approached me at an unknown time and explained that codeine had been prescribed to a patient by ENP,* [Colleague] *Z. The Registrant then explained that she went to administer the codeine to the patient on her own.'*

The panel was of the view that the evidence before it is sufficient to find charge 2b proved on the balance of probabilities.

Charge 2c)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 14 October 2019;

c) After dropping the codeine, failed to record the disposal with a second registered nurse, in the controlled drug book "

This charge is found NOT proved.

In reaching this decision, the panel took into account Witnesses 4 and 6's witness statement.

The panel bore in mind that the burden is on the NMC to prove this charge. It considered that the only evidence before it relating to this incident is the hearsay evidence from Witness 4. The panel determined that Witness 4's hearsay evidence is not supported by any documentary evidence such as the patient's name or medication record. The panel had regard to Witness 6's comment about the Patient C's codeine prescription in her witness statement which states,

'The Trust has been unable to find the patient's name in relation to this incident. Therefore, I am unable to verify to this, Documents in relation to his codeine prescription can therefore not be found'.

The panel took the view that in the absence of any patient information, a controlled drugs book or any corroborating evidence, it could not determine whether Mrs Dani had failed to record the disposal. On this basis, the panel determined that the NMC have not provided sufficient evidence to find charge 2c proved.

Charge 2d)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 14 October 2019;

d) Asked Colleague Y to re-prescribe codeine for Patient C, as you did not want to admit dropping the codeine to Colleague Z."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 4's assumption in paragraph 22 of her NMC witness statement in which she states,

'The Registrant then proceeded to ask [Witness 6] to re-prescribe the codeine although the first dose had not been administered, as she did not want to admit to [Colleague] Z that she had dropped the first dose.'

The panel determined that this charge stems from Witness 4's assumption and is not substantiated by any other evidence. Further, Witness 6 makes no other reference to this being the reason she was asked to re-prescribe the codeine.

Accordingly, the panel determined that the NMC has not proved that Mrs Dani asked Colleague Y to re-prescribe the codeine because she did not want to admit to dropping the first dose.

Charge 2e) and 2f)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 14 October 2019;

e) Failed to ascertain/disclose Patient D's allergy to penicillin.

f) Failed to complete a Cas Card for Patient D."

These charges are found NOT proved.

In reaching this decision, the panel took into account the Trust-wide Policy on Administration of Drugs, Witness 6's witness statement, Mrs Dani's responses to the regulatory concerns from the RCN and an email from Witness 6 dated 17 October 2019.

The panel had regard to the Trust's policy on Administration of Drugs, namely section 8.1.3 which states,

> *'You must check that the patient is not allergic to the medicine before administering it.'*

The panel considered Witness 6's evidence in relation to this charge to be hearsay and noted that she raised this concern following a conversation with the GP and was not a direct witness. In her witness statement she states,

> *'AH then explained that when she asked the Registrant whether or not the patient had any allergies, the Registrant confirmed that the patient did not. The Registrant had also not documented any allergies on the patient's cas card (this cas card cannot be located by the Trust and I am therefore unable to view it or produce it).'*

Although Witness 6 reiterates this concern in her email to Witnesses 3 and 4, the panel noted that there is no evidence from Patient D to confirm what was said when Mrs Dani spoke to them. It further noted that the Cas Card is not available, therefore it cannot determine whether Mrs Dani completed it at the time.

The panel had regard to Mrs Dani's denial of this regulatory concern in the RCN's response on her behalf dated 4 March 2022. It states,

> *'Ms Dani reports that she spoke to the patient about allergies. The patient told her that she had no allergies, but then became unsure about whether she did or not. Ms*

Dani then advised the patient to advise the doctor if they remembered any allergies that they may have, just in case.'

The panel took the view that this charge is based on third-party hearsay account and no direct substantive evidence. In the light of this, the panel found that the NMC have not discharged their duty to prove these charges on the balance of probabilities.

Charge 2g)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 14 October 2019;

g) Asked Colleague Y to prescribe Oramorph for Patient E;

i. Without conducting the appropriate assessment;
ii. Without checking what medication Patient E was on.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's witness statement and Witness 6's email dated 17 October 2019.

The panel had regard to Witness 6's statement in which explains this incident. It states,

'…The Registrant approached me asking me to prescribe Oramorph for a patient who had attended for a repacking of an abscess wound… I do not think that the Registrant carried out an appropriate assessment of the patient as they did not require Oramorph…. She should have checked the medication the patient was on…'

Witness 6 escalated this concern in her email to Witnesses 3 and 4 on 17 October 2019. She expressed the opinion that Oramorph was not the appropriate medication. The panel

questioned the assertion that Mrs Dani did not conduct an appropriate assessment as there is insufficient evidence to support this. The panel determined that there is clearly a difference of opinion between Mrs Dani and Witness 6 as to what was appropriate in terms of prescribing Oramorph for Patient E's abscess.

Furthermore, without any medical records, the panel could not identify any direct evidence to determine whether Mrs Dani had checked what medication Patient E was on.

Accordingly, the panel found charge 2g not proved.

Charge 2h)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 14 October 2019;
>
> h) Did not escalate that triage times had reached over 45 minutes/2.5 hours 1

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement, in which she states,

> *'…during the same shift on 14 October 2019, triage times had risen over 2.5 hours…If triage times reach over 45 minutes, the Band 5 registered nurse conducting the triage is required to notify the ENP. The ENP should stop seeing patients and help with triage to ensure the process is sped up. During this shift, the Registrant did not notify me that triage tines had reached 2.5 hours thus I was unaware of the delay at triage.'*

Witness 6 inferred that she was the Senior ENP on duty on 14 October 2019 and sets out that Mrs Dani did not escalate the triage time concerns to her as would have been expected. The panel determined that Witness 6's statement is not hearsay as she is a

direct witness with contemporaneous notes of the concerns at the time, being her email to Witnesses 3 and 4 dated 17 October 2019.

The panel considered that prior to 14 October 2019, Mrs Dani's triage time management was a concern previously raised, therefore this charge is consistent with that.

Accordingly, the panel found charge 2h proved.

Charge 3a)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 8 November 2019;
>
> a) At around 7p.m. incorrectly administered Oxycodone 2.5mg/ml to Patient B, instead of Patient A."

This charge is found proved.

In reaching this decision, the panel took into account the Datix Report dated 8 November 2019, Mrs Dani's local statement on 22 November 2019 and Witness 1's witness statement.

The panel considered that there is direct evidence from Mrs Dani admitting to this charge. It had regard to Mrs Dani's Datix Report documenting the incident on 8 November 2019 in which she stated, *'…patient given oxycodone 2.5 mg in error.'*

It further noted that Mrs Dani admitted to this incident in her local statement on 22 November 2019 stating,

> *'At around 19:00 I needed to give Oxycodone medication to [Patient A]…I realised I'd given her medication to the wrong patient'.'*

Mrs Dani also made a verbal admission to Witness 1 at the time of the incident, which Witness 1 confirms in her witness statement,

> *'When I returned, the Registrant told me that she had administered the 2.5mg/2.5ml of oxycodone to Patient B.'*

Based on Mrs Dani's own admissions and the supporting documentary evidence, the panel found charge 3a proved.

Charge 3b) and 3c)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 8 November 2019;
>
> b) Failed to ensure that a second registered nurse checked/witnessed the administration of Oxycodone 2.5mg/ml to Patient B, in that you did not ensure that a second registered nurse checked Patient B's;
>
> iv. Name;
> v. Date of Birth;
> vi. Potential allergies
>
> c) failed to check Patient B's wristband before administering the Oxycodone 2.5mg/ml."

These charges are found proved.

In reaching this decision, the panel took into account the Trust's SOPs section 9, Witness 1 and Witness 2's witness statements, Mrs Dani's local statement dated 22 November 2019 and Mrs Dani's employee file note dated 13 November 2019.

The panel had regard to section 9.9 of the Trust's SOPs which states that *'Both practitioners must be present during the whole of the preparation and administration procedure.'* It took the view that Mrs Dani would have been aware of this policy and therefore had a duty to adhere to it.

The panel considered that Mrs Dani made admissions to both charges 3b and 3c respectively in her local statement dated 22 November 2019. She states,

> *'As this was a controlled drug, I needed a second checker… I wanted to get her medication as soon as possible. There was no other nurse around to make the second check on drugs.'*
> *…*
> *'Throughout these distractions, I missed cross-checking the information given to me against the patient's ID band.'*

In a discussion with Witness 4 on 13 November 2019, Mrs Dani confirmed that prior to administering the oxycodone to Patient B, she did not check Patient B's ID Band. Witness 4 states,

> *'…she said that she heard what was written on the drug chart and that she didn't check the patient's ID band. She said that she confirmed the patient's allergies and then administered the medication'*

This is confirmed by Witness 1 who was a direct witness to this charge as she should have been the second checker because she was the nurse who checked and signed the medication out of the CD cupboard for Mrs Dani. She describes the incident in her witness statement, stating

> *'I should have witnessed the Registrant ask Patient B their name, date of birth and check is she had any allergies, before the Registrant administered the medication. Instead, the Registrant administered the medication without me being present'*

It also noted that this account is corroborated by Witness 2, who had a conversation with Mrs Dani at the time of this incident. Witness 2 states,

'The Registrant admitted to me that she had not checked the patient's wristband or let the patient verbally confirm their own drugs before administering the oxycodone.'

The panel determined that it is clear from the evidence that Mrs Dani failed to ensure a second checker witness the administration of Oxycodone to Patient B and did not check Patient B's wristband before administering the medication.

Accordingly, the panel determined that the evidence before it is sufficient to find charges 3b and 3c proved.

Charge 3d) and 3e)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 8 November 2019;

d) Failed to immediately call a doctor to attend Patient B after the incorrect administration of Oxycodone.

e) Failed to immediately escalate the medication administration error to the Nurse In Charge.

These charges are found proved.

In reaching this decision, the panel took into account Mrs Dani's local statement dated 22 November 2019 and Witness 2's witness statement and Witness 2's internal statement.

The panel had regard to Mrs Dani's local statement describing the incident and determined that after she discovered the drug error, instead of alerting a doctor and the nurse in charge she returned to the CD cupboard to correct the medication error. Mrs Dani account states,

'I realised I'd given her medication to the wrong patient. I wanted to get her medication to her as soon as possible. There was no other nurse around to make the second check on drugs. I went to the CD cupboard, for which I already had the keys, unaccompanied… I then went to find the senior sister in charge, and informed her of what I had done.'

The panel considered that Witness 2 is a direct witness to this incident because she was alerted to the error after it occurred. Witness 2 refers to this in her witness statement, stating that,

'The Registrant could not explain why she administered the medication to Patient A before informing me that there had been a drug error with Patient B. As Patient B was the number one priority, the Registrant should have escalated the error to me first.'

This account is corroborated in Witness 2's contemporaneous internal statement in which she states,

'Registered nurse Andre Dani approached me and expressed that she had completed a drug error in the Clinical Decision Unit (CDU). She stated that she had given the wrong drug to the wrong patient… I went to the CDU immediately, I initiated and confirmed that the following actions were taking place simultaneously, …

- *…(CDU Dr) to attend patient immediately…'*

It was clear to the panel that Witness 2 was the one who escalated the situation to the doctor. This is evidenced in Witness 2's contemporaneous statement and is also confirmed in her witness statement, which states,

'When I asked the Registrant if she had called the doctor, she had not and therefore I instigated that the CDU doctor needed to attend Patient B.'

The panel noted that Witness 2 outlined the correct procedure for drug error in her statement. She states,

> *'If a drug error is made, escalation of this incident needs to be raised as soon as practicable. The patient who has been given either the wrong dose of medication or the wrong medication itself needs to be checked by a doctor as soon as the drug error becomes known. The patient is first priority in accordance with duty of candour.'*

The panel took the view that the correct procedure would have been common practice and should have been actioned by Mrs Dani immediately. The panel concluded that Mrs Dani failed in her duty to immediately alert the doctor and the nurse in charge after incorrectly administration of Oxycodone to Patient B. Therefore, it determined that charges 3d and 3e are found proved.

Charge 3f)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 8 November 2019;
>
> f) Failed to record the medication administration error in Patient B's drug chart."

This charge is found NOT proved.

The panel determined that in the absence of Patient B's drug chart it has insufficient evidence to make a decision as to whether Mrs Dani failed to record the medication administration error. Accordingly, the panel found that the NMC have been unable to discharge their duty to prove this charge on the balance of probabilities.

Charge 3g)

"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;

On 8 November 2019;

g) At around 8p.m. checked out Oxycodone 2.5mg/ml from the Controlled Drug Cupboard without;

   i. A second registered nurse.
   ii. Recording the relevant entry in the Controlled Drug Book

This charge is found proved.

In reaching this decision, the panel took into account Mrs Dani's local statement dated 22 November 2019, Patient A's drug chart dated 8 November 2019, the Controlled Drug Register and Witness 2's witness statement.

The panel found that Mrs Dani admitted that there wasn't a second registered nurse with her when she checked out the Oxycodone from the CD cupboard. This is evidenced in her local statement dated 22 November 2019 where she states,

'I wanted to give her the medication as soon as possible. There was no other nurse around to make the second check on the drugs. I went back to the CD cupboard, unaccompanied…'

In relation to recording the relevant entry in the CD Book the panel considered the entries in the Controlled Drug Register which shows that three doses of Oxycodone were taken out of the CD cupboard but only two doses were recorded in the Register. The panel also referred to the Drug Chart from 8 November 2019 which indicated that at 18:30 Mrs Dani was going to administer 2.5ml of Oxycodone but it was *'wasted'*. The chart shows that Mrs Dani then signed out another dose of Oxycodone at what appears to be either 19:00 or

19:50. The panel questioned this as there is no note or signature on the CD Register to indicate that Mrs Dani checked out 2.5ml of Oxycodone at either 19:00 or 19:50.

The panel noted that the error was corrected by Witness 2 and referenced in her local statement. It states,

> *'…a dose of the drug had been removed from the cupboard without a second checker and without any entry in the book…'*

Considering Mrs Dani's own admissions, the documentary evidence and the corroboration in Witness 2's statement, the panel found charge 3g proved in its entirety.

Charge 3h)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> On 8 November 2019;
>
> h) At around 8 p.m. administered Oxycodone 2.5mg/ml to Patient A;
>
> i. Without ensuring that the administration was checked/signed by second registered nurse.
> ii. Failed to record/document the correct time the Oxycodone was administered to Patient A."

This charge is found proved.

In reaching this decision, the panel took into account Patient A's Drug Chart dated 8 November 2019, Mrs Dani's local statement dated 22 November 2019, Mrs Dani's Disciplinary Investigation Meeting notes and Witness 2's witness statement.

The panel determined that Patient A's Drug Chart clearly shows that there is only one signature at the time the dose of Oxycodone was administered. This evidence is supported by Mrs Dani's her local statement dated 22 November 2019 in which she comments on going to the CD cupboard *'unaccompanied'* and returning to Patient A, but she makes no mention of a second checker. The panel also considered Mrs Dani's Disciplinary Investigation Meeting notes where she tells the interviewers,

> *'I went and took the medication out, I drew it all up. I gave her the med without a second checker'.*

In considering whether Mrs Dani failed to record/document the correct time the Oxycodone was administered to Patient A, the panel referred to Mrs Dani's local statement where she explains that the Oxycodone was administered around 20:00. The panel also referred to Witness 2's witness statement in which she states that the medication was administered at 20:00. However, this panel determined that this does not mirror Patient A's Drug Chart as it appears to state that the medication was administered at either 19:00 or 19:50. The panel took the view that the time written on the Drug Chart (either 19:00 and 19:50) is likely incorrect because both Mrs Dani and Witness 2 documented that Patient A's dose of Oxycodone was administered at or around 20:00.

For these reasons, the panel found charge 3h proved.

Charge 4)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> Around January 2019, acted outside the scope of your practice, in that you wrote a prescription for diclofenac for an unknown patient."

This charge is found proved.

In reaching this decision, the panel took into account Mrs Dani's employee file note dated 22 January 2019, the Scoring Matrix for Medication Incidents and Witness 3's witness statement.

The panel established that there was a failure in duty as only trained and authorised prescribing clinicians were permitted to write patient prescriptions. It bore in mind that a Band 5 nurse who is not a prescriber is not allowed to write prescriptions and they would be aware that prescribing medication was outside their scope of practice.

The panel had sight of Mrs Dani's employee file note of a discussion with Witness 3 in which she explained why she wrote a prescription for diclofenac. She told Witness 3 that *'she had written it as she thought this would be what the Dr would give the patient and wanted to help the Dr and make things go more quickly,'*

The panel also had regard to the Scoring Matrix which was signed by Mrs Dani and Witness 3. It suggests that Mrs Dani had a lack of awareness of the limitations of her role. The panel noted that there was no dispute recorded and it was treated as a developmental matter.

Accordingly, the panel found charge 4 proved.

Charge 5)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> Failed to complete an informal capability/improvement plan which commenced on 12 July 2019."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's email to HR dated 13 December 2021 containing an overview of Mrs Dani's performance issues from 2018 to

2019, Witness 4's witness statement, Mrs Dani's Disciplinary Investigation meeting notes, Mrs Dani's Informal Capability meeting letter dated 12 July 2019, the Informal Capability Review Meeting Letter dated 9 August 2019 and Mrs Dani's Capability Plan dated 12 July 2019.

The panel referred to Witness 4's email dated 13 December 2024 containing the chronology of Mrs Dani's performance issues. It noted that Witness 4 had an informal capability meeting with Mrs Dani to discuss the concerns raised in relation to her competence. Mrs Dani was placed on an informal capability plan on 12 July 2019 which Witness 4 oversaw. Witness 4 states in her email *'I set clear objectives to be achieve(sic) and gave her a supernumery(sic) period to help support this'.* Following this meeting, Witness 4 sent Mrs Dani a letter highlighting what occurred in the meeting and the referred her to the required actions set out in her improvement plan.

On 2 August 2019, Witness 4 held a review meeting and informed Mrs Dani that although there had been some progress, it was not consistent, and she was therefore extending her informal capability stage. The panel determined that the review is evidence that the improvement plan was in progress and was being monitored.

Before the capability plan could be further reviewed, the incident of 14 October 2019 occurred. This was of note to the panel as it suggests that Mrs Dani was not able to practice without incident, even whilst on an improvement plan.

The panel noted that there was a further review of Mrs Dani's capability plan on 21 October 2019. Witness 4 in her email to HR stated,

> '*I then met with Andrea again to review her informal capability objectives and the recent information I explained that I did not feel we had move any further forward and that this now needed to move to formal capability. We discussed some outstanding actions from her that I had not received her triage competency book and signed copy of the CD SOP to demonstrate that she had read it. I expressed that I was concerned that this was now a further drug error and that it also related to a CD that she was already being managed for and that any further CD related incidents would be potentially disciplinary.'*

The panel also had sight of the discussion note from the October informal capability meeting and took the view that Mrs Dani was being guided and supported but was not achieving her competencies.

On 8 November 2019, the incorrect drug administration incident occurred which became a disciplinary matter. As such, the capability plan was stopped and superseded by an Internal Disciplinary process. She therefore could not complete her the capability /improvement plan that was commenced on 12 July 2019.

For these reasons, the panel found charge 5 proved.

Charge 6)

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as band 5 nurse, in that you;
>
> Between July-November 2019 failed to complete your triage competency book."

This charge is found proved.

In reaching this decision, the panel took into account Mrs Dani's employee personal file dated 21 October 2019. The panel noted that during the informal objectives review, Witness 4 reminded Mrs Dani that the competency book she had asked to be completed was overdue, despite being given supernumerary shifts in triage. Consequently, one of Mrs Dani's actions plans from this meeting was to complete her *'triage competency pack by 31/11/19'(sic)*

The panel also referred to Witness 4's witness statement in which she states,

> *'The Registrant either was not taking the book or she was not competent in triage and therefore the book was not being signed off.'*

The panel had no evidence to suggest that Mrs Dani had completed her triage competency book between July and November 2019.

Accordingly, the panel found charge 6 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 those facts it found proved amount to a lack of competence and, if so, whether Mrs Dani's 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 suitability to remain on the register unrestricted

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Mrs Dani's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

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

The NMC identified the specific, relevant standards where Mrs Dani's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Mrs Dani was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mrs Dani's competence at the time was below the standard expected of a band 5 registered nurse.

The NMC provided the following written submissions on lack of competence:

> *'29. The NMC's guidance on 'Lack of competence (FTP-2b)' provides: "Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice."*
>
> *30. This guidance is in line with the test set out in the case of R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin), where at paragraph 39 Jackson J summarised that deficient professional performance "connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the [registrant's] work." Further guidance in defining lack of competence can be found at paragraph 75 of Holton v GMC [2006] EWHC 2960 (Admin), in which Burnton J stated that lack of competence can be judged as performance of a*

practitioner that falls below what is "expected of a competent practitioner in the circumstances."

31. The NMC submits that the conduct of Mrs Dani outlined in charges 1 to 6 represents a fair sample of her work. The charges cover a period of just under two years. The NMC submits that the evidence provided by the witnesses gives a holistic view of Mrs Dani's work during a defined period relating to consistent areas of concern and includes continued summaries of Mrs Dani's overall progress and competencies through e.g., notes of review meetings, action plans, and notes from direct observation carried out.

32. The NMC submits that Mrs Dani's level of work, as captured by charges 1 to 6, fell below the standards expected of a band 5 nurse, and placed patients at risk of harm.

33. Medication administration, recordkeeping, effective time management, and escalation of errors are fundamental competencies expected of a nurse in order to be able to provide safe and effective care to patients. The NMC submits that consistent failings in the areas highlighted therefore represent an unacceptably low standard of work.

34. At all relevant times, Mrs Dani was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. On the basis of the charges alleged, the NMC consider the following provisions of the Code have been breached in this case;

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

4 Act in the best interests of people at all times

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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 advise on, prescribe, supply, 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:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

22 Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC further provided the following written submissions on impairment:

'36. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. 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?"

37. If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

38. Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

39. When determining whether a registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

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

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

c) has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or

d) d) has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.

40. It is the submission of the NMC that limbs (a) to (c) can be answered in the affirmative in this case.

Limb (a)

41. By failing to demonstrate a level of competence over significant period in medication administration and/or management, recordkeeping, and completing triages in a timely manner despite receiving additional support, Mrs Dani placed patients at risk of harm. It is submitted that a member of the public would be extremely concerned to hear that an incompetence nurse was allowed to practise without restriction. They consequently may be deterred from seeking medical assistance when required, thus placing them at risk of harm.

Limb (b)

42. Nurses occupy a position of privilege and trust in society and are expected at all times to maintain an adequate standard of competence. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must ensure that their standard of competence at all times justifies both their patients' and the public's trust in the profession. As such it is submitted that Mrs Dani's lack of clinical competence is liable to bring the nursing profession into disrepute.

Limb (c)

43. Prioritising people, preserving safety, practicing effectively, and promoting professionalism and trust are fundamental tenets of the profession. It is submitted that in failing to demonstrate clinical competence, Mrs Dani has breached those fundamental tenets.

Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions:
(i) whether the concern is easily remediable;
(ii) whether it has in fact been remedied; and
(iii) whether it is highly unlikely to be repeated.

45. The NMC has considered its guidance entitled: Can the concern be addressed? (Reference: FTP-14a) which states: 'Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.
…
Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:

- *medication administration errors*
- *poor record keeping*
- *failings in a discrete and easily identifiable area of clinical practice*

46. The NMC submits that Mrs Dani's lack of competence could be remediated through training and supervision. The concerns are of the nature described in its guidance and relate to discrete and easily identifiable areas of clinical practice.

47. Subsequent to the NMC's investigation, Mrs Dani accepted the concerns and between 03 January 2023 and 15 January 2024 was subject to undertakings imposed by the Case Examiners. In an undated reflective piece provided on 04 March 2022 through her representatives, the Royal College of Nursing, Mrs Dani wrote:
'One should always offer high standards or the best possible attention by giving the person the service that you would like to receive. My motto in life is to " to do to others as you would like them to do to you ", and this I also extend to my care.

What happened in November 2019, had an enormous impact on my career, my standards, my moral and my mental status, I saw everything flash before my eyes. I have now learnt that wherever you work, no matter how difficult things are, you should not let it encourage you to forfeit your standards and outstepping the standards set within "the NMC Codes of conduct".

I've learnt that no matter what, I patient comes first and I should maintain my belief and trust in "the NMC Codes of conduct" which guides into being a good working nurse and safe standards for my patient.

I have also learnt to stand up and speak for myself more than be quiet. Having an older nursing career is important to me and that learning from my experience can only improve my patient care and team interaction and that I am more mindful of being a nurse and respecting my nursing career.

In view of this, I am looking at short courses to help improve my nursing education, which commence in September 2022. I have also been reading and researching new daily health and medical news, articles and reports, online tests. I deeply regret causing so much stress to you all and this is one mistake I would not want to put my patient or myself through in the future. I am very grateful for your help and time.'

48. However, Mrs Dani has not provided evidence that she e.g., understands the seriousness of the concerns or has reflected to identify factors that may have contributed to her failing to demonstrate competence so that they may be overcome. It is therefore the NMC's position that whilst Mrs Dani has demonstrated some limited insight, it could be developed further.

49. Mrs Dani has engaged minimally with the NMC'S proceedings and there has been no contact since August 2023. She has not provided any evidence of further training as it pertains to the areas of concern, as agreed to by virtue of her acceptance of the undertakings. She has not responded to requests for updates on her employment since she left the employment of the Trust, nor provided evidence of improved practice. The NMC therefore consider that the risk of repetition remains.

50. The NMC submit that there is a continuing risk to the public due to Mrs Dani's lack of full insight and remediation, and the risk of repetition.

Public interest

51. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

> *"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."*

52. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

53. Although the extract outlined above dealt with consideration for impairment by reason of misconduct, the NMC submits the principles are equally applicable to impairment by reason of lack of competence.

54. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which has not been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

55. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to

uphold proper professional standards and conduct or to maintain public confidence in the profession.

56. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. It is submitted that a member of the public would be extremely concerned to hear that an incompetent nurse was allowed to practise without restriction. As such, the need to protect the wider public interest calls for a finding of impairment to uphold standards of the profession, maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession, and the regulator, would be seriously undermined, particularly where there is a risk of repetition, as is present in this case.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments in relation to lack of competence. These included: *Calhaem v GMC* [2007] EWHC 2006 (Admin), *Holton v GMC* [2006] EWHC 2960 (Admin) and the NMC guidance, in relation to Lack of Competence, in particular section FTP-2b. The panel were also referred to Rule 31 (6) 'Rules 2004)

The legal assessor reminded the panel that lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Ms was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

In relation to Impairment, the Legal Assessor referred the panel to the relevant guidance and authorities which included: *Council for Healthcare Regulatory Excellence v (1) NMC* (2) *Grant* [2011] EWHC 927 (Admin; *Cohen v General Medical Council* [2008] EWHC 581 (Admin). The panel were referred to NMC Guidance DMA-1, FTP 15 a b c.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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 advise on, prescribe, supply, 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:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

22 Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

The panel bore in mind, when reaching its decision, that Mrs Dani should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard.

Charge 1 and Charge 2h – Failure to complete triage in a timely manner

The panel determined that Mrs Dani's actions in charge 1 and charge 2h fell below required standards of a Band 5 registered nurse. It noted that there are examples over a sustained period where there were consistent delays in her completing triage. The panel bore in mind the evidence which explained the potential risk to patients. People needed to be seen in the waiting room and as a result of her triage issues there were delays of up to 2.5 hours on occasion. The concerns regarding triage were raised by her employers on more than one occasion between 2018 and 2019. It concluded that Mrs Dani was not practicing effectively because triage should have been a basic skill for Band 5 nurse who had worked in A&E and the Clinical Decision Unit since 2006. The panel determined that this amounts to a lack of competence.

Charge 2a, 2b, 3a, 3b, 3c, 3d, 3e, 3g, 3h – Medication management errors and Controlled Drugs procedure

The panel took the view that Mrs Dani is an experienced Band 5 nurse who had worked in the Emergency Department since 2006 but was not following the set policies and procedures in place to protect patients and staff. It considered that Mrs Dani's actions could have put patients at risk. It took the view the numerous errors she made in respect of medicines management both individually and cumulatively fell below the standards expected of a Band 5 nurse.

Charge 4 – Prescription

The panel determined that a Band 5 nurse who is not a prescriber would not be writing prescriptions, and they would be aware that prescribing is outside their scope of practice. Therefore, Mrs Dani's actions in respect of charge 4 amount to a lack competence.

Charge 5 and Charge 6 – Capabilities

The panel took the view that Mrs Dani had time to complete her capabilities and competencies but did not. It noted that her triage competency should have been a priority, but she failed to complete that even though it was raised, and plans put in place to support her. Although there was slight improvement in her capabilities, it was not sufficient as she could not complete her capability/improvement plans and her informal reviews were superseded by a disciplinary process. The panel concluded that as a Band 5 nurse, she had a responsibility to maintain the knowledge and skills needed for safe and effective practice.

The panel had evidence before it which confirms that Mrs Dani was aware of the competency issues. It considered that her practice did not improve whilst being supported through capability/improvement plans, assessments and reviews. The panel saw further evidence of assessments in October and November 2019 and noted that incidents occurred during that period which resulted in her lack of competency being escalated to a formal disciplinary level following the further incidents. The panel determined that although

Mrs Dani accepted the regulatory concerns, she did not comply with the Undertakings from the NMC Case Examiners.

Taking into account the reasons given for the findings of the facts, the panel has concluded that Mrs Dani's practice was below the standard that one would expect of the average registered nurse acting in Mrs Dani's role.

In all the circumstances, the panel determined that Mrs Dani's performance in all the charges found proved demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mrs Dani's fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d. *...'*

The panel found that the first three limbs of *Grant* are engaged. Whilst no patients were harmed as a result of Mrs Dani's lack of competence, the panel determined that they were put at an unwarranted risk of harm as a consequence of Mrs Dani's ineffective triage and medication administration and management errors. Mrs Dani's lack of competence breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute because she was not working at the standard that would be expected of a registered Band 5 nurse.

The panel took the view that Mrs Dani's conduct can be remediated. The panel determined that Mrs Dani was remorseful in her reviews and during the internal investigation process. However, it found that Mrs Dani demonstrated limited insight as she refers to the incidents as *'one mistake'* in her reflective statement dated 4 March 2022. Although she accepted several of the regulatory concerns, Mrs Dani did not demonstrate an understanding of how her actions put patients at a risk of significant harm and how this impacted negatively on the reputation of the nursing profession. Further, she made no reference to how she would handle the situation differently in the future.

In its consideration of whether Mrs Dani has taken steps to strengthen her practice, the panel noted that her intentions to complete a short course to improve her nursing education was set out in the written submissions from the RCN on her behalf on 4 March 2022. However, the panel has not seen any evidence of further training. It considered that Mrs Dani's capability plan and triage competency book were not completed. The panel further noted that Mrs Dani did not engage or comply with the NMC Undertakings.

In light of the above, the panel determined that Mrs Dani is likely to repeat matters of the kind found proved. The panel therefore 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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, in this case, a finding of impairment on public interest grounds is required. A well-informed member of the public would be concerned if no finding of impairment was made despite the repeated pattern of nursing practice falling below the standards expected of a registered nurse.

Having regard to all of the above, the panel was satisfied that Mrs Dani's fitness to practise is currently impaired.

Sanction

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

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

Representations on sanction

The panel bore in mind the following written submissions provided by the NMC:

> *'57. Taking into account the NMC Sanctions Guidance, the NMC consider the following sanction is proportionate: 18 months conditions of practice order with a review.*
>
> *58. The public interest must be at the forefront of any decision on sanction. The public interest includes protection of members of the public, including patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour within the profession. The public interest in this case lies with maintaining public confidence in the profession and upholding proper professional standards by declaring that Mrs Dani's failure to demonstrate competence was unacceptable.*
>
> *59. Any sanction imposed must do no more than is necessary to meet the public interest and must be balanced against Mrs Dani's right to practise in her chosen career. To achieve this the panel is invited to consider each sanction in ascending order.*

60. In its contemplation the NMC have considered the following aggravating and mitigating factors:

Aggravating factors:

- *Clinical failure across fundamental areas of nursing.*
- *A failure to comply with undertakings.*
- *Failures demonstrated for a prolonged period, despite support and supervision.*
- *A lack of full insight, remorse and remediation.*
- *Placed vulnerable patients at a significant risk of harm.*

Mitigating factors:

- *Acceptance of the concerns.*
- *Initial engagement with the regulator.*

61. With regard to our sanctions guidance the following aspects have led us to this conclusion:

61.1. ***Taking no action:*** *The allegations are too serious to take no further action. To achieve the NMC's overarching objective of public protection, action needs to be taken to secure public trust in nurses and to promote and maintain proper professional standards and conduct and to ensure that Mrs Dani can practise safely*

61.2.A ***caution order*** *is only appropriate for cases at the lower end of the spectrum. This case is not at the lower end of the spectrum because it involves significant concerns relating to basic nursing knowledge.*

61.3. A ***conditions of practice order*** *is the appropriate sanction in this case. The NMC's guidance on conditions of practice orders (SAN-3c) states that a conditions of practice order may be appropriate when factors are present including:*

> *61.3.1. No evidence of harmful deep-seated personality or attitudinal problems;*

61.3.2. Identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining;

61.3.3. Potential willingness to respond positively to retraining;

61.3.4. Patients will not be put in danger either directly or indirectly as a result of the conditions;

61.3.5. The conditions will protect patients during the period they are in force; and

61.3.6. Conditions can be created that can be monitored and assessed.

61.4. In this instance the NMC submits that the facts do not indicate harmful deep-seated personality or attitudinal problems. There are clear and identifiable areas of Mrs Dani's practice which can be addressed by assessment and retraining. Given her acceptance of the undertakings, there is a potential willingness to respond positively to retraining. If conditions are appropriately drafted any public protection concerns can be addressed, and the conditions can be appropriately monitored and assessed.

61.5. Whilst not seeking to bind the panel, the NMC suggests the following conditions:

1. You will ensure that you are supervised while being directly observed by a registered nurse of band 5 or above ('your Supervisor') any time you administer medication. Your supervision otherwise will consist of:

- *Working at all times on the same shift as, but not always directly observed by, a registered nurse of band 5 or above.*

2. You will send your case officer evidence that you have successfully completed an appropriate medication administration competence course. This course should be assessed and evidence presented, confirmed by your Supervisor.

3. You will work with your Supervisor to create a personal development plan (PDP). Your PDP will address your administration of medication and any

wider competencies to include following drug policies, acting within your competence and managing time with patients appropriately/triage management.

You will:

- *Send your case officer a copy of your PDP by the next interim order review hearing.*
- *Meet with your Supervisor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP.*
- *Send your case officer a report from your Supervisor every month. This report will show your progress towards achieving the aims set out in your PDP.*

4. You must keep us informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your case officer your employer's contact details.

5. You must keep us informed about anywhere you are studying by:

a) Telling your case officer within seven days of accepting any course of study.

b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.

b) Any agency you apply to or are registered with for work.

c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

7. You must tell your case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.

b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any current or future employer.

b) Any educational establishment.

c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

*61.6. A **suspension order** would be disproportionate. According to the Guidance (SAN-3d), in cases where the only issue relates to the nurse, midwife or nursing associate's lack of competence, a suspension order should be imposed where there is a risk to patient safety if they were allowed to continue to practise even with conditions. It is submitted that there is no evidence to suggest that if Mrs Dani were to practise with conditions a risk to patient safety would remain. There is no evidence of harmful deep-seated personality or attitudinal problems, and the concerns are not so serious so as to warrant temporary removal from the register.*

*61.7. A **striking-off order** would be inappropriate. The NMC guidance at SAN-3e provides that striking-off orders cannot be used if a registrant's fitness to practise is impaired due to a lack of competence. Furthermore, Article 29(6) of the Nursing and Midwifery Order 2001 provides that a striking-off order may not be made where a registrant has been found impaired by reason of a lack of competence "unless the person concerned has been continuously suspended or subject to a conditions of practice order, for a period of no less than two years immediately preceding the date of the decision of the Committee to make such and order." Mrs Dani has not been subject to a substantive suspension or conditions of practice order for two years.'*

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Clinical failures across fundamental areas of nursing
- A failure to comply with undertakings
- Lack of full insight and remediation
- Placed patients at risk of harm
- Failures demonstrated over a prolonged period of time, despite support and supervision.

The panel also took into account the following mitigating features:

- Acceptance of the concerns
- Initial engagement with the regulator
- Stress in personal life due to the ill health of two family members

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Dani's 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 Mrs Dani's lack

of competence 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 Mrs Dani's 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;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. Whilst the panel found a lack of competence, it determined that there is no evidence of general incompetence. It noted that comment was made about Mrs Dani's good standard of individual care. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Dani should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. It determined that it could maintain patient safety with a conditions of practice order. The panel considered that the identified areas of professional development cannot be addressed if you were not permitted to practice. The panel took the view that imposing a suspension order would be inconsistent with its findings.

The panel was aware that a striking-off order is not an available sanction at this time.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You will ensure that you are supervised while being directly observed by a registered nurse of band 5 or above (‘your supervisor’) any time you administer medication until you have successfully completed an appropriate medication administration competence course, have been deemed to be able to safely manage and administer medication by your supervisor. The course should be assessed, and the evidence presented, confirmed by your supervisor.

2. Your supervision must consist of you working at all times on the same shift as, but not always directly observed by, a registered nurse of band 5 or above.

3. You will work with your supervisor to create a personal development plan (PDP). Your PDP will address your administration of medication and any wider competencies to include following drug policies, acting within your competence and managing time with patients appropriately/triage management.
   You will:

- Send your case officer a copy of your PDP by the next interim order review hearing.

- Meet with your supervisor monthly to discuss your progress towards achieving the aims set out in your PDP.

- Send your case officer a report from your supervisor every month. This report will show your progress towards achieving the aims set out in your PDP.

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

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

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

e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

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

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

The period of this order is for 18 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Dani has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC, including making your future intentions in relation to your nursing career known.
- A reflective statement addressing the regulatory concerns
- Attendance at a future review
- Testimonials and references from any employer or voluntary work
- Evidence of relevant training and continuous professional development

This will be confirmed to Mrs Dani in writing.

Interim order

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

Representations on interim order

The panel took account of the written representations made by the NMC:

> *'62. If a finding is made that Mrs Dani's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *63. If a finding is made that Mrs Dani's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined. In making this order, the panel took account of the impact the order will have on you and is satisfied that this order, for this period, is appropriate and proportionate.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Dani is sent the decision of this hearing in writing.

That concludes this determination.