Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

17-21 October 2022
7-11 November 2022
28 November – 1 December 2022
17 April 2023 – 12 May 2023
9 – 11 and 13 October 2023
6 November 2023
15 November 2023
15 March 2024
24-25 April 2024
1-2 and 8-15 May 2024
2-3 September 2024

Virtual Hearing

Name of registrant:	**Xandra Ann De Leon Samson**
NMC PIN:	14C0035O
Part(s) of the register:	RN1: Adult nurse, level 1 (31 March 2014)
Relevant Location:	London
Type of case:	Misconduct/Lack of Competence/Health
Panel members:	Rachel Forster (Chair, Lay member) Lorraine Wilkinson (Lay member) Pamela Campbell (Registrant member)
Legal Assessor:	Simon Walsh (17– 21 October 2022, 7-11 November 2022, 28 – 1 December 2022, 17 April 2023 – 12 May 2023, 9-11 and 13 October 2023, 6 November 2023, 15 November 2023, 15 March 2024, 10-15 May 2024, 2-3 September 2024) Andrew Granville-Stafford (24-25 April 2024 and 8 – 9 May 2024) Jayne Wheat (1 - 2 May 2024 only)
Hearings Coordinator:	Max Buadi (17 October to 21 October 2022) Dilay Bekteshi (7 November to 11 November 2022, 15 March 2024)

	Opeyemi Lawal (28 November to 1 December 2022 and 17 April 2023 to 25 April 2023, 13 November 2023) Chantel Akintunde (26 April to 12 May 2023) Sophie Cubillo-Barsi (6 November 2023) Leigham Malcolm (24-25 April, 1-2, 8-15 May and 2-3 September 2024)
Nursing and Midwifery Council:	Represented by Ayanna Nelson, Case Presenter instructed by the NMC
Miss Samson:	Present and not represented at the hearing
No case to answer:	**Hammersmith Charges** 1(d)(vii), 1(h)(i), 1(j)(iii), 2(c), 3(b), 4(a) and 6(c) **Ealing Charges** 5(a), 5(b), 10(b) (second element), 15(d), 17, 18 and 19 (first element of schedule 1)
Facts proved:	**Hammersmith charges** 1a), 1b), 1c) ii), 1c) iii), 1c) iv), 1d) i), 1d) ii), 1d) iii), 1d) iv), 1d) v), 1d) vi), 1e) i), 1e) ii), 1e) iii), 1e) iv), 1e) v), 1e) vi), 1e) viii) (first limb only), 1f), 1g), 1j) i), 1j) ii), 2a) i), 2a) ii), 2a) iii), 3a), 3c), 3d), 3e), 3f) ii), 3g), 3h), 3i), 4b), 4c), 4d), 4e), 4f), 4g), 4h), 4i) i), 4i) iii),4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii), 6a), 6b), 6d), 6e), 6f), **Ealing charges** 1), 2), 3a), 3b), 3c), 4a), 4b), 6a), 6b), 7), 8), 9), 10a), 10(b) (first element), 11), 12a), 12b), 13), 14), 15a), 15b), 15c), 16a), 16b), 19)
Facts not proved:	**Hammersmith charges** 1c) i), 1e) vii), 1e) viii) (second limb only), 1e) ix), 1h) ii), 1i), 1j) iv), 2b), 3f) i), 4i) ii) **Ealing charges** N/A
Fitness to practise:	Impaired (on the grounds of misconduct and your health)
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

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

At the outset of the hearing Ms Nelson, on behalf of the Nursing and Midwifery Council (NMC) reminded the panel that some of the charges relate to health matters. She submitted that these matters do not appear to be linked with the factual context of this case. However, she submitted that if the facts are found, then this case could effectively become a health case.

Ms Nelson also submitted that on the face of it, there were health matters that were not linked to the factual context, but that there may be an underlying health issue in which case, this could become a health case and need to be heard entirely in private.

Ms Nelson submitted that it may become impractical to change the hearing from public to private session as and when these issues arise.

In light of the above, Ms Nelson invited the panel to hold the entirety of this hearing in private. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You said that the case should be held in public as you do not foresee any health matters arising in this case that may be an issue.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(2) provides that a hearing that relates solely to a registrant's physical or mental health must be conducted in private, Rule 19(3) states that the panel may hold hearings partly or wholly in private only if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel rejected the application. The panel bore in mind that most of the charges in this case do not relate to health matters. It also bore in mind that at this stage of the hearing, matters relating to your health have only been inferred. The panel has not been presented with evidence to suggest that matters relating to your health are a factor in this case.

In light of the above, the panel was of the view that at this stage of the hearing Rule 19(3) is not yet engaged. The panel was of the view that if and when there is proper and sufficient evidence (usually in the form of an expert medical opinion) to suggest that a matter relating to your health is relevant to these proceedings, that might be an appropriate time for either party to make a further application under this rule.

Decision and reasons on application to postpone hearing

You provided the panel with written representations to support your application to postpone this hearing which the panel have read. It stated:

> *'1. I, Xandra Ann De Leon Samson, NMC Registrant, of an address known to the NMC would say as follows:*
>
> *2. I would like to request the panel to consider an adjournment of the fitness to practice hearing in relation to the NMC referral made by Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust.*
>
> *2. This is for the following reasons:*
>
> *3. I have not had sufficient time to review the hearing bundles and witness statements, and to prepare for the cross examination of witnesses.*
>
> *4. Providing sufficient time to review the evidence is just and equitable in this case.*
>
> *5. Based on my preliminary review of the hearing bundle, there were evidence submitted to the Trust that were not included such as the Chronology of Events I submitted along with the Appeal to ICHNT as well as the Minutes of the Meeting I submitted for an informal performance management meeting. I am concerned that there may be other relevant documents that was submitted to the Trusts to help with my case that was not included in the bundles and this will require a*

thorough review to identify these, which I could not do with the limited time I had to prepare for the hearing.

6. There were also a lot of inconsistencies and inaccuracies in the witness statements that I have to challenge and this requires a significant amount of preparation time.

7. The first bundle was initially sent to me in December 2021. During that time, the city where I now live was hit by a super typhoon causing severe devastation. In the aftermath of this calamity, we lost electricity and internet for 3 months. It was only fully restored mid March 2022 and I had to request the case manager to resend the bundle to me then. I was only sent the draft bundle for the first case at that time.

8. I was unable to look into the bundle right away as my focus at that time was to gather evidence of continuing professional development in order to show that I have strengthened my practice to address the learning opportunities in the allegations.

9. Two months later, we had a huge fire situation in our neighbourhood, which caused damage to our home. I had to postpone the work I am doing for this case until we were able to fix the damage and settle down.

10. I spent the months of July and August 2022 gathering all my evidence of training and the reflective accounts I have written addressing the allegations.

11. [PRIVATE]

12. I have only just started looking into the bundles in mid September. Only then did I realise that this will require a significant amount of work and time.

13. I am unrepresented and does not receive support from any legal professional. Therefore, I lack the experience required to be able to make an informed appraisal of the work involved in preparing for this case.

14. Also, it would take me a longer preparation time to put together my case as opposed to a legal professional.

15. Two of the hearing bundles were only sent to me last Friday 14 October 2022. I had not had a chance to look into this with the very limited time I have. I have been occupied with preparing my questions for the cross-examination over the weekend, which I have only managed to finish for a few of the witnesses.

16. It is also difficult for me to go through the evidence and the witness statements as I have found this to be stressful and upsetting so I had to take a break from time to time.

17. [PRIVATE].

18. [PRIVATE].

19. It is also unfortunate that one of the files I was preparing for the cross-examination of witnesses got corrupted yesterday and it took me a significant amount of time to restore this. This has kept me from finishing the preparation I had to make for the cross-examination of witnesses.

20. In view of the above circumstances, I seek that the panel consider an adjournment of the hearing with a view to reconvene in 3 to 6 months time.

21. I look forward to a favourable decision on this request.'

[PRIVATE].

You also told the panel that you received the hearing bundles on Friday 14 October 2022, and this was insufficient time to read and absorb them in depth.

You also said that you have only prepared cross-examination for 10 witnesses and you need more time.

Ms Nelson opposed your application. Nevertheless, she submitted that the NMC has a considerable degree of sympathy with you regarding the issues you have had to deal with in the past year.

However, Ms Nelson submitted that it would be in the public interest for this matter to be dealt with expeditiously. She submitted that the oldest charges relate to matters in June 2017 which is in excess of five years ago. She submitted that the memories of witnesses fade during this time. She also submitted that most of the NMC witnesses provided their witness statements two to three years ago.

Ms Nelson also submitted that there are 23 witnesses who have been informed of this hearing and 14 are due to give evidence this week. She submitted that they would have made personal and professional alterations to accommodate this hearing. As a result, postponing this hearing would cause them considerable inconvenience.

Ms Nelson submitted that there are 23 witnesses and this poses logistical difficulties in terms of ensuring they are all available at a particular time.

[PRIVATE].

Ms Nelson submitted that it would not be necessary for the hearing to be postponed at this stage.

In response to panel questions, Ms Nelson informed the panel that you were sent the draft NMC bundles in March 2022 and these were the same as those sent to you on Friday 14 October 2022 except they included an index and with different pagination.

The panel heard and accepted the advice of the legal assessor who referred it to Rule 32(4) as follows:

> *'32 (4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to-*
> *(a) the public interest in the expeditious disposal of the case;*
> *(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and*
> *(c) fairness to the registrant.'*

You made further submissions following the advice of the legal assessor.

Regarding the public interest in the expeditious disposal of this case, you said that postponing would not make much difference on the ability of witnesses to recall events. You said that the events happened some time ago and the witnesses will most likely rely on the statements they have submitted to help them recall what has happened.

Regarding public protection, you informed the panel that an interim suspension order is currently in place.

Regarding potential inconvenience to the witnesses, you said that as this hearing is being conducted virtually, the witnesses can be informed well in advance of the date of the next hearing. You said that the postponement may allow them to make better preparations for this hearing. You also informed the panel of a case conference relating to this hearing that occurred in September 2022.

Regarding fairness, you said that it is essential that you are given sufficient preparation time for this hearing. You said that the impact of injustice if you are not given enough preparation time outweighs the inconvenience to the witnesses of the other party. You said that the potential impact of a negative outcome affecting your ability to practise as a nurse is more severe than the inconvenience of rescheduling.

[PRIVATE].

You said that you understand that you should have raised the need for more preparation time at that case conference. You said that you are not represented and you are not receiving any support from a legal professional. You said that you would like the panel to take into consideration that you lack the experience to have made an informed appraisal at that time regarding the amount of time you would need to prepare the case.

In reaching its decision, the panel has considered the submissions from Ms Nelson and your written and oral representations. The panel had particular regard to the relevant Rules, the NMC guidance, entitled “When we postpone or adjourn hearings”, and to the overall interests of justice and fairness to all parties.

The panel noted that the charges are serious and was satisfied that there is a strong public interest in the expeditious disposal of this case.

With regards to potential inconvenience, the panel also bore in mind that the witnesses are all professional healthcare staff. It was of the view that not proceeding today may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services.

The panel then moved onto the issue of fairness to you. It carefully considered the written representations you presented to the panel and the oral representation you made.

The panel noted that you stated there is documentation that you had previously submitted to the Trust that may not be currently included in the bundles and that you would need more time to check this. However, the panel was of the view that this would not take very long to verify.

The panel bore in mind that you could have addressed this at the case management conference in September 2022 but these issues were not brought up at that time. The

panel also bore in mind that this hearing is listed for 15 days. It is listed from 17 to 21 October 2022, 7 to 11 November 2022 and 28 November 2022 to 2 December 2022. As the 15 days allocated are not consecutive, the panel was of the view that you will have sufficient time between the hearing dates to make an application for any documentation you believe the panel needs to see at a later stage.

The panel was not satisfied that lack of documentation was a sufficient reason to postpone the hearing.

The panel noted that you have stated that you need more time to prepare for witnesses as you have currently only prepared questions for 10 of the witnesses.

Whilst the panel noted that it takes time to prepare to cross-examine witnesses, especially for a non-represented Registrant, the panel noted that you have had sight of the draft bundles, which have not materially changed in the final bundle version, for this case since March 2022 and have therefore had over six months to prepare your case.

Additionally, as mentioned above, the panel noted that due to the fact that the hearing is not listed for 15 days consecutively, you will have extra time in between the hearing dates to prepare for the additional witnesses.

The panel was not satisfied that lack of preparation time for cross examination was a sufficient reason to postpone the hearing.

The panel noted that you received the bundle in March 2022. The panel is aware that attending a hearing can be a difficult process and the preparation can seem daunting. However, it was of the view that you have had sufficient time to prepare for this hearing. It also considered that due to the hearing being not being listed for 15 days consecutive days, you will have sufficient time between hearing dates to prepare further.

The panel was not satisfied that lack of preparation time was a sufficient reason to postpone the hearing.

The panel also took account of the fact that there have been several challenging matters outside of your control that have disrupted your preparation for this hearing.

The panel sympathises with the difficulties you have experienced. However, it was of the view that you have nevertheless had sufficient time to prepare for this hearing and will have additional time to further prepare for this hearing going forward.

[PRIVATE].

The panel was not satisfied that awaiting a [PRIVATE] was a sufficient reason to postpone the entirety of the hearing.

[PRIVATE].

The panel understands that the process can be daunting. It noted that while you are not represented, the panel is experienced in dealing with registrants who are not represented and will ensure that you have a fair hearing.

The panel was not satisfied that in these circumstances [PRIVATE] was a sufficient reason to postpone the hearing.

In light of the above, the panel determined to proceed with the hearing.

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Nelson to amend the wording of charges, pertaining to Hammersmith Hospital, 1a), 1b), 1c) ii, 1e) vi, 1e) vii), 1g), 1h), 1i), 2a) i, 3g), 4h).

Ms Nelson submitted that the proposed amendment for charge 1a) was to clarify the nature of the allegation. She submitted that based on the stem of the charge, the allegation is that you failed to do something and adding the word ‘not’ does not manifestly change the charge or cause you any injustice.

With regards to charge 2a) i, Ms Nelson submitted that proposed amendment provides clarity on what is actually alleged.

Ms Nelson submitted that the proposed amendment for charges 1b), 1c) ii, 1e) vi, 1e) vii), 1g), 1h), 1i), 3g) and 4h) were to correct typographical errors and made the charges more workable.

Proposed amendments

1) *Failed to provide appropriate care to one, or more, patients, in that you:*

   a) *Did **not** undertake and/or timeously undertake, the admission of one, or more, patient(s) on 7 June 2017;*
   b) *Did not provide a~~n~~ handover in relation to your patient(s) when going on a break on 8 August 2017;*
   c) *In relation to Patient B on 11 August 2017:*
      ii) *did not ensure such a~~n~~ handover was undertaken timeously;*
   e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
      vi) *Did not comply with an ~~Aespetic~~ **Aseptic** Non- Touch Technique ('ANTT') when inserting a vascular access device;*
      vii) *Did not notice that Patient R was on Glyceryl Trinitrate *'GTN' ~~i~~infusion intravenously;*
   d) *Did not restart and/or handover that you had not restarted, Patient D's ~~Frusemide~~ **Furosemide** infusion on 20 November 2017;*
   h) *Did not clean the sluice/bedpan ~~for~~ during the nightshift of 5/6 January 2018 for:*
   i) *Did not undertake an~~d~~ ECG in a timely manner on 2 March 2018*

2) *Failed to keep clear and accurate records and/or document observation in that you:*
   a) *On 11 August 2017, and in relation Patient B:*

*i) Made ~~non contemporaneous~~ **retrospective** records and~~/or~~ did not record such records as having been made retrospectively;*

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

*g) On 20 November 2017, inserted **a** new cannula for Patient E when it was not necessary to do so/clinically required;*

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

*h) Did not follow instructions ~~I~~ **in** respect of moving Patient A to Ward C8 on 02 March 2018;*

Regarding the charges relating to Ealing Hospital, the panel heard an application made by Ms Nelson to amend the wording of charge 12b). She submitted that the proposed amendment was to correct a typographical error and made the charge more workable.

12) In relation to the administration of S/C Insulin Lantus to a patient on, or around 16 February 2019, failed to:

b) retrospectively sign~~ed~~ for the administration on 18 February 2019;

Ms Nelson submitted that she believes that there are no objections to these amendments. She submitted that the amendments have been discussed with you and there is no prejudice against you.

You told the panel that you are content with the proposed amendments.

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

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

The panel noted that the proposed amendment to these charges were not disputed. It therefore determined to allow the amendments.

Details of charge (as amended)

That you, a Registered Nurse, whilst working at the Hammersmith Hospital between 1 February 2016 and 8 May 2018:

1) *Failed to provide appropriate care to one, or more, patients, in that you:*

   a) *Did not undertake and/or timeously undertake, the admission of one, or more, patient(s) on 7 June 2017;*
   b) *Did not provide a handover in relation to your patient(s) when going on a break on 9 August 2017;*
   c) *In relation to Patient B on 11 August 2017:*
      i. *inadequately completed/undertook a handover;*
      ii. *did not ensure such a handover was undertaken timeously;*
      iii. *did not ensure that Patient B had a diabetes referral/review;*
      iv. *did not recognise that a catheter insertions record was not in place;*

   d) *Did not provide care to all patients during your shift on 21 September 2017 in that you:*
      i. *Did not participate in a ward round relating to Patient L;*
      ii. *Told Patient L that they did not need to return to the hospital for a blood test, contrary to the advice given by a doctor;*
      iii. *Did not carry out one, or more, patient safety checks;*
      iv. *Did not participate in the ward round(s);*
      v. *Did not communicate with the doctor and/or nurse in charge following the ward round(s);*
      vi. *Told Patient M that they would be prescribed blood thinner medication, without first consulting a doctor;*
      vii. *Failed to undertake and/or record one, or more, sets of clinical observations;*

e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   i. *Had to be prompted to assist Patient N, who was exposed, in covering up;*
   ii. *Did not recognise and/or assist Patient N, who was attempting to mobilise;*
   iii. *Did not reconnect Patient N's infusion pump which was 'alarming';*
   iv. *Did not tell a patient who was nil by mouth ('NBM') that they could not eat;*
   v. *Did not answer the HAC telephone on one, or more, occasion;*
   vi. *Did not comply with an Aseptic Non-Touch Technique ('ANTT') when inserting a vascular access device;*
   vii. *Did not notice that Patient R was on Glyceryl Trinitrate *'GTN' infusion intravenously;*
   viii. *Did not prioritise and/or take Patient R's blood pressure;*
   ix. *Did not manage one, or more, monitor alarms;*

f) *Incorrectly, discharged Patient C on 20 November 2017;*
g) *Did not restart and/or handover that you had not restarted, Patient D's Furosemide infusion on 20 November 2017;*
h) *Did not clean the sluice/bedpan during the nightshift of 5/6 January 2018 for:*
   i. *Patient H;*
   ii. *One, or more, unknown patient(s);*
i) *Did not undertake an ECG in a timely manner on 2 March 2018;*
j) *Did not assist in providing emergency care/support to one, or more, patient(s) on:*
   i. *19 March 2017;*
   ii. *8 August 2017 at around 17:15;*
   iii. *5/6 January 2018;*
   iv. *One, or more, unknown dates;*

2) *Failed to keep clear and accurate records and/or document observation in that you:*
   a) *On 11 August 2017, and in relation Patient B:*
      i. *Made retrospective records and did not record such records as having been made retrospectively;*
      ii. *Did not contemporaneously record Patient B;'s observations;*

iii. *Did not ensure that a catheter insertion record was in place;*

b) *On 9 October 2017, did not document the care provided to Patient R;*
c) *On 9 October 2017, did not record neurovascular observations for two patients who were post-angiogram;*

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*

a) *On 26 June 2017, did not administer two pairs of IV Pabrinex to Patient U;*
b) *On 26 June 2017, did not adequately administer medication to an unknown patient and/or failed to complete a DATIX report;*
c) *On 14 August 2017, incorrectly administered Amoxcillin / medication to Patient S;*
d) *On 21 August 2017, refused to administer and/or permit a colleague to administer Haloperidol to Patient K;*
e) *On or around 28 August 2017, did not administer medication to Patient I;*
f) *On 9 October 2017:*
   i. *Failed to check Patient O's blood glucose level when asked to do so;*
   ii. *Went to give diabetic medication to Patient O without first checking their blood glucose level;*
g) *On 20 November 2017, inserted a new cannula for Patient E when it was not necessary to do so/clinically required;*
h) *On 20 November 2017, did not ensure that Patient F was correctly discharged with their medication and/or that such discharge was recorded;*
i) *On 26 December 2017, incorrectly administered immediate release oxycodone to Patient G;*

4) *Failed to follow instruction from senior members of staff and/or colleagues in that you:*
a) *Acted as the Nurse in Charge on 19 March 2017;*
b) *In or around July 2017. did not assist with the morning wash for one of your allocated patients;*
c) *Did not administer medication to Patient B on 11 August 2017;*

d) *On 9 September 2017, refused to follow a request to assist the Nurse in Charge in answering the telephone;*
e) *Did not remove Patient H's catheter on 21 January 2018 and/or handed over that the catheter should not be removed;*
f) *Did not take breaks as assigned by the NIC on 20 February 2018;*
g) *Did not follow instructions relating to the provision of care to Patient P on 2 March 2018;*
h) *Did not follow instructions in respect of moving Patient A to Ward C8 on 02 March 2018;*
i) *Did not move Wards when instructed to do so on:*
    i. *31 March 2017;*
    ii. *29 August 2017;*
    iii. *13 October 2017;*
    iv. *25 December 2017;*
    v. *26 December 2017;*
    vi. *27 January 2018;*
    vii. *or around 22 February 2018;*
    viii. *23 March 2018;*

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

FURTHER or ALTERNATIVELY, you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as Band 5 Staff Nurse between 1 February 2016 and 8 May 2018 as follows:

5) *In relation to any and/or all matters set out at charge 1- 4 above;*

6) *By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas:*
    a) *Oral medication management;*
    b) *IV medication management and administration;*
    c) *Time management of self and patient case load;*

d) *Delivery of basic nursing care without help or supervision;*
e) *General attitude to managers and work colleagues;*
f) *To be able to follow reasonable requests from shift leaders and managers;*

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

That you, a Registered Nurse whilst working for the North West University healthcare Trust ('the Trust'):

1) *On 12 December 2018, banged your nursing documentation around and/or kicked furniture at work;*

2) *On 16 December 2018, failed and/or refused to administer a treatment dose of Tinzaparin to a newly admitted patient with a Pulmonary Embolism;*

3) *On 20 December 2018:*
   a) *clarified information at handover directly from one, or more patient(s), instead of from nurses/colleagues;*
   b) *inappropriately challenged a colleague regarding the administration of lorazepam medication to a patient;*
   c) *inappropriately challenged a colleague regarding a patient discharge;*

4) *On 13 January 2019, failed and/or refused to administer Rivaroxaban to a patient with new Atrial Flutter:*
   a) *timeously;*
   b) *as initially instructed;*

5) *On 23 January 2019, failed to administer:*
   a) *Paracetamol to a patient at the correct prescribed time of 12:00;*
   b) *Clenil Modulite Inhaler to a patient at 08:00 and/or at all;*

6) *Failed and/or refused to administer Celecoxib to a patient with T10 fracture and metastatic cancer:*
   a) *on 25 January 2019;*
   b) *on 27 January 2019;*

7) *On 3 February 2019, failed to attend to/assist with a patient with who had a high risk of falls;*

8) *On 10 February 2019, failed and/or refused to administer IV Co-Amoxiclav to a patient admitted with delirium secondary to UTI;*

9) *On 13 February 2019, failed and/or refused to administer Sando K on one, or more, occasions to a patient admitted to the Acute Medical Unit with hypokalaemia;*

10) *On 16 February 2019 administered IV Tazocin to a patient:*
   a) *without ensuring that the dose and/or route was second checked before administration;*
   b) *when not trained and/or authorised to do so by the Trust;*

11) *On 16 February 2019, failed to administer and/or sign for the administration of Lantus solostar to a patient;*

12) *In relation to the administration of S/C Insulin Lantus to a patient on, or around, 16 February 2019:*
   a) *failed to sign timeously for the administration;*
   b) *on 18 February 2019, retrospectively signed for the administration;*

13) *On 18 February 2019, shouted at a colleague during a handover;*

14) *On one, or more, occasion, used your own self- made handover sheet;*

15) *On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including:*

a) *Arguing with nursing and medical staff;*
b) *Challenging medical/patient decisions;*
c) *Refusing to assist colleagues on the Ward;*
d) *Refusing to discharge patients;*

16) On one, or more, occasion, failed to preserve patient safety:

a) *Failing to transfer patients in a timely manner;*
b) *Failing to complete documentation in a timely manner;*

17) [PRIVATE].

18) [PRIVATE].

19) [PRIVATE].

AND in light of the above, your fitness to practise is impaired by reason of your misconduct in relation to charges 1, 17 and 18; by reason of your misconduct and/or lack of competence in relation to charges 2-16 inclusive; and by reason of [PRIVATE] in relation to charge 19.

Schedule 1 (private)

[PRIVATE].

Decision and reasons on application for an alternative time arrangement

Ms Nelson informed the panel that you were intending to make an application in respect of the proposed timings of the hearing. She reminded the panel that you reside in the Philippines and the time difference is seven hours post British Summer Time (BST). She submitted that when the United Kingdom returns to Greenwich Mean Time the time difference will be eight hours.

Ms Nelson submitted that if the hearing were to conclude at 17:30, it would take you into the very early hours of the morning and this would not be appropriate in the

circumstances. She submitted that your request is that the hearing starts at 08:30 BST and finish at 15:30 BST.

Ms Nelson submitted that she does not object to this application but it is a matter for the panel.

You said that you have nothing to add to Ms Nelson's submissions.

In light of the submissions from you and the NMC, the panel decided to accept the proposed timings.

Background

The NMC received referrals about your fitness to practise regarding concerns about your conduct. The concerns arose whilst you were employed as a Band 5 nurse at Hammersmith Hospital and later at Ealing Hospital, the latter of which is part of North West University Healthcare Trust.

You have been a registered nurse since 2014 and began working on the Heart Assessment Centre (HAC) at Hammersmith on 1 February 2016. The HAC was an initial assessment ward for patients arriving at the hospital with cardiothoracic complaints. It was also a first port of call for emergency patients brought in by ambulance.

Hammersmith Hospital had a further four wards within the cardiac directorate, and whilst you were principally contracted to work on the HAC, on occasion nurses would be asked to work a shift on another of the cardiac wards, to counter staffing issues.

It is alleged that you repeatedly refused to work on ward A7 when instructed by senior staff. It is further alleged that, overall, senior staff at Hammersmith Hospital found your behaviour challenging. In addition to your alleged refusal to change wards, it is alleged that you seemed to work with an independence that was felt not to be conducive to the smooth running of a hospital ward.

Senior staff and colleagues alleged that you would not participate in ward rounds or perform appropriate handovers to staff. It was alleged that on a number of occasions you failed to assist your colleagues when emergency patients were brought onto the ward, which would ordinarily require ‘all hands-on deck’. It was also alleged that you were often found to be ‘hiding’ or occupying herself elsewhere in an effort to avoid assisting with the emergency.

Concerns were also raised over your record keeping and medication administration. Further, there were allegations of attitudinal issues with regards to failures to provide appropriate care to patients, failures to respond to reasonable requests from colleagues, and an increasing tendency to act autonomously in the issuance of medical advice.

It was alleged that on a number of occasions you refused to administer medication to patients on the basis that you did not consider it to be clinically indicated. It was also alleged that you refused to remove a patient’s catheter, despite being asked to do so by two doctors and two senior nurses. It was further alleged that you overruled a doctor’s instruction to a patient to return to the hospital for a blood test by telling the patient they could instead attend their GP for the test. The harm in that case would be that the consequential delay could have had a significant impact on the patient’s health.

In response to the concerns, the Trust implemented a series of performance management initiatives to address the issues, first on an informal basis, but due to your alleged reluctance to engage with the programme, a formal management plan was imposed in October 2017.

You left your position at Hammersmith Hospital in May 2018 and went on to work at Ealing Hospital in October 2018. You started on the Acute Medical Unit in November as a Band 5 nurse.

It was alleged that within weeks, senior staff were noting issues with your performance that were not dissimilar to those experienced at Hammersmith Hospital. By January

2019, concerns about you were being raised on almost every shift. These alleged concerns related to your refusal to issue medication to patients or your repeated challenges of medical staff concerning the prescribing of medication. It was alleged that you frequently worked outside the scope of your practice, by inappropriately challenging clinical decision making, even after the rationale had been explained to you by senior doctors. It was also noted that you had created your own record keeping system, taking overly detailed notes which would result in you repeatedly leaving work hours after your shift had finished.

[PRIVATE]. Senior staff recall that on one occasion you had allegedly refused to perform a handover, citing an electromagnetic force on the ward.

In April 2019 you were the subject of a medical suspension. Your managers were informed of this by the Deputy Chief Nurse at the North West University Healthcare Trust.

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Nelson to amend the wording of charges, pertaining to Hammersmith Hospital, namely 1b) and the header prior to charge 5.

With regards to charge 1b), Ms Nelson reminded the panel that during Ms 1's oral evidence, Ms 1 stated that it was her belief that the incident described in charge 1b occurred on 9 August 2017. Ms Nelson submitted that you and Ms 1 are both of the belief that the incident described in Ms 1's witness statement and exhibits relates to the same incident on 9 August 2017.

In light of this, the proposed amendment was to change the date in the charge to '9 August 2017'. Ms Nelson submitted that you do not object to this amendment.

You said that you agreed with the proposed amendment.

Ms Nelson then informed the panel of discussions had between herself, the legal assessor and yourself. She said that the legal assessor had raised concerns about the wording of the charge. Subject to the panel's approval, it was agreed that a proposed amendment would be to add 'Further or' to the beginning of the header.

Ms Nelson submitted that the proposed amendment does not have any impact on the nature of the charge. She submitted that it clarifies the route by which the panel could make any subsequent findings on impairment. She also submitted that you had no objection to this amendment.

You confirmed that you had no objection to this amendment.

Proposed amendments

1) *Failed to provide appropriate care to one, or more, patients, in that you:*
   b) *Did not provide a handover in relation to your patient(s) when going on a break on ~~8~~ **9** August 2017;*

   ***FURTHER or** ALTERNATIVELY, your fitness to practise is impaired by reason of your lack of competence in that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as Band 5 Staff Nurse between 1 February 2016 and 8 May 2018 as follows:*

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

With regards to charge 1b), the panel bore in mind that Ms 1 had stated that the incident described in charge 1b occurred on 9 August 2017. It also noted that you also appear to have accepted that this was the date of the incident and did not object to the proposed amendment.

In light of this, the panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment.

With regards to the header prior to charge 5, the panel also noted that this proposed amendment was not disputed.

The panel therefore determined to allow the amendment.

Resuming 28 November 2022

Decision and reasons on application to adjourn hearing

At the outset of the resumption of this hearing, you made an application to adjourn the hearing and provided the panel with the following written submissions:

> *'I would like to request the panel to consider an adjournment of the fitness to practice hearing in relation to the NMC referral made by Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust.*
>
> *This is for the following reasons:*
> *I have now briefly reviewed the Registrant Bundle and note that this is not complete and does not sufficiently represent the submissions I have made in the course of this proceeding.*
>
> *The Registrant Bundle was only sent to me on the second week of the substantive hearing. I have received it on 08 November 2022. This was during the middle of the cross-examination of the NMC's witnesses for the first referral by Hammersmith Hospital.*
>
> *I have checked this at the earliest opportunity after the second week of cross-examination and I note the following issues:*

The first 50 pages of the 630 pages Registrant Bundle was composed of duplications of a few emails exchanged between me and the NMC regarding the second charge.

The documents are not arranged in chronological order. The first set of documents sent to the NMC by my then RCN Solicitor Eve Horren was not included in the first 50 pages of the bundle. I note that this was not included in the bundle at all.

Unlike the NMC's Exhibit Bundle, the Registrant Bundle is not indexed and paginated. This would make it difficult to refer to any relevant document in the bundle when I am presenting my case. This would mean that I cannot refer to the documents as exhibits.

On 16 November 2022, I reached out to the NMC Case Manager Mr. Mark Austin to raise the above concerns regarding the Registrant Bundle and I was told that the task of indexing and paginating the bundles would now fall on me. As in any legal proceeding, the task of preparing the bundles lies on the party that is legally represented as they would have the necessary tools. I do not have the capacity to index and paginate the Registrant Bundle in the same manner that the NMC Exhibit Bundle has been presented.

I also note that the bundle remains incomplete as there are several documents missing including the most recent ones I have sent. Some of the missing documents were the ones included in the following emails: - Exhibit 1A: Evidence of CPD for NMC Case Ref. # 06270_2018 & 071916_2019 Part 1 sent on 05 September 2022 - Exhibit 1B: Evidence of CPD for NMC Case Ref. # 06270_2018 & 071916_2019 Part 2 sent on 05 September 2022 - Exhibit 2: Reflective Evidence of Xandra Ann D. Samson for NMC Case Ref. # 067270_2018 and 071916_2019 sent on 25 September 2022 - Exhibit 3: Email from RCN Solicitor Leigh Nagler with a list of documents sent to the NMC for the First Referral

The said documents would illustrate how I have strengthened my practice throughout this process. Therefore, it is important that these are included in the Registrant Bundle.

I find the above issues problematic and may significantly undermine my defence. It would be difficult for me to present my case with the Registrant Bundle in its current state.

It is important that I am satisfied that the Registrant Bundle prepared by the NMC sufficiently exemplifies my defence in the interest of fairness. It is also important that the Registrant Bundle is sufficiently prepared in a manner that would assist the panel in their adjudication. Hence, I am seeking that a new bundle is produced by the NMC that is complete with all the documents and correspondences I have sent to the NMC, in chronological order, indexed and paginated as the NMC Exhibit Bundles, and without duplications.

This would require that ample time is given for a new bundle to be produced and I also seek that I am given enough time to review the new bundle and to request the NMC to make any necessary modifications should there be any further issues identified.

I seek that the panel consider the NMC guidance regarding the status quo on what amount of time is provided by the NMC to the Registrant to review the bundles of documents before the hearing. It would only be fair that I am afforded the same amount of time.

May I also remind the panel that the issue with the Registrant Bundle has been presented to you at the early outset of this hearing and it has been previously planned that the witnesses for the second case from Ealing Hospital will be heard before I present my case to give time for the Registrant Bundle to be remade, reviewed, and agreed upon as sufficient.

I also seek that the panel consider that I am a litigant-in-person and it may take me a longer time to review the documents than a legally qualified person. I may also need to obtain some legal advice. I seek that the legal assessor provide some guidance on this matter as it is my view that the law in the UK would be more considerate in favour of the litigant-in-person on these terms.

In view of the above circumstances, I seek that the panel consider that the hearing is adjourned after the cross-examination of the witnesses from Hammersmith Hospital and a new schedule is set upon the production of a satisfactory Registrant Bundle, which is likely at a suitable time in the first quarter of 2023.

I look forward to your favourable decision on this request.'

Ms Nelson opposed the application to adjourn. She submitted that the missing documents that were noted in your submissions were included in the first bundle that had previously been created and provided to the panel. Ms Nelson informed the panel that the second registrant's bundle provided to the panel today contains correspondence between you and the NMC and the exhibits you have attached were included in the first bundle.

Ms Nelson submitted that the fact there is a lack of an index, that documents are not fully in chronological order and that the pages are not paginated, should not prevent you from submitting your defence to the NMC. Ms Nelson submitted that given the documents are provided electronically, it should be easy to direct the panel to relevant pages.

Ms Nelson invited the panel to refuse the application to adjourn the hearing.

The panel heard and accepted advice from the legal assessor who directed the panel to Rule 32(4).

The panel determined that there is a strong public interest in the expeditious disposal of your case, because the matter was originally listed for three weeks but has now been running for two weeks and has not yet reached the conclusion of the NMC case on the first of two referrals that the panel must deal with. The panel has heard from 11 witnesses and from one witness who is part-heard and due to conclude this week. Adjourning this case and continuing much later in 2023 would make it very difficult for the panel at that time fairly to assess the evidence of witnesses who provided a significant amount of detail and who were cross examined over several days in October and November 2022. Equally, the panel determined that it is in your own interests for the matters to proceed whilst your case, as put to the witnesses, is as fresh as possible in the panel's mind.

The panel bore in mind the need for the hearing to be conducted in a way that is fair to you as a litigant in person. The panel noted that you had referred to several documents which you believed had not been included in the Registrant's bundles but which you (or your former legal representative) had sent to the NMC many months prior to the hearing. The panel noted that it is necessary for the Registrant's bundles to contain all the documents that you have submitted. The panel heard that some of the missing documents have already been included in the first bundle of documents submitted to the panel at the commencement of this hearing. However, the panel also noted that as the missing documents are in your possession, it would be possible for any that are still missing to be sent by you again to the NMC for inclusion in the bundles before the panel. The panel considered that this should not delay matters further.

The panel concluded that the issues raised by you can be easily overcome and will not necessitate an adjournment in order to be resolved. The panel further noted that the documents have been supplied in electronic format and therefore the bundles before the panel do have page numbers to which you can refer.

The panel took into account that fact that you wish to have further time to review your bundles but recognised that as you are the supplier of the documents to the NMC, that you would be well aware of the contents of your bundles. In view of the delay in hearing

evidence from the last remaining witness this week, there will be time before you give your evidence for you to review the bundles again in any event.

The panel took the view that by continuing the hearing you will not be prejudiced. It therefore refused your application for an adjournment.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Nelson under Rule 31 to allow the witness statements of Ms 6, Ms 4, Ms 5, Mr 1 and Ms 3 to stand as their evidence in chief. In preparation for the hearing, the NMC had indicated to you that all of the witnesses were expected to attend to provide oral evidence.

Ms Nelson said that despite the NMC having made sufficient efforts to try to ensure that each witness was present, they were no longer able to attend for various reasons. However, you had been informed prior to the hearing resuming for the third week that the above witnesses would not be attending, and that the NMC would seek to adduce their evidence by way of hearsay.

Ms Nelson submitted that the panel had to determine if the statements were relevant to the charges and if it would be fair to admit them as hearsay evidence bearing in mind the reason for the absence of the witnesses. The panel would also need to assess whether their evidence was sole and decisive evidence for any specific charge. If so, the panel would also need to consider whether the evidence was demonstrably reliable or capable of challenge in some other way. Even if not sole and decisive, she submitted that the panel should also consider the nature and extent of the registrant's challenge to each piece of evidence when assessing the question of fairness.

Ms Nelson said that all witnesses were notified on 23 September 2022 by email about the dates of the hearing. Not all witnesses immediately confirmed attendance. In respect of each specific witness Ms Nelson made the following submissions:

Ms 6:

Ms 6 replied during the first week of this hearing stating that she could not attend on the day she was warned but could attend on 21 October 2022. Efforts were made to contact her on the morning 21 October, but she did not reply to emails sent and the NMC was unable to reach her by telephone. Since that time there has been no response from her to a number of further emails that were sent, or to telephone calls made. Ms 6 appeared to have declined to engage further with these proceedings.

Her statement relates to charge 1(j)(i) and charge 4(a). Ms 6's evidence is not sole and decisive. There is evidence from other witnesses in relation to both charges.

Ms 4:

Ms 4 made contact with the NMC after she received notice of the hearing. She asked for confirmation of when she would be required to attend. However, she did not attend a Go-To meeting test and since then there has been no further communication from her, despite the NMC making numerous attempts to contact her.

Her statement relates to charge 3(d) and charge 4(i)(vi).

She was the only direct witness of the incident in charge 3(d) but her evidence is not sole and decisive because she contacted Ms 1 during the shift and related her concerns to her. The matter was also raised in a performance management meeting one week later and the record of the meeting was produced by Ms 1. In relation to charge 4(i)(vi) her evidence is also not sole and decisive as three other witnesses spoke about the incident in evidence to the panel.

Ms 5:

The NMC has not been able to make any contact since notice of the hearing was sent. The NMC only has a landline and NHS email contact for her, but no response has been received. As Ms 5 is a Healthcare Assistant, the NMC is not expected to hold up-to date contact information for her.

Ms 5's statement only relates to charge 1(h)(ii) and her evidence is not sole and decisive as two other witnesses speak to this charge.

Mr 1:

The NMC has not been able to establish contact with Mr 1. Upon contacting his place of work, the NMC was told that he no longer works for the Trust and had left the UK to return to Italy. A witness confirmed this. Mr 1's registration with the NMC lapsed on 31 October 2020 and the NMC does not therefore hold up-to date contact information for him.

Mr 1's statement relates to charges 4(c) and 4(h). His evidence is not sole and decisive as other witnesses speak to these charges in considerable detail.

Ms 3:

Ms 3 was in contact with the NMC by email and said she was unavailable in week one of the hearing. She was given the opportunity to reschedule so that she could give her evidence during week two (7 – 11 November 2022). However, she stated that she was on holiday during that week. She had not been canvassed subsequently about her availability to attend as it was not anticipated at that time that the NMC would still be presenting its case into week three.

Ms 3's statement relates to charge 1(j)(iii) and charge 4(i)(vi).

Ms 3 was the only witness to charge 1(j)(iii) on 5/6 January 2018 and therefore her evidence is sole and decisive in respect of this charge, although other witnesses give evidence in respect of the same alleged conduct occurring on 'dates unknown'. The panel had heard evidence from other witnesses in respect of charge 4(i)(vi) and therefore Ms 3's evidence is not sole and decisive in respect of this charge.

Ms Nelson submitted that, in terms of determining the nature of any challenge by you, the panel should note that you have not denied the factual nature of many of the charges but have instead sought to provide justifications as to why the alleged incidents/failures had occurred. Any challenge of these witnesses would likely be in a similar manner to that of the other witnesses, which would not take matters further where the same evidence has already been heard from many other witnesses in this case. There has been no evidence in any of the cross-examination of other witnesses in this matter to suggest that their witness evidence is unreliable. The accuracy of witness accounts has not been challenged by you as your cross examination has focused on the justification of your actions. Many witnesses have said they got on with you but were critical of your practices. The evidence of these witnesses is relevant and the decision on fairness is for the professional judgement of the panel.

Ms Nelson submitted that there will be no prejudice incurred by admitting these statements into evidence and invited the panel to admit all five witness statements as evidence.

You submitted written submissions detailing your reasons as to why you oppose the application.

‘…

2. *I oppose the NMC’s application to adduce the statements made by the following witnesses to this case as hearsay evidence:*

Ms 3
Ms 4
Mr 1
Ms 5
Ms 6

3. *This is for the following reasons:*
   3.1. It is not in the interest of fairness.

3.2. It is important that I am given an opportunity to test their evidence for accuracy and poor context.

3.2.1. There is disputed fact in the evidence supplied by Ms 4. It is disputed that the administration of the medication Haloperidol which is the matter in Charge 3d was appropriate for the circumstances.

3.2.2. It is disputed that Mr 1's account of the incident referred to in Charge 4h gave due consideration to the full context within which I was working.

3.2.3. In terms of Ms 6's witness statement, there is the question on whether she supplied her evidence that was used in support of Charge 1j.i because she was concerned that I did not help with the emergency or whether it was because she thought I could have supported them better if I had more preparation for the nurse-in-charge role. This is not clear in her witness statement, but there are parts that suggest that she provided the statement for learning purposes and better support from the management.

3.2.4. There were indications of indecisiveness in Ms 3's witness evidence in support of Charge 1j.iii as she has stated she had poor recall of the incident and did not notice what was I involved in when the Primary arrived as she was focused with her own task.

3.2.5. Ms 5 gave evidence for the charge in support of Charge 1a.2. It is sought that the panel consider the gravity of this charge in considering the admissibility of this evidence. It can also be noted that she had indicated in her witness statement that she did not mind doing the task and was indifferent to the comment ("Comfort can do it") that was made, which does not support the charge.

3.3. Some of these witnesses were the ones who provided statements to the management at Hammersmith Hospital that were used as evidence to this case, so they can be regarded as the sole and/or main witness of the incidents referred to in the charges.

3.3.1. Ms 3 is the sole witness for Charge 1j.iii. There was no secondary account as she had not complained about this to the management.

3.3.2. Ms 4 is the only witness present when the incident referred to in Charge 3d occurred. Therefore, she is the sole and main witness to this charge. Ms 1 who provided a witness statement on this charge only received secondary account of Ms 4's evidence.

3.3.3. Mr 1 is the only witness present during the first few hours of the incident referred to in Charge 4h. Mr 1 was not the only witness who provided evidence for this charge, but he was the only one present during the initial hours where it was alleged that I had caused a delay in the transfer of a patient.

3.3.4. Ms 6 submitted the email that was used by the management as evidence for Charge 1j.i and Charge 4a. Her narrative can be considered the main evidence to these charges.

3.4. The witnesses' lack of participation in this proceeding may indicate they were only obliged to provide statements in support of this NMC case. Their lack of engagement in this process could indicate a lack of willingness.

3.5. Four of these witnesses are NMC registrants. It is a lame excuse that these Registrants cannot be contacted because NMC registrants have an obligation to provide the NMC with current and up-to-date contact details. As for Ms 5, if she is still an employee at the Trust, her current and up-to-date contact details can be obtained through the management at the Trust.

3.6. The hearing is conducted via live video link so the witness can attend the hearing from a remote location.

4. In making a decision on this application, please may I remind the panel of the following NMC guidance in regard to 'Evidence' which can be found on the NMC's website:

"Evidence may be unfair where it cannot be challenged. For example, this could be where the person who gives the evidence cannot be questioned, where it relates to a subjective opinion as opposed to an objective (although possibly disputed) fact."

"Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However, there may be circumstances in which it would not be fair to admit it, for example, where it is the sole and decisive evidence in respect of a
serious charge and it isn't 'demonstrably reliable' and not capable of being tested."

5. *Therefore, I seek that the panel reject the NMC's application to adduce the abovementioned witnesses' statements as hearsay evidence.*

6. *I also seek that the panel make an order that the NMC take steps to contact the said witnesses and make arrangements for them to provide oral evidence. And if this is not possible, I seek that their statements are regarded of minimal weight and untested, therefore, inadmissible.'*

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He directed the panel to the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* and in particular to the principles highlighted by the judge in paragraph 45 of the judgment.

The legal assessor also commented on the cases of *Ogbonna v NMC [2010] EWCA Civ 1216* and *El Karout v NMC [2019] EWHC 28 (Admin)* referred to in your written submissions. The first of these required the panel to consider carefully the efforts made by the NMC to secure the attendance of the witness. The second addressed the nature and format of a witness's evidence which may not be of particular relevance in this case.

Ms 6:

The panel determined that the NMC has made reasonable efforts to contact Ms 6 to try to secure her attendance. Prior to the commencement of the hearing, the witness had

agreed to attend on a specific date. Despite what Ms 6 said in paragraph 12 of her witness statement about preferring not to attend a hearing, the NMC had no reason to doubt the willingness of this witness to attend this hearing. Ms 6's subsequent and unexpected disengagement from the process on day 2 of the hearing was not something the NMC could have anticipated.

The panel determined that Ms 6's evidence is not sole and decisive in respect of charges 1(j)(i) and 4(a) as Ms 1 speaks to both charges. The panel has heard from Ms 1 and has heard your extensive cross examination of her in respect of both charges. The panel is therefore aware of the issues you wish to raise. Mr 2 also speaks to charge 1(j)(i) and was cross examined by you in regard to this.

The panel notes in paragraph 3.2.3 of your written submissions that you suggest that Ms 6 may have provided parts of her statement for learning purposes and better support from management. However, the panel determined that Ms 6 was aware that she was providing a statement for use in this hearing and she had signed this statement to this effect.

The panel noted from your submissions in your paragraph 3.3.4 that you refer to the email from Ms 6 to Ms 1 as being the main evidence to charges 1(j)(i) and 4(a). However, this email has also been exhibited by Ms 1 as SS5 and the panel has explored it with her.

Therefore, the panel concluded that it is fair to admit Ms 6's evidence.

Ms 4:

The panel determined that the NMC has made reasonable efforts to contact Ms 4 to try to secure her attendance. Ms 4 had made contact with the NMC prior to the hearing starting to enquire when she would be required to attend but failed to attend a Go-To Meeting test. She appears to have ceased to engage with the hearing since then despite numerous attempts by the NMC to contact her. The panel determined that her non-engagement cannot be considered to be the fault of the NMC.

Although, Ms 4 was the only witness to charge 3(d), she had reported the incident to Ms 1 and Ms 1 has exhibited her notes of what was reported at SS3. The panel acknowledges the evidential weakness of these notes which are themselves hearsay. The incident was also recorded in SS34 which are notes of an informal management meeting. This is a more formal record than SS3 and is the record of a meeting at which you were present, but the panel acknowledges you have not signed them as being an accurate record. They are again not strong support for an admission of a hearsay statement. However, the panel considered your lengthy cross-examination of Ms 1 in respect of this incident. Your cross examination proceeded on the basis that the incident occurred and that your actions were appropriate. Therefore, the panel determined that it would be fair to admit Ms 4's statement.

In relation to charge 4(i)(vi), Ms 4's evidence was not sole and decisive, the panel heard evidence from Ms 7 and Ms 8 in relation to this charge and therefore the panel determined that it would be fair to admit Ms 4 statement as you have been able to put your position to other witnesses.

Ms 5:

The panel determined that the NMC has made reasonable efforts to contact Ms 5 to try to secure her attendance. The NMC has an NHS email and a landline number for Ms 5. These were effective when she provided her statement in February 2020 but neither produced a response from her in 2022. The panel accepted that as she is a Healthcare Assistant, the NMC is not expected to hold up-to date contact details for her. The panel determined that her non-engagement cannot be considered to be the fault of the NMC.

The panel determined that Ms 5's evidence is far from sole and decisive in respect of charge 1(h)(ii). Indeed, this charge is referred to at length by Ms 9 and Ms 1 and you cross-examined both in detail in respect of it. The panel note what you say in paragraph 3.2.5 of your written submission and will give appropriate weight to your submission in due course.

The panel therefore determined that it would be fair to admit Ms 5's statement.

Mr 1:

The panel was of the view that the NMC has made reasonable efforts to contact Mr 1. Initial contact was made to obtain his witness statement in October 2019 through his work contact details. However, when his place of work was contacted in September 2022, the NMC was informed that he no longer works for the Trust and had returned to Italy. The panel was told that Mr 1's registration with the NMC lapsed on 31 October 2020 and therefore there is no longer a requirement for the NMC to hold up-to date contact information for him. His non-attendance at the hearing is not as a result of any fault by the NMC.

Mr 1's statement is not sole and decisive in relation to charges 4(c) and 4(h). Mr 3 and Ms 9 gave extensive evidence about charge 4(c) and you cross examined them both in detail about this charge. In relation to charge 4(h), the panel notes your submission that Mr 1 was the only witness present during the initial hours of this incident. However, the panel heard evidence from Ms 9 about this incident and about the instructions to move Patient A that were given to you throughout the day. Furthermore, you cross-examined Ms 9 about this incident in detail.

The panel noted in your paragraph 3.2.2 your comments about references to the full context in which you were working. The panel has heard you cross examine other witnesses about the context of this incident and will take this into account in due course.

The panel therefore determined that it would be fair to admit the statement of Mr 1 into evidence.

Ms 3:

The panel was of the view that the NMC has not made reasonable efforts to contact Ms 3 to allow her to attend to give evidence this week. Although Ms 3 was given the opportunity to reschedule to attend in Week 2 of the hearing, she said she was on holiday at that time and so could not attend. However, Ms Nelson stated that she was not canvassed as to her availability to give evidence in the third week of the hearing at

all and was not contacted again by the NMC. Therefore she was not afforded an opportunity to attend the hearing to give evidence at a later date.

The panel therefore decided that it would not be fair to admit her statement in evidence.

Resuming 17 April 2023

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

At the outset of the hearing, Ms Nelson made a request that this application be heard wholly in private on the basis that your case involves reference to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to hear the application in private.

Decision and reasons on application to adjourn hearing

You made an application to adjourn the hearing and provided the panel with the following written submissions, dated 17 April 2023:

> *'…I am writing to apply for a 2-weeks postponement of the fitness to practice proceeding scheduled to recommence today 17 April 2023 for the following reasons:*
>
> [PRIVATE]
>
> *I have prepared a written witness evidence which the panel and the NMC may wish to go over during the time that I am unable to participate in the hearing.*

Should there be any, I am also able to respond to questions or concerns if this is sent via email.

I am hoping for your compassionate understanding and kind consideration of this matter.

It is very important for me to be able to participate in the proceeding to defend my case and I believe that this is in the interest of justice and fairness…'

Ms Nelson did not oppose the application to adjourn and stated that the NMC's position was neutral.

[PRIVATE]

Ms Nelson noted the recommendation from [PRIVATE]. She also noted that this case is being heard in two parts, concerns relating to issues in the Hammersmith Hospital and the concerns raised in Ealing Hospital. It had been anticipated that this week (17 April 2023 – 21 April 2023) would be used to conclude the evidence with regards to determining the Hammersmith facts, including hearing your evidence. However, your evidence could, without prejudice to you or the case, be heard at a later stage after the panel has heard the NMC's case regarding the Ealing facts.

Ms Nelson told the panel that witnesses are warned to give evidence relating to the Ealing facts next week (24 April 2023 – 28 April 2023) and rearranging them would cause significant inconvenience and could potentially result in evidence not being concluded within the anticipated time frame.

Ms Nelson therefore invited the panel to grant only one week's adjournment. She submitted that this would be fair as the medical certificate advising one to two weeks of voice rest was dated 12 April 2023. Therefore, adjourning for one week will allow you 12 days of voice rest.

Ms Nelson submitted that the hearing should reconvene on Monday 24 April 2023. She further submitted directions for you:

> You should update the NMC about [PRIVATE] (with any supporting evidence if necessary) by 14:00 (UK TIME) on Friday 21 April 2023.

The panel heard and accepted advice from the legal assessor who directed the panel to Rule 32.

The panel took into account Rule 32(4):

> *'32 (4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to-*
> *(a) the public interest in the expeditious disposal of the case;*
> *(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and*
> *(c) fairness to the registrant.'*

The panel is aware of the public interest in the expeditious conduct of a case which is already long running, relates to concerns that happened five years ago and has already extended beyond the original three weeks listed for the whole case. The panel has not yet commenced hearing evidence relating to the Ealing Hospital facts. The panel agreed with Ms Nelson that a two-week adjournment would cause significant disruption to the future conduct of the case. A one-week adjournment would be significantly less disruptive as the panel could commence hearing the Ealing facts next week in accordance with the revised timetable.

The panel next considered potential inconvenience to any witnesses. This was considered to be a very important factor. A two-week adjournment would mean that witnesses who had been warned for next week would need to be stood down and rearranged. A one-week adjournment would not inconvenience the witnesses at all.

Finally, the panel considered fairness to you which was an extremely important part of the panel's consideration. The panel noted that your medical certificate advises 7-14 days of voice rest from 12 April 2023. Recommencing the hearing on 24 April 2023 would give you 12 days of voice rest which the panel deemed to be fair and in line with medical recommendations from your Doctor. The panel was satisfied that in these circumstances, adjourning the hearing until Monday 24 April 2023 would not be unfair to you.

The panel agreed with Ms Nelson's submission that you should update the NMC about [PRIVATE] (with any supporting evidence if necessary) by 14:00 (UK TIME) on Friday 21 April 2023 and the panel so directs.

It will be clear from the above that the panel is concerned about the expeditious disposal of this case. It considers your Registrant's bundle relating to the Hammersmith charges, provided on 17 April 2023 to be helpful in ensuring an efficient hearing. It hopes that you will be able to provide a similarly helpful document in relation to the Ealing charges.

The hearing is to be relisted at 08:30 (UK TIME) on Monday 24 April 2023 and will be heard by Microsoft Teams link, which will be sent to you separately.

As you are subject to an interim order, the panel needs to make no further order.

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

At the outset of the hearing, Ms Nelson made a request that witnesses oral evidence in relation to the Hammersmith case be held in private on the basis that proper exploration of this case involves some reference to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application.

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

Having heard that there will be reference to your health, the panel determined to hold the entirety of the witness's oral evidence in private.

Decision and reasons on application to amend the charge

The panel heard a joint application made by you and Ms Nelson to amend the wording of charges 3(e), 4(i)(viii) and the first footer in respect of the Hammersmith Hospital allegations, as well as charges 9, 12 and 19 (the schedule) in respect of the Ealing Hospital allegations.

Ms Nelson submitted that the proposed amendments are to correct grammatical errors and to provide accuracy to the charges.

Proposed amendments

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

*e) On **or around** 28 August 2017, did not administer medication to Patient I;*

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

*b) **In or around July 2017 d**id not assist with the morning wash for one of your allocated patients ~~on 28 July 2017~~;*

…

i) Did not move Wards when instructed to do so on:

*viii) **or around** 22 February 2018;*

FURTHER or ALTERNATIVELY, ~~your fitness to practise is impaired by reason of your lack of competence in that~~ you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as Band 5 Staff Nurse between 1 February 2016 and 8 May 2018 as follows:

9) *On 13 February 2019, failed and/or refused to administer Sando K on one, or more, occasions to a patient admitted to the Acute Medical Unit with ~~hypothermia~~ **hypokalaemia**;*

12) *In relation to the administration of S/C Insulin Lantus to a patient on, or around 16 February 2019 ~~failed to~~:*
    a) ***failed to sign** timeously ~~sign~~ for the administration;*
    b) ***on 18 February 2019** retrospectively sign**ed** for the administration ~~on 18 February 2019~~;*

Schedule 1 (private)

[PRIVATE].

You indicated that you had no further submissions to add to this application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Decision and reasons on application of no case to answer on Hammersmith charges

The panel considered an application from you that there is no case to answer in respect of all the charges, except charge 1(d)(ii), that relate to the Hammersmith case. This application was made under Rule 24(7).

You made the following submissions in written format:

> *'…*
> *10. In the succeeding section, I will outline my reason for applying for a 'No Case to Answer' judgment for each charge. I also attach another document where this is laid out in table format.*
>
> ***Charge 1a: Failed to provide appropriate care to one, or more, patients, in that you: Did not undertake and/or timeously undertake, the admission of one, or more, patient(s) on 7 June 2017***
>
> ***Insufficient Evidence / Context***
>
> *11. In her witness statement, [MS 1] referred to [Ms 9] as the reporter of this incident. However, in her statement, [Ms 9] states that she is unable to recall the details of the incident.*
>
> *12. [Ms 9] further indicated that I raised a concern about support in getting the patient admission done. Nurses are encouraged to raise that support is needed when required.*
>
> *13. [Ms 9] reflected a poor concept of teamworking by stating that:*
>
> *"I would have expected the Registrant to be able to cope with admitting one patient without fail and without requiring support to do so." (Witness Statement of [Ms 9] para 44)*
>
> *14. If she was concerned as to why I was asking for support in completing the admission process for one patient, she should have asserted this with me to resolve the concern rather than going straight to [Ms 1] to report the issue.*

15. The evidence is based on statements that are poorly reflected upon on the basis of principles of good leadership and teamworking.

16. It also did not show that the management has considered possible causes as to why I was struggling with the admission.

17. It also appears that the purpose of raising this concern was to assign blame rather than explore measures to prevent further occurrence of the alleged act in the interest of patient safety.

Charge 1b: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide a handover in relation to your patient(s) when going on a break on 8 August 2017

Insufficient Evidence

18. The evidence does not establish why a handover before I went for my break in this instance was necessary to preserve patient safety.

19. In her notes of the meeting with [Ms ED], [Ms 1] simply cited that a handover was not undertaken before break but there is no indication that the issue was further explored.

20. A handover before a staff goes for break may not be needed at all times.

Charge 1c.i: Failed to provide appropriate care to one, or more, patients, in that you: In relation to Patient B on 11 August 2017: Inadequately completed / undertook a handover

No Evidence

21. [Ms 1]'s witness statement para 24 does not address this charge.

22. Exhibit SS/3, SS/6, and SS/34 do not address this charge. Although it was mentioned that the handover took what was thought to be a long time (45 minutes), there was no evidence to suggest the handover was inadequately completed.

23. Exhibit GB/20 does not appear to contain any evidence material to this charge.

Charge 1c.ii: Failed to provide appropriate care to one, or more, patients, in that you: In relation to Patient B on 11 August 2017: Did not ensure such a handover was undertaken timeously

Insufficient Evidence

24. In her witness statement para 24-32, [Ms 1] indicated that she was concerned the handover took longer than what she expects. This, however, does not establish why this was a concern in terms of maintaining patient safety or providing appropriate care.

Charge 1c.iii: Failed to provide appropriate care to one, or more, patients, in that you: In relation to Patient B on 11 August 2017: Did not ensure that Patient B had a diabetes referral / review

Context

25. The evidence shows that I have handed over to [SN C] that the patient needed a diabetes nurse referral. This is evidence that an action was taken to ensure that a diabetes nurse referral was organised for Patient B.

26. The evidence does not appear to show that [Ms 1] was concerned of identifying the possible causes of why the alleged act was not accomplished according to her expectations. It appears that [Ms 1] was quick to assign blame in this situation which is not the purpose of the fitness to practice process.

27. It is also important that the process is carried out in a fair manner and part of this is trying to understand the situation the nurse is in when the concern occurred as well as considering the availability or lack of support.

Charge 1c.iv: Failed to provide appropriate care to one, or more, patients, in that you: In relation to Patient B on 11 August 2017: Did not recognize that a catheter insertion record was not in place

Unlikely to Lead to a Finding of Impairment / Context

28. This is unlikely to lead to a finding of impairment as likely cause is system failure.

29. The evidence shows that other nurses involved in the patient's care also failed to take note that a catheter insertion record was not in place.

Charge 1d.i: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21 September 2017 in that you: Did not participate in a ward round relating to Patient L

No Evidence / Insufficient Evidence

30. Exhibit SS/1 & SS/2 does not clearly state that a Band 5 Staff Nurse working in the unit is expected to join the ward round.

31. [Ms 2]'s evidence in her witness statement para 21-22 indicate that a nurse is expected to carry out patient safety checks after receiving bedside handover from the outgoing nurse. This task takes priority over joining the ward rounds which normally happens at the same time. [Ms 2]'s witness statement does not support this charge.

32. Exhibit GB/20 does not contain evidence material to this charge.

33. [Ms 11] stated in her witness statement para 13 that I was dealing with another patient in the next bed space while the ward round was ongoing. It, however, does not establish why joining the ward round should take priority over attending to the need/s of that patient.

Charge 1d.iii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21 September 2017 in that you: Did not carry out one, or more, patient safety checks

Insufficient Evidence

35. The evidence does not show that this is a pattern of behaviour. It appears this was a one-time only incident.

36. It also does not tell us whether the matter was brought up to my attention and what actions I took afterwards.

37. It does not explore the reason why I failed to carry out this task as expected.

38. It cannot be established this is related to impairment without these further details.

Charge 1d.iv: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21 September 2017 in that you: Did not participate in the ward round(s)

No Evidence /Insufficient Evidence

39. Please refer to Charge 1d.i. This charge appears to be related to Charge 1d.i.

40. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 1d.i.

Charge 1d.v: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21

September 2017 in that you: Did not communicate with the doctor and/or nurse in charge following the ward round(s)

Insufficient Evidence

41. [Ms 11] in her statement mentioned her observation of a lack of interaction with the doctors and nurse-in-charge. However, this does not establish the necessity for having the conversation.

42. [Ms 11] stated that I was "on the computer" during the ward round. The Trust has an electronic health record system. [Ms 11]'s statement could indicate I was reading the doctor's notes during the ward round which would keep me updated of what was going on with the patient and the medical plan. In such case, a conversation with the doctor or the nurse-in-charge may not be necessary after the ward round.

Charge 1d.vi: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21 September 2017 in that you: Told Patient M that they would be prescribed blood thinner medication, without first consulting a doctor

Insufficient Evidence

43. [Ms 11] stated in her witness evidence para 33 that it was not that I told the patient that he was to be prescribed blood thinners that she was concerned with as it is most likely the case but the manner I communicated.

44. This is unlikely to be serious enough to lead to a finding of impairment. This does not indicate that the act was unkind, unsafe, or unprofessional.

Charge 1d.vii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 21 September 2017 in that you: Failed to undertake and/or record one, or more, sets of clinical observations

Insufficient Evidence

45. The evidence in support of this charge was a short statement from [Ms 2] alleging that I had failed to "undertake clinical observations on patients" as she quotes having heard from this from [Ms 11] as part of her observations on 21 September 2017.

46. There is, however, no evidence from [Ms 11] in relation to this charge.

47. Exhibit GB/14 & GB/15 do not contain evidence material to this charge.

Charge 1e.i: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Had to be prompted to assist Patient N, who was exposed, in covering up

Context

48. The evidence indicates that I was engaged with another task when Patient N needed the assistance, and I did not notice this until my attention was called to assist her.

49. It was also established during the cross-examination that anyone from the team could have assisted Patient N when she needed assistance including [Ms 11] who was working with us at that time. It was unnecessary to delegate this task to me if she had seen the patient herself and was free to assist. It was an opportunity for her to lead by example, but instead she complained profusely that I failed to attend to this patient whose care was allocated to me. We are encouraged to work together as a team and not in isolation. This meant we should be ready to assist all patients in the ward and not just the one's allocated to us. The same goes for other members of the team.

50. The evidence demonstrates unrealistic expectations about a person's ability to manage multiple tasks at the same time ([Ms 11] expects that I have seen the patient from the corner of my eye) and a poor concept of teamworking.

51. I see no purpose as to why this charge should be pursued as this is unlikely to lead to a finding of impairment.

Charge 1e.ii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not recognise and/or assist Patient N, who was attempting to mobilise

Context / Unlikely to Lead to a Finding of Impairment

52. Please refer to Charge 1e.i. This charge appears to be related to Charge 1e.i.

53. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 1e.i.

Charge 1e.iii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not reconnect Patient N's infusion pump which was 'alarming'

Context / Unlikely to Lead to a Finding of Impairment

54. Please refer to Charge 1e.i. This charge appears to be related to Charge 1e.i.

55. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 1e.i.

Charge 1e.iv: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not tell a patient who was nil by mouth ('NBM') that they could not eat

Context

56. In her evidence, [Ms 1] acknowledged that informing the patient they have to be 'nil by mouth' for a procedure is a team responsibility.

57. The cause of this failure is likely a system failure rather than an individual concern.

Charge 1e.v: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not answer the HAC telephone on one or more occasion

Insufficient Evidence

58. The evidence does not show that [Ms 1] has properly explored the reasons why I could not answer telephone calls. This is not fair and does not assist with the ultimate purpose of the fitness to practice process to identify a course of action to preserve public safety.

Charge 1e.vi: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not comply with an Aseptic Non-Touch Technique ('ANTT') when inserting a vascular access device

Insufficient Evidence / Context

59. In her evidence, [Ms 1] stated that she was supervising me in this instance. If she was supervising me, that would mean that I was subject to her instruction. She could have directed me to observe ANTT during this task.

60. [Ms 1]'s evidence to this charge does not reflect good leadership and mentoring practice.

61. She also did not explore the nature of the cause of failing to comply with ANTT in this instance and if there were any further observations.

Charge 1e.vii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9

October 2017 in that you: Did not notice that Patient R was on Glyceryl Trinitrate 'GTN' infusion intravenously

Insufficient Evidence / Context

62. From [Ms 1]'s evidence, it can be implied that I was aware that the patient was on a GTN infusion.

Charge 1e.viii: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not prioritise and/or take Patient R's blood pressure

Insufficient Evidence / Context

63. Based on [Ms 1]'s evidence, when she instructed me to take the patient's blood pressure, I was assisting the patient to put on her dressing gown and get settled in a chair.

64. It was important to ensure the patient's comfort before taking their blood pressure as any feeling of discomfort could have an impact on their blood pressure. It does not appear that [Ms 1] took this into consideration in her complaint.

65. Her approach in dealing with this matter also reflect a cutthroat culture rather than a supportive one.

Charge 1e.ix: Failed to provide appropriate care to one, or more, patients, in that you: Did not provide care to all patients during your shift on 9 October 2017 in that you: Did not manage one, or more, monitor alarms

Insufficient Evidence

66. In her evidence, [Ms 1] failed to explore the reasons for the failure to manage the monitor alarms.

67. During the examination, she also affirmed this can be done by anybody within the team.

Charge 1f: Failed to provide appropriate care to one, or more, patients, in that you: Incorrectly, discharged Patient C on 20 November 2017

Insufficient Evidence / Context

68. The evidence shows I was engaged in another task when this patient left the ward so that I was unable to see that she had left her discharge medications behind. There is also evidence to show the reason why I was unable to empty the medication pod – that the patient left while I was checking discharge medications for another patient, before the shift changeover, so that the task was left for the night staff to complete.

69. It is evident from [Ms 1]'s evidence that she did not consider the above points and was therefore not looking at this matter in an objective manner.

Charge 1g: Failed to provide appropriate care to one, or more, patients, in that you: Did not restart and/or handover that you had not restarted Patient D's Furosemide infusion on 20 November 2017

Insufficient Evidence / Context

70. This involves disputed fact, which would be difficult to resolve as the evidence appears to be balanced.

71. Exhibit SS/9 is a complaint from [Ms 13] that Furosemide infusion was not started but she did not mention in her email that this was not discussed during the handover and then later on in her statement she alleged that it was not handed over.

72. Exhibit SS/10 is an email from myself to [Ms 1] following our discussion of [Ms 13]'s complaint where I stated [Ms 13] told me at handover that the Furosemide infusion needed to be started.

73. It is possible that [Ms 13] forgot about restarting the Furosemide infusion and thought of passing the blame on me for the delay in readministering this medication.

74. This can perhaps be resolved by looking at the context. I was only redeployed in this ward and did not have knowledge of their practice with Furosemide infusions. I was under performance management during this time and was supposed to be under the nurse-in-charge's supervision, which means she should oversee my work. I was also not allowed to administer IV medications at that time and was reliant on the support of the nurse-in-charge for administering IV medications to my allocated patients. Had the nurse-in-charge been supporting me effectively on this occasion, errors arising from my lack of awareness to the normal processes in this ward would have been prevented.

Charge 1h.i: Failed to provide appropriate care to one, or more, patients, in that you: Did not clean the sluice/bedpan during the nightshift of 5/6 January 2018 for: Patient H

Insufficient Evidence / Context

75. There is insufficient evidence to show that Patient H who was allegedly under my care needed the use of 5 bedpans during this shift. The claim was made by [Ms 9] who was due to do her dayshift on that day and it was alleged that the bedpans were used during the night. [Ms 9] did not witness that I had used the bedpans, but she was quick to blame me in her statement.

76. During cross-examination, we note [Ms 1] and [Ms 9]'s antagonistic demeanour towards me. This explains their tendency to throw the blame on me when issues like this arise.

77. It can be noted that cleaning the sluice/bedpan was a task for the whole team to address. It is evident from her evidence that [Ms 1] struggled to manage this fairly and assertively.

78. This was more of a leadership concern rather than an individual matter.

Charge 1h.ii: Failed to provide appropriate care to one, or more, patients, in that you: Did not clean the sluice/bedpan during the nightshift of 5/6 January 2018 for: One, or more, unknown patient(s)

Insufficient Evidence / Context

79. Please refer to Charge 1h.ii. This charge appears to be related to Charge 1h.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 1h.ii.

Charge 1i: Failed to provide appropriate care to one, or more, patients, in that you: Did not undertake an ECG in a timely manner on 2 March 2018

Insufficient Evidence / Context

80. The evidence in relation to this in GB/25 indicate that [Ms 2] kept me from undertaking this task as she thought this was a routine ECG and non-urgent. A series of events happened afterwards that kept me from undertaking this task.

81. There is no further evidence to illustrate how the delay in taking the ECG was a concern.

Charge 1j.i: Failed to provide appropriate care to one, or more, patients, in that you: Did not assist in providing emergency care/support to one, or more, patient(s) on: 19 March 2017

Insufficient Evidence

82. The evidence suggests there were issues with the support that was provided by the team as they failed to communicate they required assistance to myself so I can address it before they raised the issue with the matron.

83. There were indications this matter was not dealt with in a fair manner and the complaint was meditated upon poor concept of teamworking.

84. Also, the purpose of fitness to practice is not to punish nurses for past events. There was a further evidence to show my proactive engagement with the team during emergencies (Exhibit SS46).

85. In Exhibit SS46, [Ms KB] stated that: "XS was present during primary/emergency calls, she was an effective and proactive member of the team." (KB Email to GB and SS on 21 March 2018)

Charge 1j.ii: Failed to provide appropriate care to one, or more, patients, in that you: Did not assist in providing emergency care/support to one, or more, patient(s) on: 8 August 2017 at around 17:15

Insufficient Evidence

86. As with Charge 1j.i, this is unlikely to lead to a finding of impairment as there is further evidence to show my proactive engagement in dealing with emergencies.

Charge 1j.iii: Failed to provide appropriate care to one, or more, patients, in that you: Did not assist in providing emergency care/support to one, or more, patient(s) on: 5/6 January 2018

Insufficient Evidence

87. Ms. Nelson raised that they are keen to apply for a 'no case to answer' on this charge for the lack of evidence.

Charge 1j.iv: Failed to provide appropriate care to one, or more, patients, in that you: Did not assist in providing emergency care/support to one, or more, patient(s) on: One, or more, unknown dates

Insufficient Evidence

88. As with Charge 1j.i, this is unlikely to lead to a finding of impairment as there is further evidence to show my proactive engagement in dealing with emergencies.

Charge 2a.i: Failed to keep clear and accurate records and/or document observation in that you: On 11 August 2017, and in relation Patient B: Made retrospective records and did not record such records as having been made retrospectively

Insufficient Evidence

89. The evidence shows there was a way to identify from the electronic health record system if the observations were recorded in real time or retrospectively.

90. Indicating in the records whether observations were recorded retrospectively in the manner [Ms 9] deemed appropriate does not impact patient safety nor the need to maintain accurate records.

Charge 2a.ii: Failed to keep clear and accurate records and/or document observation in that you: On 11 August 2017, and in relation Patient B: Did not contemporaneously record Patient B's observations

Insufficient Evidence / Context

91. The evidence reflects poor leadership and management as factors to this incident.

92. [Ms 9] was passing the blame on me when she also was accountable in ensuring this task was accomplished timely as the nurse-in-charge. The nurse-in-charge must oversee the care provided to acutely unwell patients.

93. The evidence is poorly meditated upon.

94. The likely cause of this failure is lack of support.

Charge 2a.iii: Failed to keep clear and accurate records and/or document observation in that you: On 11 August 2017, and in relation Patient B: Did not ensure that a catheter insertion record was in place

Context

95. This is unlikely to result in a finding of impairment as likely cause is system failure.

96. The evidence shows multiple nurses during the course of giving care to Patient B failed to note that a catheter insertion record was not in place.

Charge 2b: Failed to keep clear and accurate records and/or document observation in that you: On 9 October 2017, did not document the care provided to Patient R

Other Reasons

97. The evidence shows that [Ms 3] was adjusting the infusion rate for this patient as at that time I was not allowed to give IV medications (Witness Statement of SS para 62). Therefore, she was responsible for completing the medication administration charting for this patient.

Charge 2c: Failed to keep clear and accurate records and/or document observation in that you: On 9 October 2017, did not record neurovascular observations for two patients who were post- angiogram

Insufficient Evidence

98. The evidence appears to be hearsay evidence only (report [Ms 1] received from an unnamed nurse) not substantiated with further details. There is no evidence of the patient's chart provided to show I failed to do this task.

Charge 3a: Failed to adequately administer medication and/or undertake safe medication management in that you: On 26 June 2017, did not administer two pairs of IV Pabrinex to Patient U

Unlikely to Lead to a Finding of Impairment

99. This is unlikely to lead to a finding of impairment as the error was acknowledged, reported, and actions were taken to rectify the mistake and preserve patient safety. Also, the likely cause of this error was human error.

Charge 3b: Failed to adequately administer medication and/or undertake safe medication management in that you: On 26 June 2017, did not adequately administer medication to an unknown patient and/or failed to complete a DATIX report

No evidence

100. I completed a DATIX report for this incident (Exhibit SS/16).

101. Please refer to Charge 3a.

Charge 3c: Failed to adequately administer medication and/or undertake safe medication management in that you: On 14 August 2017, incorrectly administered Amoxicillin / medication to Patient S

Unlikely to Lead to a Finding of Impairment

102. This is unlikely to lead to a finding of impairment as the error was acknowledged, reported, and actions were taken to rectify the mistake and preserve patient safety.

Charge 3d: Failed to adequately administer medication and/or undertake safe medication management in that you: On 21 August 2017, refused to administer and/or permit a colleague to administer Haloperidol to Patient K

Other Reasons

103. During cross-examination, [Ms 1] clarified that what she was concerned with was not that I kept [Ms 4] from administering Haloperidol but the manner it was done, which she considered to be obstructive.

104. The issue therefore does not relate to my ability to safely undertake the medication administration process but to my communication and conflict handling skills.

Charge 3e: Failed to adequately administer medication and/or undertake safe medication management in that you: On 28 August 2017, did not administer medication to Patient I

Context

105. The evidence shows that the reason why I declined to do the medication administration was because there was an incoming emergency and I did not want to do this under time pressure (Exhibit SS/28).

106. This demonstrates safe practice.

Charge 3f.i: Failed to adequately administer medication and/or undertake safe medication management in that you: On 9 October 2017: Failed to check Patient O's blood glucose level when asked to do so

Insufficient Evidence

107. In her evidence, [Ms 11] referred us to Exhibit HS7 (the Trust Diabetes Policy) to support that the patient should have had their blood sugar checked before the administration of this medication. When asked to point us to the specific policy during cross-examination, [Ms 11] was unable to find a relevant section in the policy that directs this.

108. The evidence also shows that the patient's blood sugar was checked in the morning at around 0500H and was due to be checked again at around 1100H per ward routine, which was why I did not find the need to check it before administering the medication.

109. The evidence did not indicate a need to immediately check the patient's blood sugar as in the case when they have symptoms.

110. The evidence also shows that I eventually took [Ms 11]'s instruction to check Patient O's blood glucose level (Witness Statement of [Ms 11] para 54).

Charge 3f.ii: Failed to adequately administer medication and/or undertake safe medication management in that you: On 9 October 2017: Went to give diabetic medication to Patient O without first checking their blood glucose level

Insufficient Evidence

111. Please refer to Charge 3f.i. This charge appears to be related to Charge 3f.i. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 3f.i.

Charge 3g: Failed to adequately administer medication and/or undertake safe medication management in that you: On 20 November 2017, inserted a new cannula for Patient E when it was not necessary to do so/clinically required

Insufficient Evidence

112. This is likely to lead to a disputed fact and in order to resolve this, it would be necessary to refer to the patient's notes and medication chart which were not provided in this case.

113. The evidence in SS/10 shows that the cannula was inserted because the patient was on IV antibiotics per the handover.

Charge 3h: Failed to adequately administer medication and/or undertake safe medication management in that you: On 20 November 2017, did not ensure that Patient F was correctly discharged with their medication and/or that such discharge was recorded

Insufficient Evidence

114. This is likely to lead to a disputed fact and in order to resolve this, it would be necessary to refer to my nursing notes which were not provided in this case.

115. [Ms 13] referred to my nursing notes in her witness statement but did not exhibit my nursing notes.

116. [Ms 13] in her witness statement stated that the patient's father collected the medication and apologised that the patient had left the medication behind. This indicates that the medication has been endorsed to the patient and that they took full responsibility for leaving it behind.

117. [Ms 13] has assigned blame on me for this incident, which was not truly fair because I had done my part when I gave the medication to the patient and she was responsible for leaving it behind.

Charge 3i: Failed to adequately administer medication and/or undertake safe medication management in that you: On 26 December 2017, incorrectly administered immediate release oxycodone to Patient G

Unlikely to Lead to a Finding of Impairment

118. This is unlikely to lead to a finding of impairment as the error was acknowledged, reported, and actions were taken to rectify the mistake and preserve patient safety.

119. Also, this is likely due to unfamiliarity with the available formulations of Oxycodone, and this limitation has been addressed.

Charge 4a: Failed to follow instruction from senior members of staff and/or colleagues in that you: Acted as Nurse in Charge on 19 March 2017

Insufficient Evidence / Context

120. [Ms 1] made her annotation of this incident without consulting with me, which means that the evidence is not fair or unbiased.

121. It can be noted that there is no evidence from SR [Ms 12] who was present during this incident and designated me as nurse-in-charge.

122. This is unlikely to lead to a finding of impairment because nurses should be encouraged to take on opportunities to practice our leadership skills and take on leadership roles, which should be supported by the management.

Charge 4b: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not assist with the morning wash for one of your allocated patients on 28 July 2017

Insufficient Evidence / Context

123. The evidence shows that I asked for support in doing this task, which the management was hesitant to provide (Witness Statement of SS para 97). A series of events happened afterwards leading to a meeting with [Ms 2] and the practice educators.

Charge 4c: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not administer medication to Patient B on 11 August 2017

Context

124. The evidence shows that there was a hesitation to give the medication because the prescribed diluent is not as recommended in the drug reference guide.

125. [Ms 9] then intervened and offered to give the medication for this patient while I was expressing my concerns to [Mr 3].

Charge 4d: Failed to follow instruction from senior members of staff and/or colleagues in that you: On 9 September 2017, refused to follow a request to assist the Nurse-in-Charge in answering the telephone

Unlikely to Lead to a Finding of Impairment / Context

126. This is unlikely to lead to a finding of impairment as the likely cause is staffing issue.

Charge 4e: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not remove Patient H's catheter on 21 January 2018 and/or handed over that the catheter should not be removed

Insufficient Evidence

127. The evidence shows that there had been a conversation with the patient's next-of-kin and their decision was to keep the urinary catheter in.

Charge 4f: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not take breaks as assigned by the NIC on 20 February 2018

Unlikely to Lead to a Finding of Impairment

128. This is unlikely to lead to a finding of impairment as likely a management issue.

Charge 4g: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not follow instructions relating to the provision of care to Patient P on 2 March 2018

Insufficient Evidence / Context

129. The evidence shows that I was dealing with this patient's care in a systematic manner (Exhibit GB/26) prioritising tasks according to the medical plan.

130. The evidence shows that [Ms 2]'s instruction was to give the patient her lunch.

131. The evidence also shows that the patient was having her nebuliser at that time and an ECG was supposed to be taken as she just had an acute episode.

She became drowsy while on her seat and her blood pressure dropped to 70mmHg systolic.

132. Based on the evidence, it can be noted that [Ms 2]'s instruction to feed the patient was not a priority at that time.

Charge 4h: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not follow instructions in respect of moving Patient A to Ward C8 on 02 March 2018

Insufficient Evidence / Context

133. There is evidence to show that I felt I was approached by [Ms 9] in a hostile manner as she instructed me to transfer this patient to Ward C8 (Exhibit SS/36).

134. The evidence also does not show that the management considered my version of events, which renders their evidence unfair and biased. In considering a concern that involves conflict between two parties, it is important to get both sides of the story.

135. This is unlikely to lead to a finding of impairment as likely cause is poor management / leadership.

Charge 4i.i: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 31 March 2017

Other Reasons

136. [PRIVATE]*.*

Charge 4i.ii: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 29 August 2017 *Page* ***20*** *of* ***23***

Context

137. [PRIVATE].

138. [PRIVATE].

139. In Exhibit GB13, I explained the reason for my concern in regard to working in Ward A7.

140. This shows that there has been a good enough reason to refuse working in Ward A7 in the interest of preserving patient safety.

141. Furthermore, this can be remedied through redeployment or moving to another workplace.

Charge 4i.iii: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 13 October 2017

Context

142. Please refer to Charge 4i.ii. This charge appears to be related to Charge 4i.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 4i.ii.

Charge 4i.iv: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 25 December 2017

Context

143. Please refer to Charge 4i.ii. This charge appears to be related to Charge 4i.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 4i.ii.

Charge 4i.vi: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 27 January 2018

Context

144. Please refer to Charge 4i.ii. This charge appears to be related to Charge 4i.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 4i.ii.

Charge 4i.vii: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 22 February 2018

Context

145. Please refer to Charge 4i.ii. This charge appears to be related to Charge 4i.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 4i.ii.

Charge 4i.viii: Failed to follow instruction from senior members of staff and/or colleagues in that you: Did not move Wards when instructed to do so on: 23 March 2018

Context

146. Please refer to Charge 4i.ii. This charge appears to be related to Charge 4i.ii. I apply for a 'no case to answer' judgment for this charge for the same reasons given in Charge 4i.ii.

Charge 5: FURTHER OR ALTERNATIVELY, your fitness to practise is impaired by reason of your lack of competence in that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as Band 5 Staff Nurse between 1 February 2016 and 8 May 2018 as follows: In relation to any and/or all matters set out at charge 1- 4 above

No Evidence

147. In light of the aforementioned reasons for charge 1-4 above, there is no evidence to support this charge.

Charge 6a: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: Oral medication management

No Evidence

148. Please refer to Exhibit GB/30. This had been addressed.

149. Further trainings and competency assessments were also undertaken in relation to this following my resignation from the Trust.

Charge 6b: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: IV medication management and administration

Other Reasons

150. This can be remedied by taking on further training in relation to IV Medication Management and Administration, which every healthcare facility conducts for staff nurses upon commencing employment in their institution.

Charge 6c: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: Time management of self and patient case load

Insufficient Evidence

151. Please refer to Exhibit GB/30 as this identified problem had been addressed.

152. This can be remedied by moving to another area of practice with a more manageable workload.

Charge 6d: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: Delivery of basic nursing care without help or supervision

Insufficient Evidence

153. The basis for this objective was a one-time incident only where I asked for support in assisting the patient with his morning wash and I asked for assistance.

154. I have evidence of relevant competencies being achieved prior to working at the Trust.

155. Further training and competency assessment on the basis of this objective can also be undertaken if relevant to my nursing employment, which would often be organised by the employer.

Charge 6e: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: General attitude to managers and work colleagues

Insufficient Evidence

156. There is evidence to show my positive attitude towards my colleagues as can be taken from [Ms KB]'s email in Exhibit SS46 where she had stated that: "She was happy, chatty and very well engaged with not only the patients but also the staff. We worked with [Ms 12] and [Ms E] on the Sunday."

157. During cross-examination, the managers involved in this case has displayed their hostile attitude towards me, which would suggest how the working environment may be a factor in this concern.

158. This may be remedied by working with a management with a more positive approach to leadership and with expectations that I can reasonably achieve.

Charge 6f: By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas: To be able to follow reasonable requests from shift leaders and managers

Insufficient Evidence

159. As per the evidence, it is my understanding that the reason why this has not been signed off is in relation to my refusal to move to Ward A7.

160. [PRIVATE].

You also provided the panel with an evidence matrix, demonstrating where you believe the NMC has either provided no evidence or insufficient evidence in support of each charge, which the panel has read in full.

In light of your submissions, you invited the panel to determine that there is no case to answer in respect of all the charges, except one, in the Hammersmith case due to either no evidence or insufficient evidence provided by the NMC.

Ms Nelson submitted that the NMC opposes this application in respect of all the charges in the Hammersmith case, with the exception of charge 1(j)(iii).

Ms Nelson referred the panel to the two-limb test outlined in the case of *R v Galbraith* [1981] 1 WLR 1039.

Ms Nelson submitted that, in respect of charge 1(j)(iii), the NMC concedes that there is no evidence to support this charge. This is because the NMC was unable to secure the attendance of Ms 3 whose evidence spoke directly to this charge; and the hearsay application for Ms 3's evidence was rejected by the panel earlier on during this hearing.

In respect of the charges that you claim the NMC has provided no evidence to support, Ms Nelson submitted that the panel has available before it written statements and

exhibits from witnesses, all of whom have given oral evidence during this hearing. She submitted that the panel has yet to hear your oral evidence in respect of these charges. Ms Nelson therefore submitted that there is in fact evidence available which supports and speaks directly to these charges.

With regard to charge 5, Ms Nelson submitted that the panel should disregard your submissions on this. She submitted that this is because the charge concerns whether your fitness to practise is impaired due to lack of competence, which the panel at present is unable to consider as the hearing is still at the facts stage.

In respect of the remaining charges that you claim the NMC has provided insufficient evidence to support, Ms Nelson submitted that the panel also has available before it written statements and exhibits from witnesses, all of whom have given oral evidence during this hearing. Ms Nelson therefore submitted that there is in fact sufficient evidence available which supports and speaks directly to these charges.

Ms Nelson submitted that there is no merit to your application for no case to answer in respect of any of the charges in the Hammersmith case, with the exception of charge 1(j)(iii). In light of her submissions, Ms Nelson invited the panel to refuse this application.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor who directed the panel to the test in *Galbraith* [1981] as further explained in *R v Shippey* [1988] CrimLR 767.

The panel found this application particularly difficult to deal with. Applications of 'No Case to Answer', which by their very nature, suggest a fundamental flaw in the NMC's case or in the NMC's approach to an allegation, should be the exception rather than the rule. It is simply extraordinary for any panel to be faced with what are effectively over 90 separate applications that a single registrant has no case to answer.

The panel noted that it was very clearly explained to you the important difference between applications under Rule 24(7) and applications under Rule 24(8) of the Rules

2004. Applications under Rule 24(7) must allege that there is either no evidence to support an allegation that a specific fact (or set of facts) existed or that the evidence presented by the NMC to support such an allegation is so “weak or tenuous” that no reasonable panel properly directed could find the fact (or set of facts) proved. These are, respectively, the two limbs of the standard *Galbraith [1981]* test that the panel must apply when addressing your application. In contrast, applications under Rule 24(8) should allege that the facts of a case (either as admitted or as found proved) are insufficient to support a finding of impairment (on whichever ground impairment is alleged under Art 22(1)(a) of the Order 2001).

The panel further noted that it was also clearly explained to you that it was your responsibility to decide under which rule you would make your application(s). You did this and the panel wished to make it clear that it is dealing at this stage with an application you have said is made under Rule 24(7). The panel will therefore be asking itself the ‘Galbraith’ questions highlighted above. The panel also reminds itself that it must assess your application based on the NMC’s case on each point being taken “at its highest”.

Against this background the panel found many of your individual points in this application to be clearly unsustainable. For example, when you accept on the face of your application that a particular thing happened, any application that suggests there is no evidence to support the fact that a particular thing happened is immediately doomed to fail. Many of your individual points are matters that might (and the panel says no more than ‘might’ and specifically expresses no view on the merits) engage Rule 24(8) rather than Rule 24(7). When that is the case, an application based on Rule 24(7) is unlikely to succeed.

To summarise, the sole question the panel is asking itself at this stage is whether there is evidence from the NMC based on which the panel could (not ‘would’), having received proper direction, find proved the facts on which an allegation of impairment of fitness to practise is subsequently based.

The panel addressed each charge in your application separately as follows:

Charge 1(a):

The panel determined that there was evidence available in support of this charge. The panel had written statements provided by Ms 1 and Ms 9, along with Ms 1's exhibit (SS/3), and oral evidence it heard from Ms 1 and Ms 9 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(b):

The panel determined that there was evidence available in support of this charge. The panel had written statements provided by Ms 1 and Ms 2 along with their exhibits (SS/34 and GB/20), and oral evidence it heard from Ms 1 and Ms 2 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(c)(i)

The panel determined that there was evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibits (SS/3, SS/6 and SS/34), and the oral evidence it heard from Ms 1 during the course of the hearing. It further noted that Ms 2's exhibit (GB/20) also supports this charge. Whilst the panel acknowledged that paragraph 24 did not address the charge, paragraphs 25 to 26 did in fact address the charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(c)(ii):

The panel determined that there was evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibit (SS/3), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraphs 25 to 26 of Ms 1's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(c)(iii):

The panel determined that there was evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibit (SS/34), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraph 26 of Ms 1's statement directly addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(c)(iv):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 1(d)(i):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 11, and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraph 13 of Ms 11's statement directly addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(d)(iii):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 11 along with her exhibit (HS/1), and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraphs 21 and 26 of Ms 11's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(d)(iv):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 11, and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraph 13 of Ms 11's statement directly addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(d)(v):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 11, and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraph 31 of Ms 11's statement directly addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(d)(vi):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 11, and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraphs 32 to 35 of Ms 11's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(d)(vii):

The panel determined that there is insufficient evidence available in support of this charge. It noted that the only evidence available which addresses this charge is the somewhat vague hearsay evidence of Ms 2, which is not corroborated by the primary witness to this charge (Ms 11). This is because Ms 11 did not address the allegation set out in this particular charge either in her witness statement or during her oral evidence. It therefore decided that there was no case to answer in respect of this charge because the NMC's evidence is weak (as per Galbraith).

Charges 1(e)(i), 1(e)(ii) and 1(e)(iii)

The panel determined that there is evidence available in support of these charges. The panel had written statements provided by Ms 1 and Ms 11 along with their exhibits (SS/3 and HS/6), and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraphs 33 to 35 of Ms 1's statement and paragraphs 41 to 46 of Ms 11's statement address this charge. It was therefore satisfied that there is a case to answer in respect of these charges.

Charge 1(e)(iv):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibit (SS/3), and the oral evidence it heard from Ms 1 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(e)(v):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 1(e)(vi):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 1(e)(vii):

The panel determined that there was evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibits (SS/3 and

SS15), and the oral evidence it heard from Ms 1 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(e)(viii):

The panel determined that there was evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibits (SS/3), and the oral evidence it heard from Ms 1 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(e)(ix):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 1, and the oral evidence it heard from Ms 1 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(f):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 13 along with her exhibits (RJ/1 and RJ/2), and the oral evidence it heard from Ms 13 during the course of the hearing. The panel noted that paragraphs 7 to 16 of Ms 13's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(g):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 13 along with her exhibits (RJ/1 and RJ/2), and the oral evidence it heard from Ms 13 during the course of the hearing. The panel noted that paragraphs 17 to 22 of Ms 13's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(h)(i):

The panel determined that there was no evidence in support of this charge. The NMC had provided no evidence relating specifically to Patient H and therefore no panel properly directed could determine that the sluice/bedpan of Patient H had not been cleaned during the nightshift of 5/6 January 2018. Pursuant to the first limb of the Galbraith test, the panel determined that there was no case to answer in respect of this charge.

Charge 1(h)(ii):

The panel determined that there is evidence available in support of this charge. The panel had written statements provided by Ms 9 and Ms 5, and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraph 7 of Ms 5's statement and paragraphs 45 to 49 of Ms 9's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(i):

The panel determined that there is evidence available in support of this charge. The panel had the exhibits of Ms 2 (GB/25 and GB/26), along with the oral evidence it heard from Ms 2. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(j)(i) and 1(j)(ii):

The panel determined that there is evidence available in support of this charge. The panel had written statements provided by Mr 2 and Ms 6, and the oral evidence it heard from Mr 2 and Ms 6 during the course of the hearing. The panel noted that paragraphs 6 to 8 of Mr 2's statement and paragraphs 5 to 8 of Ms 6's statement address this charge. It further noted that the exhibit of Ms 1 (SS/3) support these charges. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 1(j)(iii):

The NMC conceded this point and the panel agreed that there was no evidence to support this charge. The panel referred back to its earlier decision to reject the NMC's application for the admission of Ms 3's hearsay evidence. It noted that Ms 3's evidence was the sole and decisive evidence in respect of this charge. In the absence of such evidence, the panel decided that there was no case to answer in respect of this charge.

Charge 1(j)(iv):

The panel determined that there is evidence available in support of this charge. The panel had written statements provided by Ms 1, and the oral evidence it heard from Ms 1 and Ms 9 during the course of the hearing. The panel noted that paragraphs 16 to 23 and 93 to 95 of Ms 1's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 2(a)(i):

The panel determined that there is evidence available in support of this charge. The panel had written statements provided by Ms 1 and Ms 9 along with their exhibits (SS/7, SS/13, SS/14, MM/5, MM/7 and MM/8), and the oral evidence it heard from Ms 1 and Ms 9 during the course of the hearing. The panel noted that paragraphs 5 to 7 and 38 of Ms 9's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 2(a)(ii):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 9 along with her exhibits (MM/5, MM/7 and MM/8), and the oral evidence it heard from Ms 1 and Ms 9 during the course of the hearing. The panel noted that paragraphs 5 to 7 and 38 of Ms 9's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 2(a)(iii):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibit (SS/8), and the oral evidence it heard from Ms 1 during the course of the hearing. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 2(b):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibits (SS/3 and SS/15), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraphs 59 to 64 of Ms 1's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

You referred in your application to evidence from Ms 3 (or to other witnesses who refer to her evidence) but the panel wishes to remind you that it has excluded the witness statement of Ms 3 and neither the NMC nor you are able to refer to it in this case.

Charge 2(c):

The panel determined that there is insufficient evidence available in support of this charge. It noted that the only evidence available which addresses this charge is the somewhat vague hearsay evidence of Ms 1, which is unsupported by any further evidence. It therefore decided that there was no case to answer in respect of this charge because the NMC's evidence is weak (as per Galbraith).

Charge 3(a)

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this

charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 3(b):

The panel determined that there was no evidence available in support of this charge. This is because there is evidence that you completed the DATIX report in respect of the patient named on it, but there is no evidence that you failed to complete a DATIX report for another unknown patient. It therefore decided that there was no case to answer based on the first limb of the Galbraith test.

Charge 3(c):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 3(d):

The panel determined that there is evidence available in support of this charge. You accepted the facts set out in this charge in the course of your cross-examination of Ms 1. The panel had written statements provided by Ms 1 and Ms 4 along with Ms 1's exhibits (SS/3 and SS/34), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraphs 102 to 103 of Ms 1's statement and paragraphs 4 to 7 of Ms 4's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(e):

The panel determined that there is evidence available in support of this charge. The panel had written statements provided by Ms 2 and Ms 12 along with their exhibits (GB/10, GB/12, GB13 and JG/1), and the oral evidence it heard from Ms 2 and Ms 12

during the course of the hearing. The panel noted that paragraph 20 of Ms 2's statement and paragraphs 8, 9 and 12 of Ms 12's statement directly address this charge. It further noted that the exhibit of Ms 1 (SS/28) also supports this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

With regard to the date on which the alleged incident took place, an amendment has already been made to correct this date in the charges following the panel's decision to accept your joint application to amend the charges, made earlier on during this hearing.

Charge 3(f)(i) and 3(f)(ii):

The panel determined that there is evidence available in support of these charges. The panel had a written statement provided by Ms 11, and the oral evidence it heard from Ms 11 during the course of the hearing. The panel noted that paragraphs 47 to 54 of Ms 11's statement directly address these charges. It was therefore satisfied that there is a case to answer in respect of these charges.

Charge 3(g):

The panel determined that there is evidence available in support of this charge. The panel had a written statement provided by Ms 13 along with her exhibit (RJ/2), and the oral evidence it heard from Ms 13 during the course of the hearing. The panel noted that paragraphs 28 to 29 of Ms 1's statement directly address this charge. It further noted that the exhibits of Ms 1 (SS/9, SS/10 and SS/1) also support this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(h):

The panel determined that there is evidence available in support of this charge. The panel has a written statement provided by Ms 13 along with her exhibits (RJ/1 and RJ/2), and the oral evidence it heard from Ms 13 during the course of the hearing. The panel noted that paragraphs 30 to 37 of Ms 1's statement directly address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(i):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 4(a):

The panel determined that there is no evidence to support this charge. The panel noted that whilst there is evidence to support the allegation that you acted as the 'Nurse in Charge' as set out within the charge, there is no evidence that you were given an instruction by anybody not to act as 'Nurse in Charge'. This is an essential element of the stem of the charge and because it is missing, the panel determined that there is no case to answer based on the first limb of the Galbraith test in respect of this charge.

Charge 4(b):

The panel determined that there is evidence in support of this charge. The panel had a written statement provided by Ms 1 along with her exhibits (SS/2 and SS/3), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraph 97 of Ms 1's statement addresses this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

With regard to the date on which the alleged incident took place, an amendment has already been made to correct this date in the charges following the panel's decision to accept your joint application to amend the charges, made earlier on during this hearing.

Charge 4(c):

The panel determined that there is evidence in support of this charge. The panel had written statements provided by Ms 1, Ms 2, Mr 3 and Mr 4 along with their exhibits (SS/13, SS/14, SS/17. SS/18. SS/19, SS/20, SS/26, SS/34, GB/3, GB/4, GB19, GB/20,

MS/1, MS/2, TC/1 and TC/2), and the oral evidence it heard from these four witnesses during the course of the hearing. The panel determined that the written prescription by the doctor constitutes an instruction with regard to the administration of medication to Patient B that any nurse would be expected to follow. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charges 4(d):

As you appeared during your cross-examination of Ms 1 to accept that you did not answer the telephone, an application under Rule 24(7) suggesting there is no evidence that you did not answer the telephone must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 4(e):

The panel determined that there is evidence available in support of this charge. The panel has a written statement provided by Ms 7 along with her exhibits (KP/1 and KP/2), and the oral evidence it heard from Ms 7 during the course of the hearing. The panel noted that paragraphs 5 to 27 of Ms 7's statement address this charge. It further noted that the exhibits of Ms 1(SS/37, SS/38 and SS/40) also support this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(f):

The panel determined that there is evidence available in support of this charge. The panel has a written statement provided by Ms 10 along with her exhibit (MD/1), and the oral evidence it heard from Ms 10 during the course of the hearing. The panel noted that paragraphs 5 to 9 of Ms 10's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(g):

The panel determined that there Is evidence in support of this charge. The panel has written statements provided by Ms 1 and Ms 2 along with their exhibits (SS/43, GB/25 and GB/26), and the oral evidence it heard from Ms 1 and Ms 2 during the course of the hearing. The panel noted that paragraph 43 of Ms 1's statement and paragraphs 34 to 37 of Ms 2's statement addresses this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(h):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 9 and Mr 1 along with the exhibits of Ms 9 (MM/2 and MM/3). The panel noted that paragraphs 20 to 28 of Ms 9's statement and paragraphs 7 to 20 of Mr 1's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(i):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 9 along with her exhibit (MM/1), and the oral evidence it heard from Ms 9. The panel noted that paragraphs 5 to 12 of Ms 9's statement address this charge. It further noted that the exhibit of Ms 2 (GB/20) also supports this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(ii):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 2 and Ms 11 along with their exhibits (GB/11 and HS/1). The panel noted that paragraph 19 of Ms 2's statement and paragraphs 5 to 6 of Ms 11's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(iii):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 2 and Ms 11 along with their exhibits (GB/11 and HS/8). The panel noted that paragraph 24 of Ms 2's statement and paragraphs 58 to 59 of Ms 11's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(iv):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 1, Ms 9 and Mr 2, along with their exhibits (SS/35, SS/36, SS/37, SS/38, AN/2 and MM/2), and the oral evidence it heard from all three witnesses during the course of the hearing. The panel noted that paragraphs 115 to 117 of Ms 1's statement, paragraphs 15 to 18 of Ms 9's statement, and paragraph 11 of Mr 2's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(v):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 1 and the oral evidence it heard from her during the course of the hearing. The panel noted that paragraphs 87 to 88 of Ms 1's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(vi):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 1, Ms 4, Ms 7 and Ms 8 along with their exhibits (SS/38, SS/39, SS/40, SS/41, KP/3 and AC/1), and the oral evidence it heard from all four witnesses during the course of the hearing. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(vii):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 12 along with her exhibit (JG/2), and the oral evidence it heard from Ms 1 during the course of the hearing. The panel noted that paragraphs 17 to 20 of Ms 12's statement address this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(i)(viii):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 2 along with her exhibits (GB/27 and GB/31), and the oral evidence it heard from Ms 2 during the course of the hearing. The panel noted that paragraphs 49 to 53 of Ms 2's statement address this charge. It further noted that the exhibit of Ms 1 (SS/47) also supports this charge. The panel was therefore satisfied that there is a case to answer in respect of this charge.

Charge 5(sic):

The panel referred to its decision to accept amendments made to this charge, following the NMC's joint application to amend the charges, made earlier on during this hearing. As a result, these words have become a stem to the charges that fall under charges 5 and 6. Therefore, your no case to answer application cannot be applied to these words.

Charges 6(a), 6(b), 6(d), 6(e) and 6(f):

The panel determined that there is evidence in support of these charges which refer to your formal management plan. The panel looked closely at this document, which is sometimes also referred to as your formal performance management plan (GB/30). The panel has a written statement provided by Ms 2 along with her exhibits (GB/17, GB/18, GB/28, GB/29, GB/30 and GB/46), and the oral evidence it heard from Ms 2 and Ms 11 during the course of the hearing. The panel noted that paragraphs 26 and 31 of Ms 2's

statement address these charges. It further noted that the exhibits of Ms 1 (SS/27 and SS/29) also support these charges. The panel was therefore satisfied that there is a case to answer in respect of these charges.

Charge 6(c):

The panel determined that there is insufficient evidence available in support of this charge. The panel could see in exhibit GB/30 that the section on time management of self and patient caseload had been completed and signed off. It therefore decided that there was no case to answer based on the first limb of the Galbraith test in respect of this charge.

Decision and reasons on application of no case to answer on Ealing charges

The panel considered an application from you that there is no case to answer in respect of all the charges that relate to the Ealing case. This application was made under Rule 24(7).

You made the following submissions in written format:

> *'10. In the succeeding section, I will outline my reasons for applying for a 'No Case to Answer' judgment for each charge. I also attach another document where this is laid out in table format.*
>
> ***Charge 1: On 12 December 2018, banged your nursing documentation around and/or kicked furniture at work***
>
> ***Unlikely to Lead to a Finding of Impairment***
> *11. This is unlikely to lead to a finding of impairment given that I have acknowledged the concern, apologised, and demonstrated insight.*
> *12. [Ms 15] affirmed that I had apologised and reassured the management this will not happen again. She also affirmed there were no further instances after this incident.*

13. This was only a one-off incident.

Charge 2: On 16 December 2018, failed and/or refused to administer a treatment dose of Tinzaparin to a newly admitted patient with a Pulmonary Embolism

Context

14. The evidence shows there was a good reason to hold the medication and request for a doctor's review.

15. [Ms 15] affirmed that there was a plan to consult with the Consultant on whether it was necessary to give the Tinzaparin. She also affirmed that she organised for the medication to be given to the patient by another nurse as she did not think it was necessary to escalate the matter to the Consultant.

Charge 3a: On 20 December 2018, clarified information at handover directly from one, or more patient(s), instead of from nurses/colleagues

Unlikely to Lead to a Finding of Impairment

16. [Mr 7] and [Ms 15] learned about this from a complaint made by RN Boateng. They failed to get my version of events at that time. It would be unfair for me to have to answer this allegation several years after the incident as I am unlikely to be able to recall what happened.

17. In addition, it appeared that the concern was not that I clarified information from the patient rather how the action made RN Boateng feel challenged and uncomfortable. Naturally, I will not be able to address the concern if this was not brought up to my attention.

Charge 3b: On 20 December 2018, inappropriately challenged a colleague regarding the administration of lorazepam medication to a patient

No Evidence

18. The evidence shows that there was a good enough reason to challenge the administration of this medication as the patient was settled in bed, which meant the medication was not necessary at that time.

19. The medication was prescribed on a PRN basis which means it should only be given as required.

20. This meant that it should only be given if the patient displays challenging behaviour that can become a threat to his own safety and that of others.

Charge 3c: On 20 December 2018, inappropriately challenged a colleague regarding a patient discharge

Insufficient Evidence

21. The evidence does not provide sufficient details such as the reason for the challenge. Without knowing the reason for the challenge, it cannot be established that the challenge was inappropriate.

Charge 4a: On 13 January 2019, failed and/or refused to administer Rivaroxaban to a patient with new Atrial Flutter timeously

Insufficient Evidence / Context

22. No medication chart nor details in reference to time of medication administration and prescribed timing to establish the medication was not given timeously was included in the evidence.

23. This is not a medication that requires to be given in strict timing.

24. This medication is ideally given at the same time each day. This was the patient's first dose.

25. There was a good enough reason for the delay in administering the medication – the need to establish its indication.

Charge 4b: On 13 January 2019, failed and/or refused to administer Rivaroxaban to a patient with new Atrial Flutter as initially instructed

Insufficient Evidence

26. The evidence shows (DATIX report) that I have given the medication soon after I was shown its indication on the patient's notes.

Charge 5a: On 23 January 2019, failed to administer Paracetamol to a patient at the correct prescribed time of 12:00

Insufficient Evidence

27. It is not known if the patient was to take this medication round-the-clock and for what reason.

28. The patient's notes and drug chart were not provided in support of this allegation, it would be difficult for me to answer this allegation as I am unlikely to recall what happened several years down the line. This is not in the interest of conducting this process in a fair manner.

Charge 6a: Failed and/or refused to administer Celecoxib to a patient with T10 fracture and metastatic cancer on 25 January 2019

Insufficient Evidence

29. The evidence shows that the medication was not given on 2 occasions because the patient refused it after being informed of the risk of taking the medication.

30. It is unclear from the evidence if the claim that the patient refused it on 2 occasions is a disputed fact.

31. A patient has a right to refuse to take medications.

32. As the patient's notes and medication chart were not provided in support of this case, it would be difficult for me to answer this allegation. This is not in the interest of conducting this process in a fair manner.

Charge 6b: Failed and/or refused to administer Celecoxib to a patient with T10 fracture and metastatic cancer on 27 January 2019

33. Please see reasons provided for Charge 6a. I apply for a 'no case to answer' judgment on this charge for the same reasons.

Charge 7: On 3 February 2019, failed to attend to/assist with a patient with who had a high risk of falls *Page* ***5*** *of* ***9***

Insufficient Evidence

34. [Mr 7] affirmed that he did not take my version of events in relation to this charge. There is also no record that shows this issue was brought to my attention.

35. The evidence contained in his email JA/05 was mostly based on speculation about my thoughts regarding patient safety.

36. Evidence must be fair and unbiased.

Charge 8: On 10 February 2019, failed and/or refused to administer IV Co-Amoxiclav to a patient admitted with delirium secondary to UTI

Insufficient Evidence

37. The evidence shows that the medication was held, and a doctor's review was requested in view of the result of the patient's infection markers (WBC = 8.5 CRP = 17.2). It was alleged that I still refused to administer it even after the doctor has reviewed this and indicated they want the medication to be given. This is an unlikely outcome of a doctor's review given the patient's blood test results.

38. This requires expert advice.

39. During cross-examination, the witnesses denied having knowledge of the implications of the patient's blood test results on the need to continue the IV antibiotic.

40. There is also an indication that this was poorly investigated as [Ms 15] did not have the clinical knowledge to determine the appropriate action in this circumstance. She should have consulted this with a medical Consultant.

41. To make findings of fact in relation to this allegation, it is important that the panel have sight of the patient's medical notes to establish the outcome of the doctor's review and/or obtain expert advice.

42. Without the medical notes, drug chart, and my nursing notes, it would also be difficult for me to establish my defense. This is not in the interest of conducting this process in a fair manner.

Charge 9: On 13 February 2019, failed and/or refused to administer Sando K on one, or more, occasions to a patient admitted to the Acute Medical Unit with hypokalemia

Insufficient Evidence

43. As per the evidence, Sando K is given for the treatment of low potassium level. The patient's potassium level is in the normal range at 4.3 mmols/L when the medication was held. The witnesses were not aware of any condition of the patient where she would have a tendency to continuously lose potassium. It can be inferred that the patient did not require a further dose of this medication if her potassium level was in normal range.

44. It is claimed that the medication is still required as the patient's potassium level was thought to be "borderline".

45. In order to address the disputed fact in this case, this requires expert advice.

46. This was poorly investigated. The witnesses showed a lack of understanding of the implication of the blood test result to the need to continue this medication. They did not refer to the Trust protocol for the management of hypokalemia.

47. Without the medical notes, drug chart, and my nursing notes, it would also be difficult for me to establish my defense. This is not in the interest of conducting this process in a fair manner.

Charge 10a: On 16 February 2019, administered IV Tazocin to a patient without ensuring that the dose and/or route was second checked before administration

Unlikely to Lead to a Finding of Impairment / Context

48. This is unlikely to lead to a finding of impairment as this was a one-time incident only. The evidence shows I acknowledged that it was necessary to have another nurse second check the administration as I approached a senior nurse to ask them to check and sign for the administration when I realised the mistake. This was more likely a human error.

49. The witnesses provided evidence to affirm that we work in a very busy ward environment with a lot of distractions and staff often have to rush to get things done.

Charge 10b: On 16 February 2019, administered IV Tazocin to a patient when not trained and/or authorised to do so by the Trust

Other Reasons

50. [Ms 15] provided evidence that we had an agreement that I may administer IV medications pending Trust training and completion of competencies on the basis that I have completed training and competency assessments at my previous workplace. This was due to the IV training schedule backlog at the Trust versus the service delivery needs of the unit.

Charge 11: On 16 February 2019, failed to administer and/or sign for the administration of Lantus Solostar to a patient

Unlikely to Lead to a Finding of Impairment / Context

51. This is unlikely to lead to a finding of impairment as likely cause is human error.

52. The witnesses provided evidence to affirm that we work in a very busy ward environment with a lot of distractions and staff often have to rush to get things done.

Charge 12a: In relation to the administration of S/C Insulin Lantus to a patient on, or around 16 February 2019, failed to timeously sign for the administration

53. This is unlikely to lead to a finding of impairment as likely cause is human error.

54. The witnesses provided evidence to affirm that we work in a very busy ward environment with a lot of distractions and staff often have to rush to get things done.

Charge 12b: In relation to the administration of S/C Insulin Lantus to a patient on, or around 16 February 2019, retrospectively signed for the administration on 18 February 2019

Insufficient Evidence

55. There is no evidence to show that retrospective signing is not permitted as per the Trust policy or the NMC standards.

Charge 13: On 18 February 2019, shouted at a colleague during a handover

Context

56. [Mr 7] alleged that I shouted at him as I thought he slurred the word “dumb" into a sentence he was saying in order to vex me.

57. [Mr 7] could not recall what I told him while I was allegedly shouting.

58. [Mr 7] admitted to making a comment about my ability to understand and speak the English language, which was inappropriate.

59. [Mr 7] could be exaggerating to add more weight to his complaint against me.

60. [Mr 7] did not show good conflict resolution skills in addressing this situation. He was combative in his approach.

61. This evidence cannot be relied upon as objective and unbiased.

Charge 14: On one, or more, occasion, used your own self- made handover sheet

62. The evidence is mostly undermining comments about the usefulness of this tool because some staff were concerned it could prolong handover time.

63. There is no evidence that the use of the tool can negatively impact patient safety.

64. For Charges 15a, 15b, 15c, and 15d, I will provide my reasons for applying for an NCTA as one in the next section.

Charge 15a: On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including arguing with nursing and medical staff

Charge 15b: On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including challenging medical/patient decisions

Charge 15c: On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including refusing to assist colleagues on the Ward
Charge 15d: On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including refusing to discharge patients Duplication of Charges / Insufficient Evidence
65. Some of the evidence used in these charges relates to the other charges such as: Charge 15a to Charge 2

Charge 15b to Charge 2
Charge 15c to Charge 7
66. For the above charges, it would appear that I am being charged twice for the same offence.

67. Also, most of the evidence provided by [Ms 15], [Mr 7], and [Mr 6] in support of these charges are hearsay evidence lacking in specific details.

68. Without details of specific incidents where these allegations are based on, it would be difficult for me to provide my response. This is not in the interest of conducting this process in a fair manner.

Charge 16a: On one, or more, occasion, failed to preserve patient safety by failing to transfer patients in a timely manner

Context
69. [Mr 7]'s evidence reveals difficulties in accomplishing the task of transferring patients due to the nature of the ward being a busy environment and the tendency that support may not be available at all times.

Charge 16b: On one, or more, occasion, failed to preserve patient safety by failing to complete documentation in a timely manner

Context

70. [Ms 15] acknowledged that there will be times when nurses in the unit will have to stay behind to close nursing documentation due to the nature of the ward being a busy environment and the need to close the nursing documentation near the end of the shift when nurses might not be able to find the time to do so due to overlapping tasks such as the need to complete the medication rounds, receive new admissions, and handover care.

71. There is no evidence that this has led to a patient safety incident.

Charge 17: Failed to cooperate with the London North West University Healthcare Trust's investigation [PRIVATE].

Unlikely to Lead to a Finding of Impairment

72. This is unlikely to lead to a finding of impairment as there is now evidence of [PRIVATE].

73. The purpose of the fitness to practice process is not to punish nurses for past events but to determine if the registrant's current fitness to practice is impaired.

Charge 18: [PRIVATE].

Unlikely to Lead to a Finding of Impairment

74. This is unlikely to lead to a finding of impairment as there is now evidence of [PRIVATE].

Charge 19: [PRIVATE].

Unlikely to Lead to a Finding of Impairment

75. This is unlikely to lead to a finding of current impairment based on the [PRIVATE].

You also provided the panel with an evidence matrix table, demonstrating where you believe the NMC has either provided no evidence or insufficient evidence in support of each charge, which the panel has read in full.

You requested in your oral submissions that the panel ignore any reference to Rule 24(8) in your evidence matrix table and clarified that this application is being made under Rule 24(7).

In light of your submissions, you invited the panel to determine that there is no case to answer in respect of all the charges in the Ealing case due to either no evidence or insufficient evidence provided by the NMC.

Ms Nelson submitted that the NMC opposes this application in respect of all the charges in the Ealing case. She asked the panel to refer to the previous submissions she made in respect of the charges relating to the Hammersmith case which form part of your no case to answer application.

With regard to charge 10(b), Ms Nelson submitted that Ms 15 in her oral evidence stated that, despite you not being trained by the Trust to administer the IV medication at the time, she did authorise you to perform this task in light of your previous training. On this basis, Ms Nelson submitted that, whilst this charge could be proved on the first part (i.e. that you were not trained by the Trust to administer the medication), the panel may feel that the regulatory concern no longer exists as it has now been confirmed that you were in fact authorised to administer the medication at the time.

In respect of the remaining charges, Ms Nelson submitted that your application is premature and misguided as you seem to focus your submissions on the context of the evidence provided by the NMC, and the reliability of witnesses. She submitted that the panel at this stage cannot consider such matters until the close of your case and when deliberating on whether the facts are proved.

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

Ms Nelson therefore submitted that there is in fact evidence available which supports and speaks directly to these charges.

[PRIVATE].

The panel took account of the submissions made and heard and accepted the earlier advice of the legal assessor who had directed the panel to the test in *Galbraith* [1981] as further explained in *Shippey* [1988].

The panel addressed each charge separately as follows:

Charge 1:

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 2:

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 15 along with her exhibit (VB/03), and the oral evidence it heard from Ms 14 during the course of the hearing. The panel noted that paragraph 11 of Ms 15's statement addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 15 and Mr 7 along with their exhibits (VB/08 and

JA/02). The panel noted that paragraphs 18 to 19 of Ms 15's statement and paragraphs 9 to 10 and 12 of Mr 7's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(b):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 15 and Mr 7 along with Ms 15's exhibits (VB/08), and the oral evidence it heard from Ms 15 and Mr 7 during the course of this hearing. The panel noted that paragraph 19 of Ms 15's statement and paragraphs 11 to 12 of Mr 7's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 3(c):

The panel determined that there is evidence in support of this charge, specifically that you 'inappropriately' challenged a colleague regarding a patient discharge. The panel has a written statement provided by Ms 15 and Mr 7 along with Ms 15's exhibits (VB/08), and the oral evidence it heard from Mr 7 during the course of this hearing. The panel noted that paragraph 19 of Ms 15's statement and paragraph 13 of Mr 7's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 15 along with her exhibit (VB/09), and the oral evidence it heard from Ms 15 during the course of this hearing. The panel noted that paragraph 21 of Ms 15's statement addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 4(b):

The panel determined that there is evidence in support of this charge. The panel has written statements provided by Ms 14 and Ms 15 along with Ms 14's exhibit (JP/01). The panel noted that paragraph 7 of Ms 14's statement and paragraph 21 of Ms 15's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charges 5(a) and 5(b):

The panel noted that a document (JP/01) was created by Ms 14 and Ms 15 to collate DATIX incidents which include the incidents referred to in this allegation. However, this document is not supported by any other evidence in respect of charges 5(a) and 5(b). The NMC has not provided any primary evidence in order to verify this document (e.g. patient notes and drug chart). As a result, you are not able to effectively challenge this evidence. It therefore decided that there is no case to answer in respect of these charges because the NMC's evidence is too weak (as per Galbraith).

Charge 6(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 15 and Mr 7 along with Mr 7's exhibit (JA/03) and the oral evidence it heard from Ms 14 and Mr 7 during the course of the hearing. The panel noted that paragraphs 23 to 25 of Ms 15's statement and paragraphs 14 to 17 of Mr 7's statement address this charge. The panel further noted that Ms 14's exhibit (JP/01) also supports this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 6(b):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 15 and Mr 7 along with Mr 7's exhibit (JA/03) and the oral evidence it heard from Ms 14 and Mr 7 during the course of the hearing. The panel noted that paragraphs 23 to 25 of Ms 15's statement and paragraphs 14 to 17 of Mr 7's statement address this charge. The panel further noted that Ms 14's exhibit (JP/01) also

supports this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 7:

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 16, which you did not challenge. The panel noted that paragraphs 4 and 5 of Ms 16's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 8:

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 9:

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 10(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 6 and Mr 5 along with Mr 6's exhibit (SB/01). The panel noted that paragraphs 8 to 9 of Mr 6's statement and paragraphs 5 of Mr 5's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 10(b):

The panel determined that there is evidence in support of the first element of this charge. The panel heard Ms 15's oral evidence where she confirmed that you were not trained to administer IV medication by the Trust. However, the NMC has conceded the second element of this charge as Ms 15 in her oral evidence stated that the Trust nevertheless did authorise you to administer IV medication at the time as long as you were accompanied by a second nurse. It was therefore satisfied whilst there is a case to answer in respect of the first element of this charge, there is no case to answer in respect of the second element of this charge.

Charge 11:

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 12(a):

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 12(b):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 5 along with his exhibit (PA/01), and the oral evidence it heard from Mr 5 during the course of the hearing. The panel noted that paragraph 6 of Mr 5's statement addresses this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 13:

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 5 along with his exhibit (PA/01). The panel noted that paragraphs 7 to 8 of Mr 5's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 14:

As you appear on the face of your application to accept the facts of this allegation an application under Rule 24(7) must fail. The panel noted that your submissions on this charge concern whether there could be a finding of impairment: this is perhaps a matter for Rule 24(8).

Charge 15(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 7, Mr 6 and Ms 15 along with exhibits VB/09, VB/11 and VB/21, and the oral evidence it heard from all three witnesses during the course of the hearing. The panel noted that paragraphs 4 to 8, 13, 15 and 20 of Mr 7's statement, paragraph 6 of Mr 6's statement and paragraphs 5 to 16 of Ms 15's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 15(b):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 7 and Ms 15 along with Ms 15's exhibit (VB/08). The panel noted that paragraphs 4 to 5, 9 and 21 of Mr 7's statement and paragraph 19 of Ms 15's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 15(c):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Ms 16 and Mr 7. The panel noted that paragraph 4 of Ms 16's statement and paragraphs 21 and 32 of Mr 7's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 15(d):

The panel determined that there is no evidence in support of this charge. It noted that in exhibit JA/02 (an email from Mr 7 to Ms 15) Mr 7 stated that you were hesitant to discharge the patient at the time, not that you refused to discharge the patient. It therefore decided that there is no case to answer in respect of this charge (as per Galbraith).

Charge 16(a):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 7 and Ms 15 along with exhibits JA/01, VB/01, VB/02, VB/03, VB/04, VB/05, VB/06 and VB/07, and the oral evidence it heard from these two witnesses during the course of the hearing. The panel noted that paragraphs 4 to 8, 26 and 28 of Mr 7's statement and paragraphs 5 to 16, 14 and 34 of Ms 15's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 16(b):

The panel determined that there is evidence in support of this charge. The panel has a written statement provided by Mr 7, Mr 6 and Ms 15. The panel noted that paragraph 27 of Mr 7's statement, paragraph 5 of Mr 6's statement and paragraphs 35 to 36 of Ms 15's statement address this charge. It was therefore satisfied that there is a case to answer in respect of this charge.

Charge 17:

The panel determined that there is no evidence in support of this charge. [PRIVATE]. It therefore decided that there was no case to answer in respect of this charge (as per Galbraith).

Charge 18:

The panel determined that there is no evidence in support of this charge. [PRIVATE]. It therefore decided that there was no case to answer in respect of this charge (as per Galbraith).

Charge 19:

The panel determined that there is evidence in support of this charge, but only in respect of the second element of schedule 1. [PRIVATE]. It was therefore satisfied that there is a case to answer in respect of the second element of the schedule 1 to this charge.

Resuming 6 November 2023

[PRIVATE].

You dd not oppose Ms Nelson’s submissions.

The legal assessor indicated that he agreed with the proposed approached suggested by the NMC.

Given that no effective progress can be made until the panel has considered further evidence from Dr 1, it determined that it would be fair and in the interest of justice to pause the hearing at this juncture.

Resuming 13 November 2023

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Nelson, on behalf of the NMC, to amend the wording of charge 19.

[PRIVATE].

"That you, a registered nurse:

19. [PRIVATE].

AND in light of the above, your fitness to practise is impaired by reason of your misconduct in relation to charges 1, 17 and 18; by reason of your misconduct and/or lack of competence in relation to charges 2-16 inclusive; [PRIVATE].

Schedule 1 (private)

[PRIVATE].

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to reflect the [PRIVATE]and make the charge factually accurate.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Nelson on behalf of the NMC and by you.

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

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

- Ms 1: Matron for Cardiology at Hammersmith Hospital, part of the Imperial College NHS Trust;
- Ms 2: Senior Nurse under the Cardiac Directorate at Hammersmith Hospital, part of the Imperial College NHS Trust;
- Ms 8: Site Nurse Practitioner at Imperial College NHS Trust;
- Mr 2: Health Care Assistant in the Heart Assessment Centre at Hammersmith Hospital, part of the Imperial College NHS Trust;
- Ms 10: Band 6 Nurse in the Cardiology department at Hammersmith Hospital, part of the Imperial College NHS Trust;

- Mr 3: Senior Registrar in the Heart Assessment Centre at Hammersmith Hospital, part of the Imperial College NHS Trust at the time of the incidents;

- Ms 9: Band 5 Nurse in the Heart Assessment Centre at Hammersmith Hospital, part of the Imperial College NHS Trust, at the time of the incidents;

- Ms 7: Pulmonary Hypertension Specialist Nurse at Hammersmith Hospital, part of the Imperial College NHS Trust at the time of the incidents;

- Mr 4: Lead Pharmacist in Cardiology at Hammersmith Hospital, part of the Imperial College NHS Trust;

- Ms 11: Clinical Practice Educator in the Cardiothoracic Intensive Care Unit at Hammersmith Hospital, part of the Imperial College NHS Trust, at the time of the incidents;

- Ms 12: Ward Sister in the Heart Assessment Centre at Hammersmith Hospital, part of the Imperial College NHS Trust at the time of the incidents;

- Ms 13: Band 5 Nurse in the Heart Assessment Centre at Hammersmith Hospital, part of the Imperial College NHS Trust;

- Ms 14: Matron on the Acute Medical Unit at Ealing Hospital, part of London Northwest University Healthcare Trust at the time of the incidents;

- Mr 5: Band 5 Nurse on the Acute Medical Unit at Ealing Hospital, part of London Northwest University Healthcare Trust at the time of the incidents;

- Mr 6: Band 5 Nurse on the Acute Medical Unit at Ealing Hospital, part of London Northwest University Healthcare Trust at the time of the incidents;

- Mr 7: Band 6 Nurse on the Acute Medical Unit at Ealing Hospital, part of London Northwest University Healthcare Trust at the time of the incidents;

- Ms 15: Ward Manager on the Acute Medical Unit at Ealing Hospital, part of London Northwest

	University Healthcare Trust at the time of the incidents.
• Dr 1	Consultant Psychiatrist

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the oral evidence it heard and the documentary evidence provided, along with the oral submissions made by both you and the NMC.

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

Charge 1a)

1) Failed to provide appropriate care to one, or more, patients, in that you:

a. Did not undertake and/or timeously undertake, the admission of one, or more, patient(s) on 7 June 2017

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included witness statements from Ms 1 and Ms 9 and internal records.

In Ms 9's witness statement she said:

> *'I do not recall the details of this incident but understand that the Registrant had one admission to complete and complained that she did not have any support in completing the admission.*

One patient admission is very easy to complete and is not considered a high workload. Usually during a shift each nurse will need to complete at least four to five admissions and sometimes when working as the NIC I do nine admissions during a shift. Admissions include admitting the patient to their bed then carrying out risk assessments such as measuring their height, weight and other measurements. It is not a very taxing task.

I would have expected the Registrant to be able to cope with admitting one patient without fail and without requiring support to do so.'

In Ms 1's witness statement she said:

'Despite the Registrant only having two patients…[she] was unable to manage completing the admissions process for her two patients and complained that she did not have any support to do so. The Registrant had been working within the cardiac department for 18 months by then and the admission process should have been embedded in her knowledge.

…

The Registrant admitted one of her two patients at approximately 15:00 but despite only having one other admission to complete, she had not admitted her second patient by the time her shift ended at 20:30…'

In Ms 1's internal note, a near contemporaneous record of events updated on an ongoing basis by Ms 1, she said:

'The NIC reported to me that XS was unable to manage 2 admissions into beds 2 and complained that she did not have any support.'

During your oral evidence you stated that you had a heavy workload and were unable to take on the admissions due to this despite asking Ms 9 for help. You accepted the fact

that you had not admitted your allocated patients. You told the panel that this was a one-off event and that you are usually able to undertake admissions satisfactorily.

The panel determined that you had a duty to complete admissions of multiple patients and that this is a routine and integral part of a nursing shift on an acute ward that you would be expected to complete but failed to do so. You were allocated two patients for admission on 7 June 2017 and you only admitted one of these patients at around 15:00. You failed to admit the remaining patient. Accordingly, the panel finds this charge proved in respect of not admitting one patient at all, and not admitting the other patient timeously.

Charge 1b)

1) Failed to provide appropriate care to one, or more, patients, in that you:
   b) Did not provide a handover in relation to your patient(s) when going on a break on 9 August 2017"

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included a witness statement from Ms 1 and internal records.

In Ms 1's internal note she wrote:

> *'On 8 August 2017 SS asked XS to go for a break and she ignored [Ms 1] . This request was made again and the reasons why she needed to go to the assigned break. XS did not like this request despite the reasons why it was important to go for her break at that time. She was given 10 minutes by which to leave. XS did not leave at the assigned time but did not have over [sic] any of her patients and left the keys on-top of the nurse's station.'*

Even though Ms 1 wrote in her statement that the incident occurred on 8 August 2017, it was agreed in her oral evidence and by you that the date in this note was a typographical error, and the alleged incident did in fact occur on 9 August 2017.

During your oral evidence you accepted that you did not give a handover to your colleague because you said that it was not necessary to give a full handover before a break, as the nurse in charge, Ms KB, already knew about your patients as she had received a full handover at the beginning of the shift.

In your witness statement you stated:

> *'We do not normally do a full handover of patients before we go for our break. We only update the nurse-in-charge if there are significant changes to patient's condition or care or if there are any tasks that needs to be completed while we are on break. In that instance, all my patients are settled and in stable condition'.*

The panel determined that you had a duty to give your colleagues a brief handover to a colleague before going on break even if this was to say that all your patients were stable as issues can arise at any time. You accepted that you failed to provide a handover. The panel also noted that when you took your break this was reported to be excessively long, of an hour's duration. By not providing any handover at all when you took a break you failed to provide appropriate care for your patients.

Therefore, the panel finds this charge proved.

Charge 1c(i)

1) Failed to provide appropriate care to one, or more, patients, in that you:
   c) In relation to Patient B on 11 August 2017:
      i. inadequately completed/undertook a handover;

This charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement of Ms 1.

In Ms 1's witness statement she said:

> *'I waited whilst the Registrant handed Patient B over to the A7 nurse but it took her 45 minutes to do so … When I went to ask the Registrant why the handover was taking so long, I then also heard the Registrant hand over to [A7 nurse] that Patient B required a diabetes nurse referral. I asked the Registrant why this was as Patient B had been in the Registrant's care for eight hours by this point and it had been documented in Patient B's medical entry at 08:30 that he needed a diabetes nurse referral.'*

You stated in oral evidence that you had taken sufficient time to ensure that Patient B was handed over to [A7 Nurse] and her student. You said that you had completed a handover, and that it was thorough enough to identify care needs requiring follow-up. You said that you had gone through the patient's chart including his observations, medications, SALT assessment, CCOT assessment and Doctor's plan. [A7 Nurse] was happy to follow through with Patient B's care. You said that the handover for Patient B was complete and assisted the nurse taking over his care and facilitated safe and seamless continuity of care.

The panel determined that you had a duty to undertake a handover for the patients in your care. Based on the evidence before the panel, it determined that you had completed a handover to an adequate level even though it took some time to complete. Therefore, the panel finds this charge not proved.

Charge 1c(ii)

1) Failed to provide appropriate care to one, or more, patients, in that you:
   c) In relation to Patient B on 11 August 2017:
      ii. did not ensure such a handover was undertaken timeously;

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement of Ms 1 and internal statements.

The panel considered the paragraph referred to in charge 1c) i) from Ms 1's witness statement.

In oral evidence Ms 1 said that the handover should not have taken so long and pointed out that you were not a newly qualified nurse.

In Ms 1's internal note she wrote:

> *'XS took 45 mins to handover 1 patient. When questioned why it was taking so long XS said the patient was complex…'*

In your oral evidence you accepted that it took quite a while to hand over this patient because you had to hand over to the student nurse first and then to the staff nurse. You accepted that it took longer than 15 minutes, which was the time period deemed by Ms 1 to be the usual length of time. As Ms 1 is a senior nurse, the panel accepted this estimate of the time which would be needed for a handover to be reasonable and appropriate.

The panel determined that even though you completed the handover to both a student and their supervising nurse, to take 45 minutes on an acute ward to hand over was unreasonable. Your handover was not undertaken timeously, so therefore, the panel finds this charge proved.

Charge 1c (iii)

1) Failed to provide appropriate care to one, or more, patients, in that you:
   c) In relation to Patient B on 11 August 2017:
      iii. did not ensure that Patient B had a diabetes referral/review;

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement from Ms 1 and internal documents.

In Ms 1's internal note she wrote:

> *'…I also heard XS handover to the A7 nurse that the patient required a diabetes nurse referral. I questioned this because the patient had been in XS care for 8 hours and this request was documented in the medical entry at 08:30.'*

Ms 1 also provided Patient B's record, dated 11 August, which clearly detailed that a diabetic review was required.

During your oral evidence, you acknowledged that it was your responsibility to ensure that Patient B had a diabetes referral/review but you passed on this responsibility, towards the end of your shift at 3.45pm, to the A7 nurse at handover who was happy to complete this task. You also said that you were very busy attending to the patient's needs and had very limited opportunity to access the computer to review the doctor's plan. You said in your response to the charges that the NIC [Ms 9] had not informed you that a Diabetes nurse referral/review was necessary for Patient B and that you became aware that this was required upon taking a second look at the doctor's plan during the clinical handover at Ward A7.

You said that Patient B was under your care for the entire 8 hours of your shift. The panel determined that you should have been aware of Patient B's needs as the plan was clearly set out in his records which were available to you and which you should have read and implemented. You said that you only realised a Diabetes referral was required at the end of your shift. However, the panel determined that this did not constitute providing appropriate care for Patient B.

Therefore, the panel finds this charge proved.

Charge 1c (iv)

1) Failed to provide appropriate care to one, or more, patients, in that you:

c) In relation to Patient B on 11 August 2017:

iv. did not recognise that a catheter insertions record was not in place"

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement from Ms 1 and patient records.

In Ms 1's witness statement she said:

> *'[A7 Nurse] then said that a urinary catheter insertion record and care plan were not in place for Patient B.*
>
> *…*
>
> *Patient B had come to the HAC during the night from another area in the Hospital with the Catheter inserted. The night staff on the HAC should therefore have identified that he had a catheter inserted and that he required a catheter insertion record. This should have been handed over to the Registrant when she started her shift at 08:00 that morning, although I do not know if this was handed over. The Registrant had then failed to recognise that a catheter insertion record was not in place.*
>
> *…*
>
> *A care plan was also not in place and the Registrant should have realised this when she received handover for Patient B on the HAC at the start of her shift; on noticing, she should have created one. It was the Registrant's responsibility to ensure both documents were in place as Patient B was one of her allocated patients for her shift.'*

In Ms 1's internal note she wrote:

> *'Furthermore, the A7 nurse identified that a urinary catheter insertion record and care plan was not in place for the patient. I questioned this and XS did not have an answer for me. I explained this was unacceptable as HAC had not been busy.'*

Ms 1 also provided Patient B's Urinary Catheter record which shows that the insertion record was put in place by [A7 Nurse], not you.

In your witness statement you said:

> *'…During this process, we had identified that the patient did not have a urinary catheter insertion record and it was also identified that he needed a Diabetic Nurse referral. [A7 Nurse] was supportive, reassuring and happy to follow through with his care.*
>
> *…*
>
> *The lack of a catheter insertion record was not realised at the start of my shift as the night staff failed to handover this to me. It is likely that they have also failed to notice this.*
>
> *…*
>
> *I had very limited opportunity to access the computer whilst this patient was under my care due to other nursing priorities which is why I was unable to pick this up earlier.'*

As both you and Ms 1 said that you had received a poor handover from the night staff, you should have been more proactive and examined the patient notes during your shift in order to provide appropriate care to Patient B. You said that you had limited opportunity to access the computer whilst Patient B was under your care due to other

nursing priorities, and this was why you failed to notice the lack of a catheter insertion record until the handover at the end of your shift.

In your oral evidence you emphasised that it was the responsibility of the nurse who inserted the catheter to create a catheter insertion record. The panel accepted that this record should have been created by whoever inserted the catheter; however, the panel considered that it was your duty as the nurse caring for Patient B to ensure that all documentation was complete and therefore you should have created the insertion record.

Therefore, the panel finds this charge proved.

Charge 1d (i)

1) Failed to provide appropriate care to one, or more, patients, in that you:
d) Did not provide care to all patients during your shift on 21 Sept 2017 in that you:
i. Did not participate in a ward round relating to Patient L"

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement of Ms 11, internal records and an exhibit on the best practice on ward rounds produced by the Royal College of Physicians and Royal College of Nursing – *Ward rounds in medicine: Principles for best practice.*

In Ms 11's witness statement she said:

> *'Whilst the doctor was doing the ward round the Registrant was dealing with another patient in the next bed space. It is recommended by the Royal College of Nursing ("RCN") and the Royal College of Physicians ("RCP") that nurses should be accompanying doctors on ward rounds, so the Registrant should have been with the doctor whilst he was doing the ward round.'*

The RCP and RCN best practice guidance states:

> *'Nurses have a crucial role on ward rounds, not only sharing key information between the patient and the healthcare team, but also supporting patients in articulating their views and preferences. Absence of a nurse at the bedside has clear consequences for communications, ward-round efficiency and patient safety. Although time pressures have grown for all professions, the responsibility to set aside time for ward rounds should be a collective one for doctors, nurses, pharmacists and therapists. This can and should be negotiated by local teams.'*

In Ms 11's internal witness statement she wrote:

> *'It was noted Xandra did not partake in the ward round and didn't attempt to communicate with either the doctor or the nurse in charge during or after the ward round Reference, NMC Code: point 8.2 lacks the ability to communicate effectively with patients and colleagues.'*

You accepted that you did not participate in a ward round relating to Patient L. You said that the practice in HAC was that the NIC accompanies the medical team during ward rounds and then updates other nurses about any new orders. You also said that management had not provided instructions that staff nurses in HAC must join medical ward rounds, and that had they set new rules on this, you would have been willing to co-operate.

However, in oral evidence both Ms 1 and Ms 11 stated that it was common practice and there was an expectation for nurses to participate in the ward round with regards to the patients for whom they were caring. They also explained that the ward round involved the multi-disciplinary team coming to the foot of each bed. In the panel's view, a nurse caring for their patients should be easily able to participate as they would be in the immediate vicinity, and would be best placed to provide the multi-disciplinary team with information relating to their patients' current condition.

The panel therefore finds this charge proved.

Charge 1d (ii)

1) *Failed to provide appropriate care to one, or more, patients, in that you:*
d) *Did not provide care to all patients during your shift on 21 September 2017 in that you:*
   ii. *Told Patient L that they did not need to return to the hospital for a blood test, contrary to the advice given by a doctor"*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the statement of Ms 11.

In Ms 11's witness statement she said:

> *'A doctor (whose name I cannot recall) was undertaking the ward round on the HAC and so he approached Patient L and told him that he could go home that day (Thursday 21 September 2017). The doctor then told Patient L that he needed to come back into the Hospital on Saturday 22 September 2017 for a repeat blood test.'*

In your witness statement you said:

> *'I told him it would be fine to get the blood test done at his GP if they are able to facilitate this for him.*
>
> *It was not my intention to overrule a doctor's advice.*
>
> *[Ms 11], however, had a different opinion. While I was talking to the patient, she immediately intervened and asked me to take what I told the patient back saying that he was told by the doctor to come to the hospital for the blood test, so I*

came back to the patient and encouraged him to come back to the hospital for the blood test instead. The patient overheard what [Ms 11] had told me, and he reassured me that he will make arrangements to be driven to the hospital.

If [Ms 11] did not intervene, I would have had a conversation with the doctor about the patient's request as the doctor will need to coordinate with his GP to get the blood test organized. The doctor will also need to include a plan in his discharge summary that the blood test will be done by his GP.'

The panel determined that you had agreed that you had responded to Patient L's query by saying that it would be fine for him to get a blood test from his GP surgery rather than the hospital which was not what the doctor had requested him to do. By responding to Patient L in this way, the panel found that you had told the patient that he need not return to the hospital thus undermining the doctor's advice.

Therefore, the panel finds this charge proved.

Charge 1d (iii)

1) *Failed to provide appropriate care to one, or more, patients, in that you:*
d) *Did not provide care to all patients during your shift on 21 September 2017 in that you:*
   iii. Did not carry out one, or more, patient safety checks"

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement of Ms 11 and internal records.

In Ms 11's witness statement she said:

'During the same shift the Registrant failed to carry out patient safety checks once she had received handover which should have been her first action

…

It is a key priority that the bed spaces are checked immediately after handover to ensure they are safe. Instead the Registrant went to the computer and did not complete the checks'

In Ms 11's internal note she wrote:

'Xandra did not carry out patient safety checks after receiving handover. As a nurse who usually works in a Critical Care area, this would be the first action I would expect to be completed Reference Trust Orientation.'

During your oral evidence, you said that you did not recall the events but that on a normal day you always do the patient safety checks. You said that it is possible that you were engaged in another task which took priority over doing the patient safety checks. You also said that you might have been waiting to receive instructions from Ms 11 as to what to do.

The panel was provided with the Trust's 'Healthcare Professional Orientation Checklist', this included an action list on how to prepare and check bed spaces. The panel did not accept that you would be waiting for instructions from Ms 11 to complete the checks as her role was to support and observe you, not to instruct you on the basic tasks that were required.

Ms 11 was a practice educator assigned to work with you during your shift on 21 September 2017 to observe you working. Ms 11 said that she always begins by observing a staff member in practice in order to identify any concerns, begin a relationship from an angle of support, and give the staff member confidence to do their job and not feel like someone senior is watching over them. The panel found that, given that her task was to identify any concerns in your practice, it was more likely than not that her recorded observations are correct.

Therefore, the panel finds this charge proved.

Charge 1d (iv)

1) *Failed to provide appropriate care to one, or more, patients, in that you:*
d) *Did not provide care to all patients during your shift on 21 September 2017 in that you:*
   iv. Did not participate in the ward round(s)

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the witness statement of Ms 11.

In Ms 11's witness statement she said:

> *'Again during the same shift the Registrant failed to partake in the ward round and failed to communicate with the doctor or Nurse in Charge ("NIC") of the HAC during or after the ward round.*
> *…*
> *Instead of taking part in the ward round the Registrant was on the computer.'*

The panel relied upon the same points as made in charge 1d(i).

Therefore, the panel finds this charge proved.

Charge 1d (v)

1) *failed to provide appropriate care to one or more patients in that you:*
d) *Did not provide appropriate care to all patients during your shift on 21 September 2017 in that you:*
   v. Did not communicate with the doctor and/or nurse in charge following the ward round(s)"

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 11's witness statement.

In Ms 11's witness statement she said:

'*During the same shift [21 September 2017] the Registrant failed to partake in the ward round and failed to communicate with the doctor or Nurse in Charge ("NIC") of the HAC during or after the ward round.*
…
The Registrant worked in isolation and she could go a long period of time without talking to her colleagues.'

This was reiterated in Ms 11's oral evidence.

In your witness statement you said:

> *'It is possible that no verbal communication happened during that [sic] ward rounds between me, the nurse-in-charge and the medical team as this was not necessary.'*

The panel determined that you had a duty to communicate with the doctor/NIC in relation to the patients for whom you were caring as you would have valuable information relating to their condition during your shift as well as being in a position to act as a patient advocate. You accepted that you did not communicate with the doctor and/or NIC following the ward rounds as you did not believe this to be necessary.

Therefore, the panel finds this charge proved.

Charge 1d (vi)

1) *Failed to provide appropriate care to one or more patients in that you:*

d) *Did not provide care to all patients during your shift on 21 September 2017 in that you:*

   vi. *Told Patient M that they would be prescribed blood thinner medication, without first consulting a doctor*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 11's witness statement.

In Ms 11's witness statement she said:

> *'At one point during the morning of the Registrant's shift a patient ("Patient M") asked the Registrant if he would be prescribed blood thinner medication. The Registrant immediately responded by confirming that he would without first consulting a doctor. This was despite the doctor being two bed spaces away from the Registrant at the time whilst doing the ward round. I knew the Registrant had not checked with the doctor as I saw no attempt by her to communicate with the doctor and as far as I was aware she had not confirmed this information with the doctor beforehand.*
>
> *…*
>
> *With hindsight, it is possible that the doctor had prescribed the blood thinners for Patient M and that the Registrant saw this prescription on Cerner, however at the time when I raised the concern with the Registrant, she did not tell me that she had seen a prescription on Cerner.'*

In Ms 11's internal note she wrote:

> *'The patient in bed six asked if he was going to 'get blood thinners' and Xandra said yes, without consideration as to whether she should consult the doctors to confirm first. The doctors were 2 bedspaces away.'*

In your witness statement you said you could not recall the incident and were not aware of the concern until this referral.
You said:

> *'I was well-informed to respond to the patient's question on whether he will be prescribed blood thinners.*
> *…*
>
> *In her [Ms 11's] witness statement paragraph 33, she had stated that there was a 99% chance that the patient would get blood thinners. It seems that her concern was not that I had told patient M that he was going to have it but the manner I put it across. She stated that I should have said, "in my experience, it is possible that you will get blood thinners". I appreciate that she has a better way of putting it across and I would have been happy to adapt that approach.'*

You also stated that as Ms 11 did not regularly work in the HAC, she may not have had a lot of experience looking after patients after catheter lab procedures and may not have been familiar with the protocols. You said that you were very familiar with prescribing habits in the HAC, and therefore would have felt confident to advise Patient M of what they were likely to be prescribed. However, the panel found that Ms 11, as a Practice Educator in place on that day to observe your practice, provided credible evidence of what had happened at that time.

The panel determined that it is more likely than not you told Patient M that they would be prescribed blood thinner medication without consulting the Doctor, even though the Doctor was in close proximity. The panel agreed that it was part of your role as a nurse to explain to patients about any medication they were receiving, but that this should only be done once medication had been prescribed.

Therefore, the panel finds this charge proved.

Charge 1e (i)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
    i. *Had to be prompted to assist Patient N, who was exposed, in covering up*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 11 and Ms 1's witness statements.

In Ms 11's witness statement she said:

> *'When I arrived on the HAC the Registrant was sitting on the computer at bed space 7. The patient ("Patient N") from bed space 8 was returning from the toilet to her bed and it was clear that she was struggling. Patient N was an elderly patient in her 70s or 80s whose gown was open as she was walking, resulting in her buttocks showing. She was using the drip stand as a mobile aid and struggling to get back to her bed space.*
>
> *I would have expected the Registrant to turn away from her computer and ask if Patient N was OK. Instead she was working on her own, fixated on her computer whilst Patient N walked back with her gown open and an IV syringe inserted in her arm. It was part of the Registrant's job as a nurse to go to the other side of Patient N and assist her in mobilising. The Registrant not only failed to do this but she did not even acknowledge Patient N.'*

In Ms 1's witness statement she said:

> *'First, there were two patients who were physically exposed on the HAC, for example one of the patient's gowns was open, and I had to prompt the Registrant twice so that she could assist them in covering up. I would have expected the*

Registrant to take the initiative and help the patients without me having to tell her because being exposed was a dignity concern for the patients.'

In Ms 1's internal note she wrote:

'Prompted twice to ensure dignity of patients that were physically exposed.'

In your witness statement you said:

'I was focused on another task when Patient N attempted to mobilise to the toilet, and I did not notice right away that she needed help…

Another nurse had noticed she needed assistance, and this was provided already when my attention was called to help her.
…
If I had seen the pt before she was assisted by another nurse, I would have immediately taken steps to help her tie her gown to ensure she is properly covered up with due respect for her dignity and privacy.'

In cross-examination, you said that you were focused on another task and did not notice that the patient needed assistance. You said that you tend to be very focused and that it was not reasonable for nurses to "have eyes in the back of their head". You also maintained that another nurse was already helping with the patient, although you accepted that Ms 1 may have had to ask you twice to assist, as it can be difficult to attract your attention.

Ms 11 said in her oral evidence that nurses need to have global awareness and that patients are the priority, not computers.

The panel determined that there was evidence from two senior nurses who were on the ward at the time, one of whom was there to observe and support you, that you had failed to notice patient M's exposed state. The panel found their version of events to be credible. The panel did not find it acceptable that you were not aware of an elderly

patient walking within "*an arm's length"* of you with an alarm ringing loudly. The panel found that you have a duty as a nurse to notice what is happening in your surrounding area and with the patients in your care. It found that by failing to notice this patient and not responding to assist in covering them up when prompted by a senior nurse that you did not provide appropriate care to Patient N.

The panel finds this charge proved.

Charge 1e (ii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   ii. *Did not recognise and/or assist Patient N, who was attempting to mobilise"*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included the same evidence as used in 1e(i).

In Ms 1's internal note she wrote:

> *'[The Registrant] Stood a short distance from a patient trying to mobilise and did not look up or recognise the patient required assistance. Assistance given by Senior Nurse who was visiting the ward.'*

In oral evidence Ms 1 said that the patient needed your help as she was holding onto the bed and the IV leads were a trip hazard. She said she had to ask you twice before you responded and said it came across as though you were ignoring her.

You maintained the same reasoning as you did in the previous charge.

The panel notes that this charge is closely linked to charge 1e(i) and finds this proved for the same reasons that as there is corroborative evidence from two senior nurses that this is more likely than not to have occurred.

The panel found that you have a duty to notice and respond to the needs of the patients in your care. By not noticing or acknowledging Patient N, who was attempting to mobilise, and by allowing Ms 11 to provide the assistance needed by Patient N, you failed to provide appropriate care.

Accordingly, the panel finds this charge proved.

Charge 1e (iii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   iii. Did not reconnect Patient N's infusion pump which was 'alarming'

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 11's witness statement.

In Ms 11's witness statement she said:

> *"Patient N also had an infusion pump which was attached to the drip stand, which was alarming loudly as she walked past the Registrant… The alarm on the infusion pump was going off because it had been disconnected from the main power source when Patient N had gotten up to go to the toilet. ..The pump simply needed to be re-plugged back into the wall and if it was not the pump would fail, which meant Patient N would not receive the medication she needed.*

The Registrant would definitely have been able to see Patient N out of the corner of her eye as Patient N walked by very close to the Registrant and at one point was only an arm's length away. Again, as a nurse I would have expected the Registrant to realise that the alarm was going off and to have plugged this back in.

I stepped in and asked the Registrant to plug in the alarm and to help Patient N back to her bed but her face appeared vacant so I got up and helped Patient N back to her bed and I plugged in the alarm for her."

You maintained the same reasoning as you did in the previous two sub-charges that managing infusion pumps had not been raised in your performance management plan. You also maintained that managing alarms was everyone's role, not only yours. You also explained that the patient was already being assisted by another nurse when your attention was called to help her.

The panel determined that although everyone may intervene in silencing patient alarms, it is the responsibility of the nurse caring for a particular patient to address the cause of the alarm going off and that you failed to do this. The panel determined that Ms 11 was on the ward specifically to observe and support you and gave evidence that she had to reconnect the infusion pump because you had failed to respond. The panel considered Ms 11 to be a reliable witness and the description of you being "fixated" on the computer is consistent with other descriptions of your behaviour and your own acceptance that you tend to be focused and difficult to distract.

The panel preferred Ms 11's evidence and therefore found this charge proved.

Charge 1e (iv)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   iv. *Did not tell a patient who was nil by mouth ('NBM') that they could not eat*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and internal note.

In Ms 1's witness statement she said:

> *'There was a patient on the HAC who needed to be NBM because they were due to have a procedure. However, the Registrant failed to tell the patient that they could not eat. It is normal and essential practice to ensure patients who are required to be NBM are told by their named nurse on duty, who in this patient's case was the Registrant. The patient however was not told and went on to eat, which meant that their planned procedure was delayed or cancelled due to them eating. When I spoke to the Registrant about this, she simply said she thought that "night staff would have told the patient".*
>
> *The Registrant was the named nurse for the patient and it was her responsibility to ensure that the patient was both educated and supported pre-procedure; this included making sure that the pre-procedure checklist was complete and correct and included ensuring that the patient continued to be NBM.'*

In Ms 1's internal note she wrote:

> *'Patient NBM not informed by XS. Procedure delayed/cancelled due to feeding. XS said "she thought the night staff would have told the patient".*

In oral evidence Ms 1 said that it was everyone's duty to reinforce the "Nil by Mouth" message. When asked if other nurses had also failed to do this, she maintained that it was everyone's responsibility but that as you were the named nurse, you were ultimately responsible.

During your oral evidence you stated that you could not recall this incident and that there is no policy that sets out the protocol in terms of informing patients that they need to be NBM prior to their procedure. In cross-examination you accepted that the named nurse had the ultimate responsibility for the patients they had been allocated. However, you could not recall whether you were the named nurse for this patient on this occasion. In your written statement you said:

> *"it is unfair that management are blaming me for this failure because the task should have been completed by night staff"*

Ms 1's internal note signifies that she was supervising your practice, as Matron, and had recorded her observations of you caring for your patients on 9 October 2017. Therefore, the panel found that you were the named nurse for this patient.

The panel determined that it was the duty of all nurses caring for this patient to tell, and remind them that they were NBM. Although the night nurses should have, and indeed may have, informed the patient, the panel considered that it was your duty as the nurse caring for the patient on the day shift to make sure the patient understood that they should not eat or drink, and that you failed to do this.

Therefore, the panel finds this charge proved.

Charge 1e (v)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
    v. *Did not answer the HAC telephone on one, or more, occasion"*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and internal note.

In Ms 1's witness statement she said:

> *'At another point during the shift the HAC phone rang and the Registrant was the only person who was stood in front of it, yet she still did not answer.'*

In Ms 1's internal note relating to her observations of your supervised practice on 9 October 2017 she wrote:

> *'Did not answer the telephone when she [the Registrant] was stood in front of it and [was] the only person in the vicinity.'*

Ms 1 said in oral evidence that she saw you standing right by the phone when it was ringing and that you failed to answer it. She said that the phone was *"ringing and ringing" and* that she had had to come out the office to answer it.

In your witness statement you wrote:

> '*I am unable to recall the first occasion described in [Ms 1's] witness statement paragraph 38. It is highly possible that I was in the middle of another task when the phone rang. Otherwise, I would have answered the phone call as I always do.*'

In your oral evidence and witness statement you said that you were unable to recall the incident on 9 October 2017.

The panel placed considerable weight on the near-contemporaneous note made by Ms 1 where she was recording her observations of your practice on the day in question and found it more likely than not that you failed to answer the telephone as alleged.

Therefore, the panel finds this charge proved.

Charge 1e (vi)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
vi. *Did not comply with an Aseptic Non-Touch Technique ('ANTT') when inserting a vascular access device"*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and internal note.

In Ms 1's witness statement she said:

> *'I observed the Registrant undergoing a poor Aseptic Non-Touch Technique (ANTT). There are five moments of hand hygiene; the first one is to cleanse hands prior to touching a patient in order to minimise cross infection. In this instance I was supervising the Registrant whilst she inserted a vascular access device (a cannula) into a patient's vein. The Registrant failed to cleanse prior to touching the patient but this was corrected after I discretely prompted the Registrant. The risk of not following the ANTT process correctly is the introduction of infection into the patient's blood stream.'*

You stated that you could not recall this incident and that you have been assessed as competent in this skill. However, you said in cross-examination that you believed Ms 1 to be unduly negative in her observations of you. You said that she had prompted you to wash your hands too soon when you were about to cleanse your hands anyway.

The panel recognised that there was a breakdown in relationship and tension between Ms 1 and you but nevertheless, the panel noted that Ms 1 was supervising you inserting a cannula as part of your Personal Development Plan. She observed that you were not following correct procedure in that you had failed to cleanse prior to touching the patient

so she stopped you. Ms 1 told the panel that she had done this discreetly but that there were risks in not following procedure which required her to intervene and correct the mistake you had made.

In view of Ms 1's supervisory role here the panel found it more likely than not that she would notice if you had failed to wash your hands prior to inserting the vascular device and she had a duty to step in when she saw that you had not complied with the ANTT when inserting a vascular access device.

The panel therefore finds this charge proved.

Charge 1e (vii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   vii. *Did not notice that Patient R was on Glyceryl Trinitrate *'GTN' infusion intravenously*

This charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and internal documents.

In Ms 1's witness statement she said:

> *'During this shift I was supervising the Registrant's work. I noted that the Registrant failed to notice that a patient (Patient R) was on a Glyceryl Trinitrate ("GTN") infusion intravenously……. Patient R had not had her blood pressure taken for four hours and the Registrant had not undertaken a baseline blood pressure for Patient R upon taking over the care of Patient R, which meant that Patient R's GTN infusion could not correctly be adjusted according to her blood pressure.'*

Ms 1 also provided the panel with Patient R's records which confirms that Patient R was on a GTN infusion.

You provided evidence in your nursing notes for Patient R, which indicated that you were aware of the GTN-infusion. The notes stated that weaning the patient off the GTN infusion was part of the patient's plan of care and the rates of reduction of the infusion were documented.

Although Ms 1 considered that you had not noticed Patient R was on a GTN infusion, the panel saw your nursing notes which demonstrated that you must have been aware of the GTN infusion as the rate of reduction had been documented. Therefore, the panel found on the balance of probabilities that you had noticed Patient R was on a GTN infusion.

The panel therefore finds this charge not proved.

Charge 1e (viii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
viii. Did not prioritise and/or take Patient R's blood pressure

This charge is found proved on the first limb and not proved on the second limb.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and your nursing notes.

In Ms 1's witness statement she said:

> "*Patient R had not had her blood pressure taken for four hours and the Registrant had not undertaken a baseline blood pressure for patient R…I had to*

express to the Registrant that the priority was the blood pressure, prior to mobilisation, in order to ensure that Patient R was safe to sit out."

You said in your witness statement that it is important for patients on a GTN infusion to have their blood pressure checked 1-2 hourly to determine the effect on blood pressure (BP) and regulate the infusion.

In your witness statement you said: "*As the patient was asymptomatic, I did not find the need to check her blood pressure as a priority over conducting my initial safety checks at the start of the shift and ensuring patient comfort. I took her blood pressure at the earliest opportunity at 9.30am"*

The panel noted that the narrative on the nurse's progress report states *"care taken over at 08.30hrs…… Obs monitored – stable BP 176/56 asymptomatic".*

The panel compared the Cerner observations chart with your nursing notes. The last BP to have been recorded on Cerner was from 05:24, when the BP was 176/56. The panel found it unlikely that the patient would have had precisely the same blood pressure reading at 08:30 and therefore found it more likely than not that you had recorded the 05:24 blood pressure reading from Cerner straight into your nursing narrative notes at 08:30.

The next entry on Cerner is for 09:31 and shows a BP of 158/62. You said in cross-examination that you did not prioritise taking the blood pressure until 09:31 as you felt that the patient was asymptomatic. You said that taking the patient's BP was one of the top tasks that you were going to get done that morning but that you would finish the handover first, then do the safety checks, then make the patient comfortable.

On the basis that four hours had elapsed since the BP reading had been taken at 05:24 and on your own acceptance that you did not prioritise the taking of Patient R's blood pressure until 09:31, the panel determined that you did not prioritise taking Patient R's blood pressure and therefore the first limb of this charge is found proved.

With regard to the second limb of this charge, you say in your witness statement that: *"I took over care at 8.30am. I took her blood pressure at the earliest opportunity at 9.30am and had arranged for her* you *GTN infusion to be regulated as prescribed."* This accords with the entry in your nursing notes.

The panel was satisfied that on the balance of probabilities you did take Patient R's blood pressure, and therefore the second limb of the charge is not proved.

Charge 1e (ix)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
e) *Did not provide care to all patients during your shift on 9 October 2017 in that you:*
   ix. Did not manage one, or more, monitor alarms"

This charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement.

In Ms 1's witness statement she said:

> *'The Registrant also failed to manage monitor alarms during the shift. Monitors alert staff to abnormalities or changes to a patient's blood pressure or heart rate/rhythm…'*

In oral evidence Ms 1 said that this happened on multiple occasions but accepted that you could have been busy on one or more of those occasions.

In your witness statement you said:

‘I could not recall this incident. By this time, I have been working in the Heart Assessment Centre for 1 year and 8 months and would have known how to manage cardiac monitor alarms.

I understand that in this complaint, [Ms 1] is concerned of the noise the alarms would make in HAC if they are not dealt with right away when patient’s go off the monitor. I am always mindful of this, but on this particular occasion, it is possible that I may be involved in another task, so I was unable to deal with this right away.’

During your oral evidence you stated that it is not your sole responsibility to manage multiple monitor alarms and that you responded but not straight away because you were dealing with other patients.

The panel was not provided with sufficient details of the context of this incident, nor any contemporaneous evidence to support the single sentence assertion in Ms 1’s witness statement.

Therefore, the panel finds this charge not proved.

Charge 1f)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
f) *Incorrectly, discharged Patient C on 20 November 2017*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 13’s witness statement.

In Ms 13 witness’s statement she said:

“I told the SHO that Patient C had already been discharged and he was not happy, as he had not had a chance to review Patient C’s trop [Troponin] result before the discharge”……..

> *‘The SHO told me that he had called the Registrant earlier in the day and had told her that she needed to wait for Patient C’s Trop results to come back, which he would then review. Following this Patient C could be discharged or have further treatment, depending on the Trop result.”*
>
> *…*
>
> *At that point both the SHO and I checked Patient C’s Trop result by opening Patient C’s file, and we saw that it was a negative result. I recorded the result in the nurses’ notes and the SHO recorded it in the doctors’ notes, and he also recorded that he had not been told by the Registrant earlier in the day that the result was negative. The SHO then reviewed the results and said that Patient C had been fine to go home, however it still meant that the Registrant had incorrectly discharged Patient C because the Trop results had not been reviewed by a doctor before discharge.’*

The panel took account of an email from Ms 13 to Ms 1 sent on the same shift at 04:58 on 21 November 2017, to explain her concerns.

In oral evidence, there was a dispute between you and Ms 13 about which patient had been discharged. This was not material to the charge in question as the matter involved the question of an incorrect discharge rather than the identity of the patient in question. In your witness statement you wrote:

> *‘I told [Ms 1] about what happened and emailed her following our conversation to document what we have discussed. A copy of this email can be found in Exhibit XS146. This email was written on 17 December 2017 when what happened was still fresh in my memory. In this email, I stated that: “I have informed the patient that her Troponin I result was negative. Around 1930H, I then bleeped the on-call SHO to confirm if we are happy for the patient to go home as planned. Whilst I*

was waiting for the callback, the patient then decided to go home since her dad was already there to pick her up.'

You maintained that both you and the patient knew that the plan was for the patient to be discharged. You said that it was the patient's decision to leave the hospital pending the doctor's final review. Nevertheless, you then completed the discharge process knowing that the doctor had not yet reviewed the Troponin result.

The panel heard that the patient was being prepared to be discharged earlier in the day pending a negative Troponin result. The panel also heard that you believed you could discharge the patient if the awaited result for this patient was negative. The panel had sight of the patient notes which showed that a doctor needed to review the Troponin results, prior to discharge.

You said in cross-examination that ideally the doctor would review the results but that there are times when you cannot follow best practice because the situation does not allow that to happen. You said that this was one of those situations - the patient's transport home had arrived, her family was in a rush and she could not wait any longer. However, because you had discharged the patient from the hospital, before the doctor had reviewed the Troponin result, the panel found that you had incorrectly discharged Patient C.

Therefore, the panel finds this charge proved.

Charge 1g)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
g) *Did not restart and/or handover that you had not restarted, Patient D's Furosemide infusion on 20 November 2017*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 13's witness statement.

In Ms 13's witness statement she said:

> *'The Registrant had failed to restart the infusion and had also failed to handover to the next nurse that the infusion had not been re-started … If the Registrant was unsure she could also have approached the NIC.'*

During Ms 13's oral evidence she said:

> *'There is no documentation that you restarted the infusion and you didn't even hand it over to the night staff that you didn't hand it over. The night nurse was not aware whether to start or not. There's where the conclusion [confusion] started. It's all clearly documented in the notes.'*

In a near-contemporaneous email from Ms 13 to Ms 1, dated 21 November 2017, she wrote:

> *'In addition to that the next patient whom she looked after was on continuous frusemide(sic) infusion which was stopped for angio, (which was cancelled later) was not been restarted after she returned to ward. I restarted it in my night shift after 5 hours of gap.'*

In your witness statement you said:

> *'I had a discussion about this incident with [Ms 1] as this was an issue raised in the email sent to her by [Ms 13].*
>
> *In my email to [Ms 1] summarising our discussion on 17 December 2017, I stated that:*
>
> *"We have also discussed the reason why the Furosemide infusion was not restarted. I have explained to you that the patient stayed in the cardiac day ward*

for several hours during that day waiting for her angiogram and they have decided to cancel it. She came back to the ward nearly dinner time. I was not aware that she is to continue with the Furosemide infusion until Raj told me at handover."

I wrote this when what happened was still fresh in my memory.

[Ms 13] was aware that this patient had to be restarted on the Furosemide infusion as she was the one who told me about it at handover. She was also aware that I was not allowed to give IV medications at that time so I could not restart the infusion myself. As it was shift changeover when she told me the infusion needed restarting, as nurse-in-charge, she should have arranged for an IV competent nurse on the night shift to immediately restart the infusion. If there had been a 5-hour gap, this meant that she is responsible for this delay as she was aware the infusion had to be restarted before I even did. There would not have been a 5-hour gap if the infusion was restarted immediately after handover because the patient only came back to the ward at around dinner time.'

In oral evidence you said that you were unaware that the patient's Furosemide Infusion needed to be re-started and said that this should have been explained to you by the catheter lab staff. You did not think it was relevant to ask the question as to whether it should have been re-started.

The panel determined that, based on what you said, you had not re-started the infusion. The panel was aware that you were deemed not IV competent at that time so you could not have restarted it yourself, but as the nurse responsible for Patient D's care, the panel determined that it was your responsibility to ask for help to ensure that the treatment was re-started at the correct time. By not re-starting the infusion and not handing over that this had not been done, you did not provide appropriate care to Patient D.

The panel finds this charge proved.

Charge 1h(ii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
h) *Did not clean the sluice/bedpan during the nightshift of 5/6 January 2018 for:*
    ii. *One, or more, unknown patient(s)"*

This charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 9's and Ms 5's witness statement and Ms 1's oral evidence.

In Ms 9's witness statement she said:

> *'…During handover [Ms 1] informed us that the sluice from the nightshift had not been done.*
>
> *It is the responsibility of all staff members on the HAC to clean the sluice for their patients and it should not be left to the HCAs to do. In this particular case the sluice had not been cleaned for one of the Registrant's patients (Patient H).*
>
> *When [Ms 1] said that the sluice had not been done for Patient H, the Registrant responded by saying "[Ms 5] can do it". [Ms 5] is a HCA on the HAC and it was completely inappropriate for the Registrant to say this. It was not [Ms 5's] job to clean Patient H's sluice. Furthermore, because it had not been a very busy nightshift, the Registrant could have cleaned the sluice herself during her shift.'*

During Ms 9's oral evidence she said that you left the cleaning for the HCA to do, when cleaning the sluice is a basic part of the nursing role.

In Ms 5's witness statement she said:

'When [Ms 1] told the Registrant the sluice needed cleaning for the patients from her nightshift, the Registrant responded by saying '[Ms 5] can do it'. When the Registrant said this I did not waste my time arguing as I knew she could become very difficult so I simply went and cleaned the sluice despite having just started my shift…'

During Ms 1's oral evidence she stated that you had an over reliance on HCAs.

In your witness statement you said:

'I had not used the bedpans for my patients, and we didn't know who had used it. All my patients were mobile and self-caring at that time so there was no reason for me to use the bedpans for any of them.

I normally clean the bedpans that I use for my patients and place them in the bedpan washer for disinfection. I don't leave them lying about in the sluice. And that is a habit I have practiced throughout my nursing career as I have been trained that way…'

The panel determined that whilst there was a general duty upon nurses to make sure that the sluice and bedpans were clean, it was unable to establish a link between the overall stem of the charge and how it has a direct effect on your ability to give appropriate care to one or more patients.

Therefore, the panel finds this charge not proved.

Charge 1(i)

1) Failed to provide appropriate care to one, or more, patients, in that you

(i) Did not undertake an ECG in a timely manner on 2 March 2018

This charge is found not proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 2's witness statement.

In Ms 2's witness statement she said:

> *'By the time I got time to go to the HAC, patient lunches were being served. The doctors had done the ward round and they had requested that an electrocardiogram (ECG) be done on Patient P however the Registrant had not yet given Patient P her lunch or done the ECG. I went over to Patient P, introduced myself and told her that I would review her wound after she had her lunch as I thought that trying to look at her wound whilst she was eating may have been off-putting for her.*
>
> *I told the Registrant to give Patient P her lunch and she told me that the doctor had told her to do the ECG. I asked the Registrant whether Patient P was currently experiencing chest pain and she confirmed she was not; I therefore told the Registrant to give Patient P her lunch first and that the ECG could wait until afterwards.'*

You wrote a formal note on 3 March 2018 about this incident:

> *'…[Ms 2] then came to the bay and has asked me about the plan for Patient 2. She also interrogated me about what was going on with Patient 1 and why she is not yet having lunch. She then instructed me to give Patient 1 her lunch. As I found her approach intimidating and aggressive, I tried to limit my interaction with her. As Patient 1 was still having her nebulizer, I thought I might as well do a quick ECG so that the doctor can review this before I give her lunch. When [Ms 2] saw me at the bedside with the ECG machine and holding my mobile phone (I was checking the time), she accused me of being unprofessional. I tried to explain myself to her, but she refused to accept this and insisted that I give the patient her lunch.'*

The panel determined that there is no evidence as to when the ECG was requested or when it should have been done, and that no time was specified regarding when the ward round took place or when lunch was to be given. The NMC has not satisfied the panel that the ECG was not done in a timely manner.

Therefore, the panel finds this charge not proved.

Charge 1j(i)

1) *Failed to provide appropriate care to one, or more, patients, in that you*
j) *Did not assist in providing emergency care/support to one, or more, patient(s) on:*
    i. *19 March 2017*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's and Mr 2's witness statement and internal documents.

In Mr 2's witness statement he said:

> *'I cannot recall the name of the other nurse who was on shift with us but there was a lot of pressure during this particular shift because the Registrant was not assisting us in caring for patients. If the staff on shift work as a team, then everything that needs doing will get done but when I asked for help the Registrant's response was that she did not care. Usually if a nurse is in charge of a shift they would still help the other nurses and HCAs on the shift but the Registrant did not do this.'*

Mr 2 wrote an email, dated 24 March 2017, to Ms 1 which set out his concerns and said that you were asked to help out. She stood with folded hands when there was a cardiac arrest at the HAC. He said that there was no form of support from you whatsoever, and when asked to help out you responded "*I don't care*". He reported that this was a very unpleasant shift.

Ms 6 in her witness statement said:

> *"The registrant appeared to be avoiding the other staff members on shift and instead spent time writing on the whiteboard. She was also inside the nurses' station at one point rather than providing help to the HAC team. A good NIC should also assist with emergency patients …but on this occasion when emergency patients were brought in it seems the registrant was not able to assist… she did not have much experience of working as NIC and so she might not have known what the NIC responsibilities were…the registrant was possibly overwhelmed by being appointed as NIC and did not know what to do."*

Ms 6 also sent an email to Ms 1 on 24 March 2017 detailing this incident.

In your witness statement you wrote:

> *'I was staying at the nurse's station not only to update the board, but I was also waiting for a phone call from the Cardiology Bed Manager to coordinate the patient's transfer. I would say that all hands were on deck in dealing with this emergency albeit each one had to take different roles.'*

The panel found the evidence of both Ms 6 and Mr 2 consistent and determined that you did not assist in delivering emergency care to patients on 19 March 2017. The panel determined that in a time-critical emergency, the role of a nurse in HAC was primarily to assist directly in providing patient care rather than providing administrative assistance to the team.

The panel finds this charge proved.

Charge 1J(ii)

1) *Failed to provide appropriate care to one, or more, patients, in that you*

j) *Did not assist in providing emergency care/support to one, or more, patient(s) on:*

   ii. *8 August 2017 at around 17:15"*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence, which included Ms 1's witness statement and internal documents.

In Ms 1's witness statement she said:

> *'I became aware of these concerns when some of the nurses mentioned to me that the Registrant disappeared whenever primaries were brought in. They said that it was very common practice for the Registrant to disappear during primaries and it was a regular, ongoing thing. She was never hands-on and she would be asked many times to come and assist.*
>
> *..*
>
> *I therefore made a point of watching the Registrant on this shift on 8 August 2017 when a primary was brought in at approximately 17:15. When the patient came in I could not see the Registrant so I went to look for her on the HAC; eventually I found her in the doctors' office. The Registrant would have been aware that a primary had been brought in because the bleep had gone off which alerted the HAC so all nurses would have heard that and been aware, unless they were on a break…On this shift the Registrant disappeared when a Primary Percutaneous Coronary Intervention (PPCI) emergency patient (primary) was brought onto the HAC and did not assist with it.*
> *…*
> *I do recall that the Registrant did not come out to support the team at the time I asked.*
> *…*
> *The shift was quite a busy one, hence why I had been called in to support clinically so the Registrant should have been working with the team to minimise the pressure."*

In Ms 1's Internal note she wrote:

‘17:30 hours 2 Primary arrhythmia calls arrived on HAC. XS was not supporting these 2 calls and nobody knew of her whereabout.

Matron found XS in the medication room at the opposite end of the ward on a computer. No offer of support came from XS. The remaining staff on duty reported to me that this “happens all the time”.’

In your witness statement you wrote:

‘Based on my notes of this incident, I was waiting for a wristband to come out of the printer when [Ms 1] saw me in the doctor’s office. When we admit Primary’s in HAC, we have to print the patient’s wristband. The printer for the wristband is located in the doctor’s office. There was a technical issue with the printer which I had to fix and that was the reason why it took me a while.’

You had also written this in your grievance statement that you provided to the panel.

The panel understood that the shift on that day was busy and that all nurses, including the matron, were involved in providing urgent patient care. The panel determined that your primary role was to assist directly in providing emergency care and in assisting your colleagues. However, you did not do this, and prioritised administrative tasks instead.

Accordingly, the panel finds this charge proved.

Charge 1j(iv)

1) *Failed to provide appropriate care to one, or more, patients, in that you*

j) Did not assist in providing emergency care/support to one, or more, patient(s) on:

iv. One, or more, unknown dates

This charge is found not proved.

In reaching this decision, the panel took into account all oral and documentary evidence in relation to providing emergency care.

The panel determined that the charge is too vague and has not been quantified in terms of dates or patient identify, so it is difficult to assess.

Therefore, the panel finds this charge not proved.

Charge 2a(i)

2) Failed to keep clear and accurate records and/or document observation in that you:
a) On 11 August 2017, and in relation Patient B:
i. Made retrospective records and did not record such records as having been made retrospectively;

This charge is found proved.

The panel considered Ms 9's witness statement and Patient B's clinical notes. The notes revealed entries made at 11:15 which documented the start of your shift as being 08:30 and recorded Patient B's condition at 08:30. At 11:31, you recorded that Patient B deteriorated and experienced fast Atrial Fibrillation at 09:00. All of these entries were made retrospectively. Ms 9 said that this was poor documentation which had not been recorded in a timely fashion.

Ms 9 stated that the Critical Care Outreach Team (CCOT) nurse discovered that there had been an absence of recorded observations on Patient B since 09:30 on 11 August 2017. Ms 9 said that upon your return from your lunch break, she had questioned you about the lack of observations for Patient B. As the assigned nurse, it was your responsibility to perform and record Patient B's observations throughout the morning using the 'Cerner' electronic patient system. You said you had conducted the observations and had recorded them on a piece of paper next to Patient B's bed.

Ms 9 informed you that recording observations on paper was insufficient. It was essential to record them in real-time as they were done. Ms 9 stated that nurses are responsible for ensuring that observations are recorded contemporaneously. It was expected that you would record observations promptly, in real-time, or within ten minutes of carrying them out. Ms 9 advised you to enter the observations in your nursing notes and indicate that they were written retrospectively, rather than input them on Cerner, as Cerner does not allow for easily identifiable retrospective recording. However, despite this advice you continued to add your notes retrospectively to Cerner.

The panel looked at screenshots of Cerner, indicating that you logged the observations at 15:15, not in real-time, and without marking them as retrospectively written. In your response bundle, you said that you did not believe it necessary to indicate retrospective recording, as Cerner has a feature to identify this, demonstrated in evidence from Hammersmith Hospital. You expressed your willingness to add a comment indicating retrospective recording if you had been instructed by Ms 9 to do so.

During oral evidence, you accepted that you had retrospectively recorded the observations and acknowledged that this was not best practice. You explained that you were relying on the fact that the observations were recorded live on the cardiac monitor, and that you had intended to enter them electronically later. It was put to you during cross-examination, which you accepted, that relying solely on the monitor is not a reliable method of recording patient observations. However, you said that due to workload and lack of communication regarding the assessment of Patient B, you prioritised other tasks on that day.

The panel noted your failure to clearly mark your notes on Cerner as being retrospectively written. The panel had regard to Ms 9's evidence, who was a senior nurse, and who had informed you at the time that writing retrospectively on Cerner is equivalent to falsifying records. Despite this warning, you persisted in adding observations to Cerner several hours after they had been taken. It was clear to the panel that Cerner did not allow for easily identifiable retrospective recording.

Furthermore, the panel took into account an email exhibited by Ms 9, dated 14 October 2017, which stated that copying observations from the bedside monitor to Cerner late amounted to falsification of documentation. Ms 9 described your behaviour on that shift as rude. In oral evidence, Ms 9 said that she had the impression that you were *"trying to cover your tracks*".

Taking into account all the evidence presented, the panel concluded that you had made retrospective records and had not recorded that such records had been made retrospectively.

Therefore, the panel found this charge proved.

Charge 2a (ii)

2) Failed to keep clear and accurate records and/or document observation in that you:
a) On 11 August 2017, and in relation Patient B:
ii. Did not contemporaneously record Patient B;'s observations;

This charge is found proved.

For the same reasons and evidence as outlined in charge 2 a) i), the panel also found charge 2 a) ii) proved.

Charge 2a(iii)

2) Failed to keep clear and accurate records and/or document observation in that you:
a) On 11 August 2017, and in relation Patient B:
iii. Did not ensure that a catheter insertion record was in place;

This charge is found proved.

The panel considered Ms 1's oral and documentary evidence regarding the absence of a urinary catheter insertion record and care plan for Patient B. She stated that Patient B was the only patient for whom you were caring for most of the day. She said that [A7

Nurse] had said that a urinary catheter insertion record was not in place for Patient B. Ms 1 questioned you about this issue, but you were unable to provide an answer. Ms 1 explained that it was unacceptable as the Heart Assessment Centre (HAC) had not been busy on that date and so you would have had time to prepare both documents for Patient B.

Ms 1 said that Patient B had arrived at the HAC with the catheter already inserted, and it was expected that the night staff would have recognised the need for the insertion record and communicated it during the morning handover to you. However, this was not done, and you also failed to notice the missing record. The panel looked at a screenshot of Patient B's IDC (catheter) insertion record which confirmed that the insertion record was eventually completed by [A7 Nurse] at 18:11.

The panel considered your response in which you explained that Patient B already had a urinary catheter inserted upon arrival at the HAC from another ward, that the nurse responsible for the insertion had failed to document it on Cerner, and that this oversight was not addressed by the night staff during the handover to you in the morning.

You said that limited access to Cerner while caring for Patient B meant that you did not discover the missing insertion record until the end of your shift when handing over care to Ward A7. It also noted that you said that at the time, the integration of Cerner was still being learned, and different staff members had varying levels of proficiency. As a result, documentation inconsistencies and omissions were common during the handover process.

In cross-examination, you disagreed with the suggestion that you failed to ensure an insertion record was in place during your shift since it had been addressed at the end of your shift during handover. You said that healthcare institutions must adopt a 24-hour care culture that supports continuity and proper handover, as a poor attitude towards handovers could lead to nurses concealing unfinished tasks, mistakes, or errors, undermining the organisation's safety culture. Additionally, you clarified that it was another nurse, not you, who had initially put the catheter in place.

The panel determined that while the initial responsibility for ensuring that a catheter insertion record was in place lies with the person who inserted the catheter, it was ultimately your responsibility to follow up and ensure that a record was in place once the patient was in your care, something that you accepted when it was put to you in cross examination.

The panel recognised that although you were not the one who inserted the catheter, it was still your duty to ensure that all necessary documentation was in place during your shift for the patients in your care. The panel also considered the Clinical Nursing Standards Policy which outlines the requirement for nurses to complete all basic admission documents. The panel found this charge proved based on the fact that throughout your shift, you failed to ensure that a catheter insertion record was in place.

Charge 2b)

2) Failed to keep clear and accurate records and/or document observation in that you:
b) On 9 October 2017, did not document the care provided to Patient R;

This charge is found not proved.

The panel considered your nursing notes for Patient R regarding GTN Infusion Monitoring, which provided details about when you took over the care, administered medication, and monitored observations.

Additionally, the panel considered Ms 1's oral evidence. She said that you failed to chart Patient R's GTN infusion on their input and output chart.

The panel noted that the charge was not specifically about the failure to chart the GTN infusion. Instead, it was about your failure to document the care provided. However, you provided nursing notes which show that you have documented certain aspects of the care provided to Patient R on 9 October 2017. The panel concluded that this charge was not proved, due to insufficient evidence of what was missing given the broad and very general nature of the charge.

Charge 3a)

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*

   a) *On 26 June 2017, did not administer two pairs of IV Pabrinex to Patient U;*

This charge is found proved.

The panel considered the evidence of Ms 1, who stated that on 26 June 2017, during your shift, you made a medication error. It was reported through the DATIX incident reporting system that you were supposed to administer two pairs of IV Pabrinex medication to Patient U, but you had only administered one pair instead of the two pairs prescribed.

Ms 1 said that you filled out the DATIX form yourself, being open and honest about the incident. She acknowledged that it was a mistake, attributing it to the medication being prescribed in pairs.

The panel looked at the DATIX report regarding the IV Pabrinex incident, confirming that the medication error occurred on 26 June 2017 and was completed by you explaining the medication errors. Furthermore, the panel took into account your response, in which you accepted that you had committed a medication error and misinterpreted the prescription. Based on the evidence before it and your own acceptance of the error, the panel found this charge proved.

Charge 3c)

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*

   c) *On 14 August 2017, incorrectly administered Amoxcillin / medication to Patient S;*

This charge is found proved.

The panel considered the evidence of Ms 1, who stated that on 14 August 2017, you administered oral Amoxicillin to the wrong patient. She indicated that she became aware of the incident through a DATIX report completed by you.

According to Ms 1, it appeared that you had not thoroughly read the patient's electronic drug chart and had failed to cross-reference it with the patient's wristband. Had you done so, it would have been evident that you were administering medication to the wrong patient, as the name was incorrect. The panel also looked at the DATIX report completed by you.

The panel considered your response bundle, where you stated that on 14 August 2017, around 14:00, while rushing to complete your medication rounds due to an emergency call, you made a medication error by administering Amoxicillin to the wrong patient. Based on the evidence before it and your acceptance of the medication error, the panel found this charge proved.

Charge 3d)

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*

   d) *On 21 August 2017, refused to administer and/or permit a colleague to administer Haloperidol to Patient K;*

This charge is found proved.

The panel considered the evidence of Ms 1, who stated that during the shift on 21 August 2017, you refused to cooperate with the Nurse in Charge (NIC), Ms 4, specifically regarding the administration of Haloperidol to Patient K. Ms 4 had raised concerns to Ms 1 about your aggressive tone and behaviour, expressing a lack of support from you during the shift. Ms 1 indicated that the incident was later discussed with you and the Lead Nurse for education, Ms ED, to address the incident and the potential negative impact of your behaviour and communication. The panel considered the notes from this meeting between you and Ms ED.

Furthermore, the panel considered the evidence provided by Ms 4, who was the NIC at the time. She explained that the registrar doctor on duty had prescribed Haloperidol as a PRN medication (as required) to help calm Patient K, who was experiencing acute confusion. As the nurse assigned to Patient K's care, you refused to administer the prescribed medication, citing Patient K's lack of capacity. You insisted on requesting a Deprivation of Liberty (DOLs) assessment to determine if Patient K had capacity. Despite Ms 4's professional judgement that administering the prescribed medication was the best course of action, you continued to refuse and prevented Ms 4 from administering the medication by not allowing Ms 4 to go near Patient K and by standing between Ms 4 and Patient K's bed, saying, "*No Sister, you cannot give it."* As a result, the medication was not administered.

The panel considered your response, in which you stated that you managed the patient's agitation with therapeutic communication, believing that pharmaceutical intervention was not required at that point. You expressed concern about the potential side effects of the medication. During cross-examination, you said that you raised your voice due to the distance from Ms 4 and said you had apologised at the time. You maintained your refusal, disagreeing with Ms 4's judgement, emphasising the potential risks involved. When asked if you were better equipped to decide whether to administer the medication than your senior colleagues, you said that you could be if they had not received updated information about the effects of this drug on dementia and elderly patients. When asked in cross-examination, if you were suggesting that you had more up to date information than the registrar doctor, you stated *"I could be"* [sic].

The panel recognised that you accepted the factual basis of this charge and heard your justifications for your actions. You told the panel in cross-examination that it was your own assessment that even though it was a small dose, it was not necessary for this patient.

The panel therefore found this charge proved as you refused to administer the medication to Patient K and, by standing in front of Ms 4, did not permit her to

administer the medication to Patient K even though, as a senior colleague, she had judged this to be necessary.

Charge 3e)

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*

   e) *On or around 28 August 2017, did not administer medication to Patient I;*

This charge is found proved.

The panel considered the evidence of Ms 12 regarding the evening drug round. Ms 12 explained that the usual time for the drug round is 18:00, but medications can be administered between 17:00 and 19:00. She stated that you were allocated to care for Patient I on the Heart Assessment Centre (HAC) who required medication during this time. Ms 12 supervised you during the drug round at 17:40 and reminded you that it needed to be completed by 19:00, which you acknowledged.

According to Ms 12, when she reminded you to administer Patient I's medication again at 18:00, you responded by saying that Patient I did not need it as they had already received their medication when they returned to the HAC after an angiogram earlier in the afternoon. You said that since Patient I had received their medication later than usual, it was acceptable to administer the evening medication late as well. At that point, it was around 18:00, and there was still an hour left within the medication administration window, so Ms 12 accepted the slight delay for Patient I's medication.

Ms 12 continued to explain that with only ten minutes left before the 19:00 medication deadline, you expressed unwillingness to complete the drug round which involved just one patient, stating that you were under time pressure and needed to attend to an Acute Coronary Syndrome (ACS) patient. However, Ms 12 informed you that you did not need to care for the ACS patient as there were two other nurses on duty. Despite this, Ms 12 felt your resistance towards administering Patient I's medication. Eventually, Ms 12

administered the medication herself and documented it on Cerner. The panel also saw an email outlining the incident details from Ms 12 to Ms 1 at 22:14 on 28 August 2017.

The panel considered your response, in which you state that Ms 12 had offered to supervise and assist with your assessment for the dinnertime medication rounds on that day. However, when you were about to proceed, you heard a Primary call, indicating an emergency situation was being brought to the centre. You referred to an email dated 8 August 2017, in which you expressed the challenges of completing all the medications and feeling rushed by the senior nurse. In cross examination, you explained that you refused to do the medication administration for this patient as you did not want to be rushed and distracted as you had made a mistake before and did not want to do so again.

Based on your own acceptance of the facts and the evidence of Ms 12, the panel determined that you did not administer the medication to Patient I. It therefore found this charge proved.

Charge 3f(i)

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

f) On 9 October 2017:

i. Failed to check Patient O's blood glucose level when asked to do so;

This charge is not proved.

Ms 11 said that Patient O returned to their bed on the HAC after undergoing an angiogram at around 10:00. At 10:20, you went to administer Patient O's diabetic medication but did not first check their blood glucose level. Ms 11 referred to the 'Diabetes and Surgery in Adults' policy, which specifies that a patient's blood sugar should be checked frequently after minor surgery. Ms 11 said that you checked when Patient O had last had their glucose levels checked and you saw that it had been done at 05:00. You then said that this meant that Patient O's glucose was not due to be

checked again until 11:00, so it was not necessary to take blood sugar levels before administering the medication. Ms 11 was concerned by your response, particularly because you were a junior staff member with limited experience, and she insisted that the blood glucose level should be checked, referring to the diabetes policy. Eventually, you complied and checked Patient O's glucose levels.

During oral evidence, Ms 11 said that you initially refused to check Patient O's blood glucose levels, despite her belief that it was in the patient's best interest.

You said that you followed Ms 11's instructions because you sensed that expressing your own perspective, that checking the blood sugar was unnecessary at that moment, made her feel "*unaccommodated*". Given that you did not want the situation to escalate, you aimed to find a resolution that accommodated her concerns without compromising the patient's comfort. You therefore checked the blood sugar levels.

You did ultimately check Patient O's blood glucose level and because of the lack of a specified time frame for compliance in the charge, the panel found this charge not proved.

Charge 3f(ii)

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

f) On 9 October 2017:

ii. Went to give diabetic medication to Patient O without first checking their blood glucose level;

This charge is found proved.

You said that on 9 October 2017, you were working under the supervision of Ms 11, one of the Trust's Practice Educators. On that day, you were responsible for looking after Patient O. This incident occurred after Patient O had returned to the HAC after

undergoing a catheter lab procedure, just as you were about to administer their oral diabetic medication.

Ms 11 said that you had intended to administer Patient O's medication and then check their blood sugar level 40 minutes later, at 11:00. However, Ms 11 was concerned at this point because it would mean going six hours without checking the patient's blood sugar levels before giving them diabetic medication which would not be safe to do so. Ms 11 told you to check the blood glucose levels and you responded by saying *"I don't think so".* She asked you why you had given this response and you said it was going to be checked at 11:00. Ms 11 reiterated that the glucose needed to be checked and referred to the diabetes policy. After this, you listened and went on to check Patient O's glucose levels.

The panel also considered the 'Diabetes and Surgery in Adults' policy, specifically Appendix 4 and paragraph 5.8.3, under the section on tablet-controlled diabetes. It noted that the policy's algorithm for surgery indicates that patients on medication should have their blood glucose levels monitored frequently. Additionally, the panel acknowledged that Patient O had undergone a cardiac catheter procedure, categorised as a minor surgery and had been instructed to refrain from eating or drinking prior to the procedure which may have had an impact on Patient O's glucose level.

Given your own acceptance that you were about to give medication without first checking the blood glucose level and Ms 11's evidence, the panel found this charge proved.

Charge 3g)

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

g) On 20 November 2017, inserted a new cannula for Patient E when it was not necessary to do so/clinically required;

This charge is found proved.

Ms 13 said that the night shift on 19 November 2017, should have handed over to the day shift on 20 November 2017, about the need to remove Patient E's cannula. Ms 13 said that you should have made a decision regarding whether the cannula was still necessary for Patient E by reviewing the patient's records which showed that no further IV medications were prescribed.

According to Ms 13, *"you did half your job correctly"* by removing the cannula, but there was no need to insert a second one. She explained that there is a culture on C8 of inserting a new cannula if one is needed, but she believed that you were not aware of Patient E's medical history and simply followed the *“normal process”.* Ms 13 said that you should have checked Patient E's drug chart or asked the patient about their medical history, as this would have shown that a cannula was no longer necessary. If you had been in any doubt, you could have asked the NIC.

In oral evidence, Ms 13 confirmed that having looked at Patient E’s medical notes, she saw that no further IV drugs were prescribed for Patient E. She said that the cannula had a sticky label with a date indicating it was a new one. She clarified that cannulas are typically changed every four days, but if no IV drugs or infusions are required, then a cannula is not needed.

The panel was not provided with the medical notes for Patient E.

The panel looked at an email from Ms 1 to Ms 2 dated 21 November 2017, which stated: *"... patient whom she looked after had a cannula which I handed over to the day team to take out if she does not need it after the ward rounds, found to have a new cannula inserted without any reason."*

In your response, you explained that you inserted a new cannula for Patient E. You said that it was challenging to find a good vein for this patient, but eventually managed to insert the cannula just above their wrist. You said that later in the day, the medical team decided to discontinue Patient E's antibiotics and requested the removal of the IV cannula. Since you were occupied with another task at the time, Ms 13 removed the cannula.

The panel found clear evidence that you inserted a new cannula. It then assessed whether it was necessary or clinically required to do this, as outlined in the charge.

Ms 13 said that if you had checked Patient E's records, as she did, you would have noticed that no further IV medication was prescribed, indicating that the new cannula was not required.

You said that you recall being shown the patient's drug chart during the handover and had seen that the patient was indeed on IV antibiotics. You said that it was also on the handover sheet. You said the IV antibiotics were discontinued after you had inserted the cannula.

The panel noted that you said that you had seen that the patient was receiving IV antibiotics. However, the panel gave considerable weight to Ms 13's observation which was documented in an email sent during her shift at 04:58 on 21 November 2017, serving as contemporaneous evidence that supported Ms 13's concern. She said that she had seen the patient's records and found no requirement for IV medication and that no further IV medication had been prescribed and so there was no need for a cannula to remain in situ.

The panel preferred the evidence of Ms 13 who was an experienced nurse and whose evidence was supported by a contemporaneous record of the incident. It therefore found this charge proved.

Charge 3h)

3) Failed to adequately administer medication and/or undertake safe medication management in that you:

h) On 20 November 2017, did not ensure that Patient F was correctly discharged with their medication and/or that such discharge was recorded;

This charge is found proved.

Ms 13 said that on the 20 November 2017, around 22:00 during her shift, she noticed that Patient F's bed area had not been properly cleared by you when you discharged the patient. This had resulted in the patient leaving without their medication. Ms 13 expressed her uncertainty about whether you were even aware that Patient F had left their medication behind since you only noted in the patient's records that they had gone home and had not recorded whether you had given the patient's medication to them. Ms 13 became concerned that Patient F did not have their medication, particularly because they were 26 years old with severe heart problems and a history of non-compliance with their medication regime.

Ms 13, said that the pharmacy had sent Patient F's medication in a dosette box, intended to assist with taking medications at the correct times. She said that it was your responsibility to provide Patient F with this dosette box. Ms 13 said she called you after your shift to inquire whether Patient F had received their medication as she had noticed that some medication had been left in the patient's bed area. In response to her call, you explained that you had briefed the patient about their medication, but ultimately it was the patient's responsibility to take the medication with them.

In oral evidence, Ms 13 said that a patient leaving without their medication was not a safe discharge. Ms 13 said that it was the nurse's duty to ensure the dosette box was taken home by the patient. She stated that the discharge policy mandates nurses to check and clear the bed area of patient belongings.

In your witness statement you said that when Patient F left the ward, you were occupied with checking the take-home medication for another patient, and therefore did not notice that Patient F had left their medication at the bedside. You acknowledged that there was an expectation for staff nurses to clear the bed area and ensure that no medication was left behind, preparing it for the next patient. However, in this instance, you did not do so as the patient went home just before the shift changeover.

In oral evidence, you said you recalled Ms 13 contacting you at home that evening to tell you that the patient had left their medication behind. The panel noted that in your oral evidence, you initially said that it was the patient's responsibility to take the

medication home, however, under further questioning from the panel, you accepted that it was the nurse's responsibility to ensure that patients take their medication home.

The panel looked at an email sent by Ms 13, to her line manager Ms 1 shortly after the incident at 04:58 on 21 November 2017 detailing her concerns with incidents in your shift. She writes: "…*later on while I cleaned the bedspace, I found two dosette boxes and loose tablets on the top of bedside cupboard, which I thought belonged to the patient and she forgotten to take it home. And I could not find any documentation in the nursing notes that medications handed over to patient…I was concerned as this patient is non-compliant…I understand it is the responsibility of the nurses who discharge the patient to discard the old medicines, so the discharge process is complete*. [sic]"

You also said that you would normally document the medications given to patients in your nursing notes, but that your nursing notes had not been provided by the NMC to enable you to show what you had done. The panel has not seen the nursing notes, however it has seen evidence that Ms 13 reviewed the nursing notes prior to contacting you at home that evening and recorded that there was no entry in them to show that medications were handed over to the patient. The panel found Ms 13's evidence more compelling as this information was contained in an email, written a few hours after the incident, documenting her concern to her line manager. The panel therefore found this charge proved.

Charge 3i)

3) *Failed to adequately administer medication and/or undertake safe medication management in that you:*
   i) *On 26 December 2017, incorrectly administered immediate release oxycodone to Patient G;*

This charge is found proved.

Mr 4 was asked by Ms 1 to investigate a drug error that had been submitted on DATIX involving Oxycodone, a Schedule 2 controlled drug. In his statement, he explained the different forms of Oxycodone tablets and highlighted that the concern was that Patient G had been given an immediate release tablet instead of a modified release one. He said that the mistake occurred because you did not check the tablet adequately against Patient G's prescription, which would have revealed the discrepancy.

In oral evidence, Mr 4 said that the incorrect medication had been issued to the ward by the pharmacy team, and he acknowledged that this was an error. He said that the medication provided to the ward should have been the modified release version.

The panel looked at the DATIX report completed by the Trust pharmacy team, which confirmed that the prescription was for Modified Release Oxycodone, and that this was what should have been administered to Patient G.

Ms 1 explained that as Oxycodone is a controlled drug it requires two nurses to check and administer it, so Ms 9 was assisting you. She said it was a particularly busy shift and although both you and Ms 9 checked the drug, both of you did not realise that the drug formulation for Patient G was incorrect. The error was later picked up by the pharmacy team. Ms 1 exhibited an email exchange between herself, Ms 9, and you, informing you and Ms 9 of the joint error.

You provided a detailed explanation of how and why the error occurred, as well as the lessons learnt from it and a reflective account as requested by Ms 1. In oral evidence, you accepted that the error had occurred.

The panel recognised that the incident was handled correctly but determined that the charge is proved, as the medication error did occur.

Charge 4b)

4) *Failed to follow instruction from senior members of staff and/or colleagues in that you:*

b) *In or around July 2017. did not assist with the morning wash for one of your allocated patients;*

This charge is found proved.

Ms 1, in her witness statement, said that you were assigned to work on Ward A7 and that the NIC asked you to assist one of your allocated patients with a morning wash. However, you did not follow this request and when asked why by the NIC, you responded that you needed help with this.

In your witness statement, you explained that you were redeployed to Ward A7 but had reservations about it. You said that you were experiencing a headache and feeling extremely anxious about the situation, fearing that it might make you more prone to making mistakes. You approached the NIC and expressed that you were not feeling well and would prefer to go home. However, you were persuaded to stay and were offered the option of being paired up with another nurse as a buddy. Despite your initial hesitations, you agreed to continue working.

The NIC asked you to perform a patient wash and you responded that you would do it but needed assistance from another person. You said that before you could explain further, the NIC began complaining about your perceived unprofessionalism and suggested that you needed counselling. You found this offensive and embarrassing, prompting you to disengage from the situation and go to the clinical storeroom to take a breather.

You had a clear instruction from the NIC, which you accept was given. Although you said that you did not outright refuse to assist with the morning wash and provided justification for your non-compliance with the request, the panel determined that you did not follow the instructions of the NIC and did not assist with the morning wash of one of your allocated patients. The panel therefore found this charge proved.

Charge 4c)

4) *Failed to follow instruction from senior members of staff and/or colleagues in that you:*

   c) *Did not administer medication to Patient B on 11 August 2017;*

This charge is found proved.

The panel heard evidence regarding two types of medication: a beta blocker and Amiodarone which had been prescribed for Patient B by Mr 3, the Senior Registrar on duty and the subsequent administration of that medication. Patient B had high risk of vascular collapse or cardiac arrest and so the potential risk of harm in the situation was very high. You disagreed with the proposed methods of administration of the medication prescribed and extensively questioned Mr 3 and the Lead Pharmacist about this. Eventually you administered the beta blocker, albeit in a crushed form. However, you did not administer the Amiodarone.

Mr 3, in his witness statement, said that you came up with reasons as to why it was not appropriate to administer Amiodarone and did not appear to listen to his justifications for giving the drug in less diluent than is usual. Ultimately, he had to ask another nurse to administer Patient B's medication. He said that this wasted valuable time for a very ill patient.

Mr 4, the Lead Pharmacist, recalled your refusal to listen to Mr 3's justifications and described your challenging behaviour. He stated that you were unwilling to administer Amiodarone to Patient B in the prescribed form, leaving the NIC to administer the medication according to Mr 3's instructions.

Ms 9 was in the present on the ward at the time of the incident. In her witness statement, she said that nurses can challenge doctors and other staff members if necessary or if they do not understand their instructions. However, in this case, Ms 9 said that you should have assessed the situation and realised the potential harm to Patient B if the medication was not administered as explained by Mr 3. Ms 9 said that you persistently protested against giving the Amiodarone, and that you said *"No, I'm not giving it, that's not what's on Medusa, that's wrong."* Ms 9 ultimately ended up

administering the Amiodarone, trusting the judgment of Mr 3 and Mr 4, both experienced and knowledgeable professionals. Ms 9 expected you to listen to the medical rationale for giving Amiodarone in less diluent than normal and then give this in the best interests of the patient.

The panel looked at an email from Mr 3 to Ms 1 dated 11 August 2017, written shortly after the incident. The email described your behaviour as combative and aggressive in defending your viewpoint, insisting that you were right while everyone else was wrong. It was also supported by an email from Mr 4 on 25 August 2017.

In your witness statement, you said you had concerns about giving Amiodarone in such a concentrated format. You said you did not outright refuse to administer it, but that you were being cautious as it would be your first time to administer the drug as an infusion. It was also to be given in a preparation different from the recommendation in the 'Nurses Drug Reference Guide' (Medusa).

In cross-examination, you said that you had consulted with Mr 3 and Mr 4. When questioned about Mr 3's experience, you expressed uncertainty regarding his level of experience despite him being a senior Registrar on HAC.

The panel determined that despite a clear instruction from Mr 3 to administer Amiodarone to Patient B, you did not follow the instruction and did not administer the medication to Patient B. Therefore, the panel found this charge proved.

Charge 4d)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

d) On 9 September 2017, refused to follow a request to assist the Nurse in Charge in answering the telephone;

This charge is found proved.

In your witness statement, you said that on the day in question, only [Band 6 Mentor] and you were on shift. Considering the high patient load and the need for increased nursing supervision, it was challenging for you to assist with answering telephone calls. Your priority was providing patient care, and you explained that you were unable to take on additional tasks. You expressed your belief that refusing to handle extra workload, such as answering telephone calls, was necessary for ensuring patient safety, and you referred to the NMC Code of Conduct.

In oral evidence, you said that you declined [Band 6 Mentor's] request because of your workload and said that you could not accommodate any additional tasks.

Ms 1, in her witness statement, said she could hear the telephone ringing on the HAC from her office and observed that you did not answer it. She approached you and requested your support in answering the telephone. In response, you said *"We are short-staffed"*. However, Ms 1 told you that the HAC was not short-staffed, as there were two nurses for six patients, and she was also available on the HAC to provide support if required. The panel also looked at an undated internal statement from Ms 1 regarding this incident.

The panel accepted the evidence of Ms 1 that you were approached, and a request was made to you to answer the telephone. It noted that in your own witness statement, you accepted that you had refused her request in not assisting with phone calls on the HAC.

The panel therefore found this charge proved.

Charge 4e)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

e) Did not remove Patient H's catheter on 21 January 2018 and/or handed over that the catheter should not be removed;

This charge is found proved.

The panel looked at the DATIX investigation form dated 21 January 2018, submitted at 20:28 and completed by Ms 7. The panel noted that this was completed on the day of the incident. Under the "Description" section, it states: *"…The nurse allocated to this patient did not remove the catheter. Citing that she had a 'pressure sore' and that the patient was 'incontinent'. Patient was not incontinent prior to the current admission…The nurse in question disregarded the request of the medical team including the consultant. The consultant also advised that the catheter should come out to facilitate mobilisation and reduce the risk of infection. The nurse spoke to the NOK to discuss keeping the catheter in – this is not appropriate as it was a medical decision."*

Under the "Initial Remedial Actions" heading, it states: " *"Nurse in question was asked nicely by the registrar and senior nurse on shift and the catheter has still not been removed. She seemed to ignore their advice. I'm concerned as this has put the patient at risk and the nurse seemed to ignore the medical advice."*

Ms 7, who witnessed the incident directly, said that the doctor assessed Patient H and expressed a desire to have the catheter removed. The Registrar conducted a ward round between 09:30 to 10:00, they assessed Patient H and asked for the catheter to be removed. A few minutes later, the NIC of the shift also asked you to remove Patient H's catheter. Later that morning, a consultant came onto the HAC and did a consultant ward round and again asked for the catheter to be removed.

Ms 7 stated that the consultant's decision should have been final, as they were the consultant responsible for making decisions regarding Patient H's care.

The panel took into account the local statement of Ms 7, dated 5 March 2018. It noted that this statement was written just over a month after the incident and provided more detailed information about what occurred. The panel determined that this statement aligned with Ms 7's oral and documentary evidence. The panel also noted the following passage, which demonstrated that you handed over to the night shift that the catheter should not be removed: "*XS handed over to the night shift … about the catheter, she* [the night shift nurse] *queried why it was still in as she explained to XS that there was*

the risk of another UTI and confusion. XS insisted that the catheter stay in as [removing] *it would worsen the pressure sore."*

In your witness statement, you said that you did not remove the patient's catheter during your shift and handed over to the night nurse, requesting the day team to review the need for the catheter removal due to your concerns about the patient not being ready for mobilisation and having a pressure sore. You documented the reasons for not removing the catheter in your nursing notes. In cross-examination, you accepted that you did not remove the catheter and provided your reasons for doing so.

There is clear evidence that you did not remove Patient H's catheter on 21 January 2018, and that you handed over to the night nurse with the instruction that the catheter should not be removed.

Therefore, the panel found this charge proved.

Charge 4f)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

f) Did not take breaks as assigned by the NIC on 20 February 2018;

This charge is found proved.

Ms 1, in her witness statement, said that Ms 10, the NIC of the shift, asked you to take a break, but you refused. Ms 1 exhibited an email sent by Ms 10 to Ms 1 dated 4 March 2018, which outlined the concerns regarding this incident.

The panel looked at this email, which states: *"I told Xandra to go on a coffee break at around 11:00, but she did not go and did not even respond if she heard me. So, I informed the* [nurse] *after her break to tell Xandra to go, but she still did not go. During lunchtime, I told her to go for lunch at around 14:00, but she did not. I told her twice about the coffee break and lunch break, but she just ignored me. Her reason was that she was very busy attending to her patient. I informed her that she could hand over and*

go for a break, but she still did not listen. She was difficult to handle and went on her break at her own time, around 16:00. [sic]"

Ms 10, in her witness statement, said that she had asked you to take your break at 14:00, resulting in a delay of two hours between her initial instruction and your eventual compliance. She expressed concern that you did not respond or acknowledge her when she asked you to take the break and that she faced difficulty managing you while working on Ward C8. In her oral evidence, Ms 10 emphasised the importance of taking breaks.

During your oral evidence, you said that you could not recall any difficulties with breaks. You said that you were not informed ahead of time about breaks so that you could plan your workload. However, you said that you had no issues accepting instructions and you did not believe you would refuse them.

The panel determined that there is nothing to contradict Ms 10's evidence that you failed to follow her instructions when she asked you to take a break. Ms 10's evidence was consistent and is supported by an email sent less than two weeks after the event and the panel therefore preferred Ms 10's evidence.
Therefore, the panel found this charge proved.

Charge 4g)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

g) Did not follow instructions relating to the provision of care to Patient P on 2 March 2018;

This charge is found proved.

In her witness statement, Ms 1 said that on 2 March 2018, Ms 2 visited the ward to review Patient P on the HAC. When Ms 2 arrived, she asked you to give the patient her lunch. However, Ms 2 saw that you were using your phone instead of attending to the

patient's needs. Ms 1 said that she was present when Ms 2 spoke with you on the HAC, and that you became agitated after Ms 2 had asked you to give the patient her lunch.

The panel considered the witness statement of Ms 2 and noted her role as the senior nurse of the Cardiac Directorate at Hammersmith Hospital. Ms 2's responsibilities encompassed managerial oversight of five hospital sites, ensuring staff and patient safety, and acting as a supportive figure to matrons and ward managers who reported to her. In her witness statement, Ms 2 said that when matrons or ward managers encounter issues with staff members, they seek her advice on how best to handle those matters. She was a very senior nurse.

In Ms 2's witness statement, she said that when she arrived at the HAC, lunch was being served to patients. However, you had not yet given Patient P her lunch. Ms 2 instructed you to provide Patient P with her lunch, but you responded by informing her that the doctor had instructed you to perform an electrocardiogram (ECG). She asked you whether Patient P was experiencing chest pains at the time, and you said that she was not, so Ms 2 told you to give Patient P her lunch. Ms 2 felt that you disregarded her instructions by continuing to perform the ECG instead of attending to Patient P's meal, even though she asked you to prioritise the meal. Additionally, you were observed standing over Patient P with your phone in your hand. In response to this incident, Ms 2 prepared a statement on 2 March 2018 providing her account of the events.

In your witness statement, you said that when Ms 2 approached you to give Patient P her lunch, you were just about to conduct the ECG, and that the patient was receiving nebulisers. You felt that Patient P needed to complete the nebuliser treatment, and her condition needed to be assessed for safety reasons before she could have her meal, as she was feeling drowsy. You said that patients with decreased level of consciousness are at risk of aspiration or choking. You believed it was crucial to stabilise the patient's condition before providing her with a meal. You said that you believed that Ms 2 did not take this into consideration when she instructed you to give Patient P her lunch, and therefore, you chose not to follow her instructions in the interests of patient safety.

The panel determined that Ms 2's instruction was clear, as acknowledged in your witness statement and that as a senior nurse, she would have been able to visually assess whether Patient P was capable of receiving her lunch. It was also accepted by you that you did not follow Ms 2's instructions, citing concerns for patient safety.

Therefore, the panel found this charge proved.

Charge 4h)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

h) Did not follow instructions in respect of moving Patient A to Ward C8 on 02 March 2018;

This charge is found proved.

Ms 9, in her witness statement, said that you were on a day shift with Mr 1, a Band 5 Nurse. Upon Ms 9's arrival for her night shift on the HAC, Mr 1 informed her that he had asked you several times to transfer Patient A from the HAC to Ward C8. When Ms 9 arrived, which was approximately between 19:30 and 20:00, the porter was present on the HAC, and Patient A had not yet been transferred. Ms 9 said that around 20:10, she requested you to transfer Patient B, but you did not respond to her request. Following that, Ms 9 approached you again and inquired about the delay in transferring Patient A. She said that you responded by saying that you did not know why you should do the transfer at this time of night and that it was not fair: "*why should I finish my shift late?".* Ms 9 said that you were due to finish your shift at 20:30.

Ms 9 said that after her requests, Mr 1 once again asked you to transfer Patient A, and you responded with the same reluctance. Ms 9 believed that your obstructive behaviour could have been avoided, and instead of wasting time arguing about the transfer, you could have completed it before the handover at 20:00. Ms 9 said that the transfer would have only taken approximately 20 minutes, allowing you to leave your shift on time.

However, since you did not transfer Patient A during your shift, it meant that a nurse on the nightshift had to complete the task.

The panel looked at the DATIX report completed by Ms 9 as a result of your failure to follow her instructions and considered the interview notes with Ms 9, dated 24 April 2018, which supported her witness statement.

Mr 1, in his witness statement said that around 18:45, he asked you to transfer Patient A from the HAC to Ward C8. However, he observed that you continuously delayed the transfer. Each time Mr 1 asked, you simply did not take action. Mr 1 said that he made these requests two or three times over a span of approximately half an hour, but you did not comply. He said that you were aware of the need to transfer Patient A since you acknowledged his requests. Eventually, because you had not completed the transfer, Mr 1 had to call the porter to transfer Patient A at around 19:15 to 19:20. Mr 1 said in his statement: *"This kind of behaviour in refusing to do tasks when asked was typical of her [you] and happened on a daily basis."*

In your witness statement, you said that when the porter arrived to transfer Patient A, you were in the midst of administering nebulisers to another patient who was experiencing shortness of breath. Recognising the urgency of the situation, you had to send the porter away and inform them that you would have to call for assistance again later. Additionally, at that time, the night staff was conducting handover, and you felt it was important to remain with the patients while the rest of the team was present. Furthermore, you said that you needed to catch up on nursing documentation.

You said that both Mr 1 and Ms 9 approached you in an angry manner, demanding the immediate transfer of Patient A, without considering that you were engaged in another important nursing task. You felt that a more polite approach would have been appropriate as a gesture of goodwill, but you did not think it was appropriate to tolerate their poor behaviour. You said that the staffing was adequate and there were vacant beds in the HAC, so you believed that the team would have been able to manage the patient transfer. You also provided a timeline of events based on your perspective.

The panel noted that Mr 1's witness statement is hearsay evidence, but it was strongly supported by the near-contemporaneous DATIX report, and the evidence provided by Ms 9, who was present during the incident. It determined that there were several clear instructions to you by both Mr 1 and Ms 9 to transfer Patient A to Ward C8, but you did not follow these instructions.

The panel therefore determined that this charge is proved.

Charge 4i(i)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

i. 31 March 2017;

This charge is found proved.

The panel had regard to your employment contract which stated that you may be required to work at any location managed by the Trust.

The panel also took into account your job description, which outlines your responsibilities as a registered nurse. It states that you are expected to carry out delegated tasks and responsibilities assigned by senior staff members. The job description also highlights that it is not an exhaustive list of tasks and may be subject to variation from time to time. Your place of work was described as Cardiology rather than any specific ward.

The panel also considered the oral evidence provided by multiple witnesses, confirming that it was standard practice for staff in cardiology to work across the three wards (HAC, A7, and C8) as required or directed. There was a duty to be flexible and respond to lawful management requests for reassignment.

Ms 9, in her witness statement, stated that she was the NIC during the day shift when you were scheduled to work. Ms 1 explained that someone would need to go to Ward A7 due to staffing issues, as Ward A7 was short-staffed whereas the HAC was not at full bed capacity and had a sufficient skillset among its nurses. Ms 9 said that Ms 1 at handover had instructed that you would need to go to Ward A7 as you had not yet arrived for your shift, and the usual procedure was for the last person to arrive to be redeployed to another ward when required. According to Ms 9, upon your arrival, you were smiling and said hello and then Ms 1 told you to go to Ward A7. Ms 9 said that your face dropped, and you said that you were feeling ill and intended to go home. You then turned around and left the HAC, and Ms 9 did not see you for the remainder of the shift.

The panel saw an email sent by Ms 9 to Ms 1 on 1 April 2017, confirming your lateness and the decision made to transfer you to Ward A7.

In her oral evidence, Ms 9 stated that you arrived 15 minutes late, and since patients had already been assigned to other staff members, it was deemed appropriate to send you to Ward A7. She expressed her surprise when you chose to go home.

In your witness statement, you said that you were not feeling well on this day. When you arrived at work, 10 minutes late, Ms 9 informed you that you would be assigned to Ward A7.

You said that you had a meeting with Ms 1 regarding your performance the previous day, [PRIVATE]. You were concerned that the request to move to Ward A7 was a form of punishment for being 10 minutes late. [PRIVATE] and you approached Ms 1 to request permission to take time off, and she agreed to send you home. In cross examination, you agreed that you did not move wards when asked to do so.

There was a clear instruction from Ms 1 for you to move to Ward A7 on 31 March 2017, which you did not follow.

Therefore, the panel found this charge proved.

Charge 4i(ii)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

ii. 29 August 2017;

This charge is found NOT proved.

Ms 11, in her witness statement, recounted an incident on 29 August 2017, where she contacted Ms 2 to provide support as you were refusing to work on Ward A7. Ms 11 said that she spoke to you in Ms 2's office on Ward A7, but you avoided making eye contact with her. Despite Ms 11 asking multiple times if you wanted her assistance with your patients on Ward A7, you declined. Ms 11 said that her intention was to identify any underlying concerns that may have contributed to your hesitancy in working on Ward A7. The panel also considered the internal statement from Ms 11 in her role as a clinical practice educator, further supporting her account.

In your witness statement, you stated that you complied with the management's instruction to move to Ward A7 on that particular occasion. However, following the meeting, [PRIVATE]. [PRIVATE], including being transferred to Ward A7, which you perceived as punishment having previously experienced poor treatment from the NIC in Ward A7, facing inquiries from management regarding unfair complaints about your performance, and feeling interrogated in a manner that threatened your entire nursing career. Consequently, you found it challenging to return to the floor to continue your duties.

During cross-examination, when asked if there was anything specific about Ward A7 that you disliked, you expressed that the unfamiliar setting and people made you anxious. [PRIVATE]. You said that you subsequently consulted with a doctor on 31 August 2018 regarding these concerns.

There is clear evidence that Ms 11 provided you with instructions to go to Ward A7. The panel accepted your evidence that you did comply initially by moving to Ward A7, but once there you refused to work and left shortly after due to [PRIVATE].

On the basis that you did move wards, the panel found this charge not proved.

Charge 4i(iii)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

iii. 13 October 2017

This charge is found proved.

In Ms 11's witness statement, she said that you were required to undertake medication assessment as part of your performance management, and this involved administering medications to patients while being observed by her. However, since there were only two patients on the HAC who required oral medication, Ms 11 felt that this would not provide an accurate representation of a typical medication round. She believed that on other shifts, you may have to be responsible for administering medications for up to seven patients simultaneously, potentially with distractions from patients or colleagues. As a result, Ms 11 suggested that she could better assess you performing the medication round on Ward A7, where there would be more patients. However, you responded with *"I don't want to",* without providing a reason for your refusal.

In your witness statement, you said that you avoided working in Ward A7 due to concerns that a similar incident to one that occurred on 29 August 2017 may reoccur. You also expressed a sense of vulnerability, fearing that if any conflicts were to arise with the staff in Ward A7, the management would be unlikely to support you.

The panel acknowledged that Ms 11 held the role of a practice educator and heard that part of her assessment involved evaluating someone's performance in a realistic

setting. Ms 11's reasoning behind requesting you to conduct the drug round on Ward A7 was justified as there were only two patients on the HAC, necessitating the need to go to another ward for a comprehensive assessment. The panel determined that you refused to go to Ward A7 as requested.

Therefore, the panel therefore found this charge proved.

Charge 4i(iv)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

iv. 25 December 2017;

This charge is found proved.

Mr 2 in his witness statement, said that you began your nightshift at 19:30 when Band 6 Mentor asked you to work on Ward A7 due to staff shortages. However, you refused to comply with the request. Mr 2 also said that Ms 9 asked you to move to Ward A7, but again, you declined. He observed that you spent approximately half an hour sitting and using your mobile phone. Mr 2 confirmed that [Band 6 Mentor] had also asked you to move to Ward A7.

In oral evidence, Mr 2 said that nurses were not permitted to leave their shift until handover was completed. Dayshift nurses were scheduled to leave at 20:00, but on this particular day as handover did not occur until 19:50, they left later than expected. The panel noted that the day in question was a public holiday. The panel also took account of an email from Mr 2 to Ms 1 dated 2 March 2018, which provided a detailed account of the incident.

In her witness statement, Ms 9 said that [Band 6 Mentor] had asked you to move to Ward A7, but you refused and responded with *"I'm not going, why should I go?"* Ms 9 said that despite the shortage of staff, you remained on the HAC, choosing not to comply with the request. The incident caused a delay in the handover process, which

should have been completed between 20:00 and 20:30. Ms 9 said [Band 6 Mentor] did not leave until 22:00. The panel also looked at the interview notes from Ms 9 dated 24 April 2018, which referenced this incident on 25 December 2017.

Ms 1, in her witness statement, said that you were asked to cover Ward A7, but you refused to transfer to the ward when requested by Ms 9. Ms 1 advised Ms 9 to escalate the matter to the 24-hour Site Practitioner. The panel also had sight of the DATIX report regarding the incident that had been submitted by [Band 6 Mentor].

In your witness statement, you said that you declined to move to Ward A7 on 25 December 2017 for the same reasons stated in charge 4 (i) (iii). Although you accepted the factual basis of their accounts, you disputed the legitimacy of the request and provided justifications for your refusal.

The panel heard clear evidence, including from direct witnesses, Ms 9 and Mr 2, that you were instructed to move to Ward A7 and that you failed to follow that instruction.

The panel therefore found this charge proved.

Charge 4i(v)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

v. 26 December 2017;

This charge is found proved

Ms 1, in her witness statement, said that Ms 9 requested that you be redeployed to work on another cardiac ward. This request was made in order to have someone with more experience work alongside Ms 9, due to low staffing levels and only two nurses being present on the HAC. Despite Ms 9's request, you refused to redeploy. [PRIVATE].

You said that you do not recall being asked to move on that particular day. However, you said that if Ms 9 had requested your redeployment to the cardiac ward, you would still have refused for the same reasons outlined in charge 4 i) iii.

The panel considered the evidence, which is consistent with your previous behaviour of refusing to be moved to a different ward. Although you did not fully accept the allegation, you indicated that you would have refused if asked. Based on this evidence, the panel concluded that it is highly likely that you refused to follow instructions from senior members on 26 December 2017.

Therefore, this charge is found proved.

Charge 4i(vi)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

vi. 27 January 2018;

The panel found this charge proved.

In Ms 8's witness statement, she said she was contacted by the Matron, Ms 1, who requested her to attend the HAC due to staffing issues. Ms 8 was informed that it was crucial to relocate a junior staff member, in this case, you, from the HAC to Ward A7. However, despite being asked by Ms 1, you refused to move. Ms 8 said that she took you aside privately to discuss the reasons behind your refusal, but you said that you were [PRIVATE]. Ultimately, you did not comply with the request to move to Ward A7, and instead, Ms 12 went in your place.

The panel also considered an email from Ms 8 to Ms 1 dated 3 March 2018, which detailed the incident and your refusal to move to Ward A7.

In Ms 1's statement, she said that she asked you to move to Ward A7 in order to have the appropriate mix of senior and junior staff on that ward. However, your response was that it *[PRIVATE].* Ms 1 said that despite repeated requests, you refused to comply and proceeded to participate in the handover process on the HAC. Following this incident, Ms 1 submitted a complaint statement, escalating the matter to the HR Business Partner for the Cardiac Division in order to seek senior HR support.

Ms 7 was a direct witness to the incident. She said in her witness statement that you displayed signs of anger when refusing to move to Ward A7. Ms 7 found the situation uncomfortable and did not understand why you were making such an issue out of the request, as transferring between wards was a customary practice within the cardiology team.

The panel looked at the local statement provided by Ms 7 dated 5 March 2018, which outlined the incident in detail, including references to your body language and tone.

In response to the charge, you indicated that your position remains the same as outlined in previous charges regarding your refusal to move to Ward A7. Although you accepted the factual basis of not moving, you provided justifications and explanations for your refusal.

The panel heard clear evidence from multiple witnesses, who directly witnessed the incident, that you did not follow instructions when asked to move to Ward A7.

The panel therefore found this charge proved.

Charge 4i(vii)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

vii. or around 22 February 2018;

This charge is found proved.

Ms 12, who was the ward sister at the time, said in her witness statement that Ms 1 had already made the decision for you to be assigned to Ward A7, as there was only one nurse working. Ms 12 said that Ms 1 explained to you that you had to go to Ward A7 to work your shift. However, you responded with *"I don't want to go"* without providing an explanation for your refusal. Additionally, you said that you would be willing to go to any other ward except for Ward A7. Ms 12 emphasised that you should have followed the decision made by the Matron to ensure adequate staffing and the safety of both wards.

The panel looked at the email dated 5 March 2018 from Ms 12 to Ms 1, which outlined the incident and stated that you were agitated and refused to go to Ward A7.

In your witness statement, you said that you were asked to move to Ward A7 on this occasion to address staffing shortages. This required you to fill in the gaps at Ward A7, which was experiencing a shortage of staff, and take on a patient load comparable to regular staff. However, during this time, you were under performance management and should have been considered supernumerary. From your perspective, being redeployed to fill staffing gaps seemed contradictory to your supernumerary status.

There is clear evidence that you were instructed to move to Ward A7, but you did not comply with the instruction. You have accepted that you did not move and have provided your own justification for your refusal.

The panel therefore found this charge proved.

Charge 4i(viii)

4) Failed to follow instruction from senior members of staff and/or colleagues in that you:

i) Did not move Wards when instructed to do so on:

viii. 23 March 2018;

This charge is found proved.

In Ms 2's witness statement, she said that on 23 March 2018, both [Band 6 Mentor] and Ms 9 were unavailable to supervise you. Consequently, Ms 1 and Ms 2 made the decision to assign you to work on Ward A7 to ensure that you could be supervised by a Band 6 nurse as you were under performance management at this time. When you arrived for your shift, Ms 2 spoke to you on the HAC and instructed you to work on Ward A7. However, upon hearing this request, you remained in place with a stern expression and adamantly refused to move. Eventually, you left and went home having opted to take annual leave, indicating your unwillingness to continue working. As a result, your absence was recorded as "emergency annual leave."

The panel also looked at the statement of events, dated 23 March 2018, provided by Ms 2, which set out the incident in detail.

In your witness statement, you said that you were on annual leave on 23 March 2018, and you provided a record in your bundle that validates this claim. However, the panel noted that according to the originally designated work schedule, 23 March 2018 was a day you were supposed to work. Additionally, it noted that it was later recorded as "emergency annual leave" after you had left and refused to perform your tasks, as substantiated by the local statement provided by Ms 2.

There is clear evidence that you were instructed to move to Ward A7, but you refused and subsequently left to go home.

The panel therefore found this charge proved.

FURTHER or ALTERNATIVELY, you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as Band 5 Staff Nurse between 1 February 2016 and 8 May 2018 as follows:

5) In relation to any and/or all matters set out at charge 1- 4 above;

This charge does not require a determination at this stage. Therefore, the panel went on to consider Charge 6.

Charge 6)

6) *By failing to complete a formal management plan which was imposed on, or around, October 2017 in relation to any and/or all of the following areas:*
   a) *Oral medication management;*
   b) *IV medication management and administration;*
   c) *…*
   d) *Delivery of basic nursing care without help or supervision;*
   e) *General attitude to managers and work colleagues;*
   f) *To be able to follow reasonable requests from shift leaders and managers;*

This charge is found proved in its entirety.

The panel the considered the sequence of events that took place:

You were initially put on an informal performance management plan in or around August 2017, but you had not accepted the plan or the areas that were to be informally performance managed at that time. A meeting was therefore held with you on 19 October 2017 to establish your point of view before proceeding to a formal performance management plan. However, an agreement was not found, and the meeting concluded.

Ms 2 said in her witness statement that your lack of insight into your errors led them to place you on a formal management plan. At the conclusion of the meeting on 19 October 2017, you were provided with a copy of the formal management plan, but you refused to take it. The plan included a six-month target for improvement. Following this meeting, Ms 2 referred you for a disciplinary hearing due to concerns about your behaviour and performance.

On 12 December 2017, you filed a grievance against Ms 2. In your grievance, you raised concerns regarding the truthfulness of some of the evidence presented, the

timeliness of the disciplinary process, overbearing supervision, and unrealistic targets. The panel looked at your grievance letter dated 12 December 2017.

On 13 December 2017, the disciplinary hearing against you took place, and you requested an adjournment while your grievance was investigated and resolved. However, Mr 2 said you had been informed of the hearing several weeks in advance, and the hearing proceeded. The outcome of the hearing was the continued implementation of a formal performance management plan that had to be completed by 31 March 2018.

On 15 January 2018, you appealed the decision of the disciplinary hearing. The panel looked at your appeal letter addressed to the Divisional Director of Nursing, dated 15 January 2018.

On 26 March 2018, the appeal was dismissed, and a letter was issued detailing the outcome of the appeal. The letter stated:

> *"… I am very concerned that you have showed little or no reflection surrounding the incidents which have transpired, especially as they were severe and potentially put patient's care delivery at risk. Because of this I recommended at the hearing that you are put on supernumerary status for a period of 4 weeks. This time frame can be extended or reduced by your manager, depending on if you have achieved the following objectives:*
>
> *1. Completing your drug assessment in full.*
>
> *2. Engaging and undertaking the performance plan set out, post your disciplinary hearing in December 2017 and therefore engaging and taking reasonable management instructions."*

The panel acknowledged that there was a formal management plan in place, starting in October 2017. You had a duty to complete the formal management plan under the guidance of Ms 11. You accepted that you did not finish the formal management plan as you had resigned, and you had no opportunity to finish it or be signed off in all areas.

The panel noted that your final working day was on 8 May 2018. [PRIVATE] and then on annual leave until 1 May 2018. The panel considered the reasons you provided for not completing certain elements of the formal management plan. However, it also noted that many of the dates mentioned referred to your informal management plan, which preceded the formal management plan.

The panel considered the different versions of the formal performance management plan, including: 1) Formal Performance Management meeting notes from 19 October 2017, 2) a formal performance management plan from 21 March 2018; and 3) the formal performance management plan with supervisors' comments. You also provided a copy of the formal performance management plan in your bundle.

After careful consideration, the panel determined that the version that corresponds to your plan is 3) the formal performance management plan with supervisors' comments. This plan consists of a table with four columns, labelled 'Identified Problem,' 'Action Required,' 'Comments/Progress Reports,' and 'Completion Date'. The panel recognised this as the latest version because it contained handwritten notes, signatures and dates in the column when the 'Action Required' objectives were completed. Signatures were present next to the 'Comments/Progress Reports' column, indicating the individuals responsible for providing comments, as well as signatures in the completion box if objectives were achieved.

6a- Oral medication management

Under the heading 'Identified Problem’ and "Oral Medication Management", the panel noted that two out of three objectives were signed and completed on 16 March 2018. However, the completion of the controlled drug competency remained incomplete and unsigned. In view of this, the panel considered that the overall ‘Identified Problem’ relating to oral medication management had not been successfully completed. The panel noted that you were still employed and working at that time, but you had not fulfilled this requirement.

In your witness statement, you said that you had resigned, and you had not had the opportunity to have the performance management plan fully signed off by management. You said that some objectives were addressed, such as oral medication management (excluding the Controlled Drug Competency).

You said that the Controlled Drug competency was not complete due to the unfortunate circumstance of not having a patient in the HAC who required that specific type of drug. Nevertheless, you were permitted to administer oral medications after undergoing a final assessment supervised by [Band 6 Mentor].

You said that [Band 6 Mentor] said that she had signed you off for oral medication management, despite not being signed on the plan. However, the panel noted that this only accounted for two objectives out of three.

There is clear evidence that you did not complete all three objectives of oral medication management. You acknowledged that one objective was not completed and provided your justification for it.

The panel therefore found this charge proved.

6b- IV management and administration

The panel noted that under the heading 'Identified problem' for 'IV Medication management and administration,' one out of two objectives had been completed and signed. It noted that the action required to complete the IV administration competency booklet remained unsigned.

In your witness statement, you said that you had completed the IV drug calculation test. You also said that you partially completed the IV administration competency booklet but were unable to finish it due to resigning from your post before completion.

You presented a workbook for intravenous drug administration, but the panel noted that it was completed on 7 May 2019, which is beyond the deadline of 6 April 2018, for

completing the IV administration competency booklet that was required. The panel noted that you accepted partially completing the IV Medication management and administration in your formal performance management plan.

The panel therefore found this charge proved.

6d – Delivery of basic nursing care without help or supervision

The panel noted that under the heading 'Action Required,' regarding your requirement to complete 'Delivery of basic nursing care without help or supervision,' only two out of four objectives had been signed. The remaining objectives were the ability to show compassion and care to patients, and the ability to communicate effectively with patients before and during care delivery, in accordance with Trust values and the NMC Code of Professional Conduct.

In your witness statement, you said that this concern arose from a specific incident where you refused to wash a patient in Ward A7. [PRIVATE] and only agreed to stay on the shift under the condition that you would be working alongside another staff member. You believe that the NIC deemed your request inappropriate and lodged a complaint with Ms 2, which led to this concern being included in your performance management objectives.

You expressed your disagreement, stating that you do not think the basis for this concern was fair or appropriate, as you have competently assisted patients with personal care for many years prior to this incident. You said you had previous experience as a healthcare assistant in a nursing home, where this task was part of your basic responsibilities.

The panel concluded that your formal performance plan remained incomplete in respect of “Delivery of basic nursing case without help or supervision” with two of the four objectives not signed off, demonstrating that you had not fulfilled the requirements outlined in the formal management plan.

The panel therefore found this charge proved.

6e- General attitude to managers and work colleagues

The panel noted that under this heading within your formal management plan, there were three objectives to complete. It noted that none of the objectives was signed off.

In your witness statement, you said that management did not provide an explanation for why they believed you did not achieve this objective. You referred the panel to evidence provided by [Band 6 Mentor], which indicated your positive engagement with the performance management process. [Band 6 Mentor] also made positive comments regarding your interactions with staff. You acknowledged that there were instances where conflicts arose with your managers and colleagues due to differences in professional opinions. However, you emphasised that you always maintained a professional demeanour, adhering to the NMC Code of Conduct. You also made reference to emails that showcased your positive interactions with work colleagues.

The panel determined that despite the positive examples you provided, your formal performance plan remained incomplete in respect of ‘General attitude to managers and work colleagues’, as objectives had not been signed off.

The panel therefore found this charge proved.

6f – To be able to follow reasonable requests from shift leaders and managers

The panel noted that none of the objectives under the heading 'Identified Problem - To be able to follow reasonable requests from shift leaders and managers' had been completed.

In your witness statement, you explained that there had been a dispute regarding this objective because management wanted you to agree to move to Ward A7 whenever asked to do so in order to have it signed off. However, you refused to comply with these requests at that time due to a negative experience you had while working in that particular ward. This negative experience had resulted in [PRIVATE] whenever you

were asked to work there. As a consequence, you said that you were unable to fulfil the management's request to move to Ward A7 due to the [PRIVATE].

The panel concluded that the objectives were neither signed off nor completed. It acknowledged your acceptance that you had refused to move wards when requested, thereby preventing the signing off of this objective in the formal management plan (although it recognised that the objective was wider than merely accepting orders to move wards).

The panel therefore found this charge proved.

Ealing charges

Charge 1)

That you, a Registered Nurse whilst working for the North West University healthcare Trust ('the Trust'):

1) *On 12 December 2018, banged your nursing documentation around and/or kicked furniture at work;*

This charge is found proved.

The panel considered the witness statement from Ms 15 regarding an incident reported by Clinical Sister 1 on 12 December 2018. Ms 15 exhibited an email dated the same day, outlining how you were observed by Clinical Sister 1 banging nursing documentation and kicking furniture at the conclusion of your shift. She expressed concern about the disruptive nature of such behaviour.

The panel then considered the email written by Clinical Sister 1 on 12 December 2018. In this email, Clinical Sister 1 detailed witnessing you forcefully handling objects in the treatment room, including banging and pushing a trolley, hitting furniture, and creating loud noises. The email states:

“Concerning Xandra’s behaviour last Monday night, She did a Longday shift and I was in the night. She stayed till almost 11 pm as she was still writing her notes. My concerned was, few of us noticed her banging, pushing and kicking the trolley against the wall, she was hitting the furniture inside the treatment room, hitting the Pharmacy desk with the patient folder. I heard few noises from anywhere which I thought it was just coincidence, until I witnessed myself how she was purposely pushed and banged the steel trolley against the wall in front of me. Whilst she was sitting in the nurses desk writing her notes, you can hear how hard she flip each page of the notes and instead of placing the folder gentle on the table, she purposely dropped it…[sic]”

The panel acknowledged that this email was sent very soon after the event and provided a clear account of the events.

The panel also took into account an Informal Capability Management letter dated 10 January 2019, written by a Matron. The letter referred to a reported incident where you were observed kicking trolleys and handling paperwork in a disruptive manner. The letter states:

“*We discussed a reported incident whereby you were said to be kicking trollies and slapping paperwork about in the clinical area. You seemed most concerned with the identity of whom reported the incident and requested a copy of the email. I explained that that was unnecessary and you then acknowledged that you had behaved in that manner but offered no reasonable explanation. [PRIVATE].”*

[PRIVATE].

In oral evidence, you acknowledged deliberately using force to move objects as a means of easing your discomfort. When questioned about specific incidents involving trolley bumping and rough handling of papers, you confirmed that you had acted in this manner.

The panel therefore found charge 1) proved.

Charge 2)

2) *On 16 December 2018, failed and/or refused to administer a treatment dose of Tinzaparin to a newly admitted patient with a Pulmonary Embolism;*

This charge is found proved.

The panel considered the witness statement of Ms 15, in which she exhibited a Datix report and an Incident Report by Clinical Sister 2. These reports detailed an incident where you refused to administer a prescribed dose of Tinzaparin to a patient with Pulmonary Embolism, causing a delay in treatment. Ms 15 said that another nurse had to step in to administer the medication instead.

Further examination of the incident through the Datix report highlighted your hesitation to administer the medication without the patient having undergone a CTPA scan. Additionally, the Incident Report written on the same day as the incident indicated your concerns regarding the patient's symptoms and medical history, leading to your decision to hold off on giving the medication.

In your response bundle, you provided an explanation, citing reasons for your actions such as improvements in the patient's symptoms and concerns about potential misdiagnosis due to a false pulse oximeter reading. You also raised concerns about the patient's medical history and your view of the necessity to confirm the appropriateness of the prescribed treatment.

During your oral evidence, you accepted that a STAT dose is a one-off medication that is prescribed to address a specific symptom that a patient may have at a given point in time. However, despite your justifications and efforts to seek further review by other professionals, the panel determined that, as the patient's assigned nurse, it was your responsibility to follow the prescriber’s instructions. Therefore, the panel found you to

have failed in your duty by not administering the prescribed Tinzaparin dose to the patient in question. It therefore found charge 2) proved.

Charge 3a), 3b) and 3c)

3) On 20 December 2018:

a) clarified information at handover directly from one, or more patient(s), instead of from nurses/colleagues;

b) inappropriately challenged a colleague regarding the administration of lorazepam medication to a patient;

c) inappropriately challenged a colleague regarding a patient discharge;

This charge is found proved in its entirety.

In relation to charge 3a), the panel first considered the witness statement from Mr 7, in which he described an incident during handover where you upset RGN JB by instead of listening and verifying with the nurse, you immediately walked over to the patient and clarified the information with them directly. RGN JB found this undermining. Mr 7 also highlighted that RGN JB felt her competency was being questioned throughout the shift due to your actions. Mr 7 said that this was unprofessional and that RGN JB had been very upset.

The panel then considered an email dated 20 December 2018, from Mr 7, which reiterated the concerns raised by RGN JB during the handover. This email carried weight as it was sent on the day of the incident.

The panel also took into account your response bundle where you mentioned being unable to recall the specific incident but emphasised your belief in involving patients in their care, suggesting it as good practice. During oral evidence, you reiterated your stance and expressed a willingness to apologise if your actions had upset RGN JB, stating that involving the patient directly was a part of your practice to confirm information or address queries during handover. When questioned about the possibility

of clarifying information with a patient at handover, you acknowledged that it could have happened given your approach to involving patients in the process, although you maintained that your intention was not to undermine RGN JB.

The panel considered that a handover is a time limited process for the exchange of information between professionals and that the nurse taking over care of the patient is at liberty to ask the patient to expand on any information in a more informal way following the handover.

The panel took into account the contemporaneous email from Mr 7 and your acknowledgment that such behaviour could align with the way in which you described your practice. Therefore, based on the balance of probabilities, the panel found charge 3a) proved.

Regarding charge 3b), the panel considered the witness statement from Mr 7, detailing an incident where, when asked to be a second checker, you questioned the administration of Lorazepam to a confused and agitated patient. The nurse in charge, RGN XL, had requested you to second check the dose, but you questioned the necessity of the medication even after explanations were provided about the patient's condition and the reasons for the medication. Mr 7 states: "*The registrant then went with [RGN XL] to the patient's bedside and again began to question [RGN XL] stating that the patient was settled in bed. [RGN XL] tried to explain that they were only in bed because they had just been escorted there after trying to abscond again but the registrant would not listen."* This led to RGN XL being frustrated and they approached Mr 7 to explain what had happened.

Additionally, the panel took into account Ms 15's witness statement and an email dated 20 December 2019 from Mr 7 which highlighted that you persistently challenged the need for the medication, despite the explanations given by the nursing staff.

In your response bundle, you said that you were seeking clarification rather than challenging the nurse's decision outright. You mentioned being concerned about the patient's well-being and the need for proper justification before administering

medication. During oral evidence, you acknowledged that the purpose of second checking medication was to ensure the correct dose was administered to the correct patient. However, you said that you felt there was a need for agreement between colleagues on the necessity of treatment.

The panel determined that your behaviour was inappropriate because you repeatedly challenged, without valid reason, the administration of medicine to a patient who was not under your direct care, and thereby undermined RGN XL's decision-making, in what was an urgent situation. It also noted that as the second checker and not the nurse in charge, your persistent questioning was inappropriate because it was not part of your role and showed a lack of trust in your colleagues. Therefore, the panel found charge 3b) proved.

Regarding charge 3c), the panel considered the witness statement of Ms 15, who said that you were challenging a doctor's decision about discharging a patient, to the extent that the doctor had to ask you to 'chill out' due to your difficult behaviour.

Furthermore, the panel considered the witness statement of Mr 7, who reported that you were causing distress to a doctor by continuously questioning a patient's discharge, even after being informed that discharge was appropriate because the patient's medication had been switched from intravenous to oral antibiotics. The doctor informed Mr 7 that he was very upset because you pointed a finger towards him, and he said that even his own father had never pointed a finger at him in such a confrontational manner. Other doctors had also expressed concerns about your behaviour.

In addition, the panel considered an email from Mr 7 dated the same day as the incident where he recounted this occurrence to draw it to the attention of the ward manager, Ms 15. The panel placed weight on this communication because it was contemporaneous.

The panel also considered your response bundle. You said you do not recall the incident, but you said that you would only challenge a patient's discharge if there were valid concerns regarding the patient's condition, support at home, and overall safety.

During oral evidence, you confirmed that you would challenge a discharge if any necessary criteria for safe discharge were not met.

The panel noted that the final decision regarding patient medical discharge lies with the doctor, and challenging medical decisions was not within your role. The panel determined that you inappropriately challenged a doctor's decision regarding a patient's discharge. It therefore found charge 3c) proved.

Charges 4a) and 4b)

4) *On 13 January 2019, failed and/or refused to administer Rivaroxaban to a patient with new Atrial Flutter:*
   a) *timeously;*
   b) *as initially instructed;*

This charge is found proved in its entirety.

In respect of charge 4a), the panel determined that a registered nurse has a duty to administer medication at or very close to the prescribed time.

The panel took into account the witness statement of Ms 15 and the Datix report submitted by Ms 17 regarding an incident on 13 January 2019. Ms 15 stated that you did not administer a patient's Rivaroxaban medication because it was not the patient's regular medication, and you were unsure of the reason for its prescription. After consulting with the pharmacist and initially holding off on administering the medication, the doctor and pharmacist reviewed the prescription and confirmed the medication to have been correctly prescribed. This caused considerable delay so that you eventually administered the medication much later than prescribed.

The panel then considered the Datix report related to the incident on 13 January 2019, reported on 15 January 2019. The report outlined reasons why the medication was not given earlier, citing lack of clarity on the reason for prescribing the medication. It also

mentioned that a previous dose had been missed due to the medication being unavailable the day before.

The panel took into account your response bundle. You said that you followed the pharmacist's advice to withhold the medication until you knew the indication for it, but later administered it upon realising the patient's need for it. You highlighted a lack of communication and feedback regarding the incident, emphasising the need for a more supportive approach to such occurrences for organisational learning.

Additionally, the panel considered a report from Mr 7 dated 21 February 2019. The report highlighted instances of delayed medication administration, citing reasons such as extended time spent on patient-related tasks leading to medication omissions despite clinical assessments:

> "*Medicines Policy 6.7 NPSA Rapid Response Report, Reducing harm from omitted and delayed medicines in the hospital states the importance of administering medicines in a timely manner. The omission or delay of any medicine may be critical depending on the patient's circumstances. I have observed that most of her due medications are given 2-4 hours late. She doesn't give her medicines on time because she spends so much time in checking the ICE results of the patient and relating the results to the side effects of the medications. Then, she will decide to omit these medicines. She will also make clinical assessments and even after discussion with a medical doctor, she is still not happy to give the medicines. Examples of which are omitting the treatment dose tinzaparin for ?PE patient, omitting a Rivaroxaban dose for an AF patient…"*

The panel noted that you delayed administering Rivaroxaban until around 19:30 because it was not the patient's regular medication. You considered it necessary to understand why this drug had been prescribed and this was not indicated on the patient's chart. You said that the patient's notes were not available at that time for you to check but you had intended to check them later. The panel noted that in your oral evidence you said that the medication was prescribed to be given at 18:00. Your view was in contrast to the evidence given by Ms 15 who told the panel in oral evidence that

this type of medication is usually given at 16:00. She also said that it was not given when the doctor wanted it to be given and said that the dose was delayed by 3.5 hours.

Although you were advised by the pharmacist to hold off giving the drug until the reason could be ascertained, this matter concerned a time-sensitive administration of a drug to a patient on an acute ward who, it subsequently transpired, had already missed the first dose of the drug due to unavailability on the previous day. You did not check the patient notes yourself - this was done by Ms 17 on handover at around 19:30. You accept that you gave the medication at 19:30 which on your evidence is a delay of 1.5 hours and on Ms 15's evidence is a delay of 3.5 hours. The panel noted that you said in your response bundle that *"As per standards, oral medications can be given within two hours before and after the prescribed timing."* However, the panel could not find reference to this standard in the Trust's Medicines Policy and therefore preferred the evidence of Ms 15 that the medication was nevertheless delayed and was not given at the time that the doctor had prescribed.

Your delay in administering the medication potentially compromised the patient's care. For these reasons, the panel determined that charge 4a) is proved due to the delayed administration of Rivaroxaban to the patient.

The panel considered the same evidence as in charge 4a) for charge 4b). The panel was not provided with the patient notes, but accepted the account provided by Ms 17 in the Datix report dated 15 January 2019 at 02:46. According to her account, she checked the patient's notes which documented that on 12 January 2019, the medical SpR had explained to the patient about the new Atrial Flutter and had prescribed Rivaroxaban to minimise the risk of stroke. In the panel's view, the physician responsible for the patient had issued clear instructions in the patient notes, which were overlooked by you in favour of guidance you had sought from the pharmacist without having checked the patient's notes first. The panel was persuaded by the account in the Datix report as this was written during the following shift. The panel was satisfied that it was your duty to administer the medication as prescribed. Consequently, the panel determined that charge 4b) is proved on the balance of probabilities.

Charges 6a) and 6b)

6) *Failed and/or refused to administer Celecoxib to a patient with T10 fracture and metastatic cancer:*
   a) *on 25 January 2019;*
   b) *on 27 January 2019;*

This charge is found proved in its entirety.

The panel determined that a nurse has a duty to administer pain relief as prescribed.

The panel firstly considered the witness statement provided by Ms 14, highlighting a recurring issue where you failed to administer prescribed medication. Ms 14 stated that you often refused to provide prescribed medication to patients. Despite explanations from consultants, you persisted in your refusal, leading to unprofessional behaviour in front of colleagues and patients.

The panel also considered the witness statement of Mr 7, detailing the incidents on 25 and 27 January 2019 involving a patient with metastatic cancer and a spinal fracture who was prescribed Celecoxib for pain relief. Despite being instructed to administer the medication by both the treating consultant and the patient's family, you omitted it citing concerns about cardiovascular risk. This led to other staff members having to step in to ensure the patient received the necessary medication.

Mr 7 said that he knew that the patient's family wanted the patient to receive the medication as he had looked after the same patient on the day before and the family had told him about the patient's back pain. He also said that on 26 January 2019, one of the pharmacy technicians had told him that on 25 January 2019 you had not given the Celecoxib due to your concerns with cardiovascular risk. The pharmacist also said that the doctor on shift had spoken to you and explained that the patient had terminal cancer and was on end-of-life care and that the medication benefits outweighed the risk. However, you still refused to give the Celecoxib. On 28 January 2019, when Mr 7 was

again caring for this patient, the family told him that the nurse on the previous day had not given the Celecoxib and so they asked if he would administer it.

Additionally, the panel considered the Datix report completed by Mr 7 on 28 January 2019, corroborating the events and highlighting your omission of this medication despite being advised by medical professionals. The panel noted that this report provided a contemporaneous account of the incidents.
Ms 15 told the panel that you failed to administer the prescribed medication, leading to discomfort for the patient who was receiving palliative care. Despite reassurances from medical staff regarding the safety of the medication, you continued to omit it, causing distress to the patient and their family.

Ms 14 told the panel about what she described as your narrow-minded approach towards medication administration, despite explanations from doctors and consultants about the benefits outweighing the risks. However, she said that you consistently refused to acknowledge alternative perspectives, leading to delays in patient care.

Furthermore, in a report to management by Mr 7 dated 21 February 2019, concerns were raised about the pattern of omitted medication administration. The report emphasised the importance of timely medication delivery and expressed worries about your decision-making process, impacting patient safety:

> "*…She will also make clinical assessments and even after discussion with a medical doctor, she is still not happy to give the medicines. Examples of which are…omitting an NSAID for back pain even after Consultant's advice…"*

Your submission was that you were not satisfied that the Consultant had considered the concern with due care, so you requested a review by the medical team. You said that you had discussed the potential risks of the Celecoxib medication with the patient and their family. As the patient was already receiving adequate pain relief from their stronger pain medication, you said that the patient had decided not to take Celecoxib. You also stated that you do not recall the family requesting that you give the Celecoxib medication although you acknowledge that this is stated in the Datix report. You said that the management had "a poor understanding of the principles of palliative care" in

that they were only concerned with symptom control and did not consider potential side effects sufficiently.

There were a number of witnesses, one of whom had also been involved with the same patient's care on 24 and 28 January 2019, and there was evidence that doctors had explained to you that the benefits of this medication outweighed the risks given that the patient had a terminal condition and was in end-of-life care. The panel preferred the evidence of those witnesses over your explanation. The panel considered that your duty as a nurse is not to continue to question prescribed medication when an explanation had been given by senior colleagues that the benefits of the medication outweighed the risks.

The panel accepted that a duty to administer medication could be negated by a refusal to accept medication by a competent patient and it noted that this was the basis of your defence. However, Mr 7 told the panel that the patient had previously received Celecoxib medication with good effect and that the family was keen for this to be continued. The subsequent refusal to take Celecoxib by the patient, as detailed in your response bundle, was only after you had explained potential side effects. The panel considered it was not the role of a nurse to unduly alarm a terminal patient about potential side effects when a consultant had deemed that this was the most appropriate drug in these circumstances.

The panel therefore found charges 6a) and 6b) proved.

Charge 7)

7) *On 3 February 2019, failed to attend to/assist with a patient with who had a high risk of falls;*

This charge is found proved.

The panel determined that there was a duty upon a registered nurse to assist patients and colleagues to minimise the risk of falls, especially involving a patient who was at high risk of falls.

Ms 16 told the panel that on 3 February 2019, during a long day shift working alongside you whilst assisting a patient, she observed another patient attempting to get out of bed—a patient she knew to be high-risk for falls due to confusion. Despite calling for your help to prevent a possible fall, you said *"[Ms 16] don't worry I will just datix it, if she falls, take the patient to the toilet"*. Ms 16 raised the issue with Mr 7, who said he would address it with the ward sister.

The panel also considered the witness statement of Mr 7, who was informed by Ms 16 about the incident. He emphasised the seriousness of patient falls and the necessity to take preventative measures. He stated:

> *"Patient falls can lead to serious incidents and we will do everything we can to prevent them where possible. If we have patients who are at a high risk we will complete enhanced observations. I couldn't believe anyone on our nursing team would hold this belief which could be detrimental to the team and especially to service users."*

The panel considered the near-contemporaneous email from Mr 7 to Ms 15 dated 15 February 2019, addressing the incident involving you and Ms 16. The email outlined the incident, highlighting your inappropriate response towards preventing a possible patient fall and stressing the need for proactive measures to prevent such incidents and the detrimental impact of such behaviour on the team and service users.

The panel also considered your response bundle. You were unable to recall the incident. You denied the allegations and asserted your commitment to patient safety. You stated: "*I take every necessary step to ensure that patient safety is maintained at all times. I always ensure that I act in a manner that would influence my colleagues to take patient safety seriously and act in the interest of maintaining this."*

The panel preferred the evidence from Ms 16 and the email from Mr 7 because there was considerable detail in Ms 16's witness statement and the email from Mr 7 was a near-contemporaneous account, sent to his senior colleagues shortly after being

informed by Ms 16, as he was so concerned. In contrast to this, you were unable to recall the incident and were only able to provide generalisations to the panel as to how you believe you would have acted in those circumstances.

The panel therefore found charge 7) proved on the balance of probabilities.

Charge 8)

8) On 10 February 2019, failed and/or refused to administer IV Co-Amoxiclav to a patient admitted with delirium secondary to UTI;

This charge is found proved.

In your response bundle, you explained your perspective on this incident, highlighting your diligence in ensuring patient safety and appropriate medication administration. You mentioned reviewing the patient's blood test results; these showed some improvement, leading you to question whether there was a need to continue the antibiotics. Despite recognising the need for instructions in prescriptions to be followed, you found the nurse-in-charge's interpretation of continuing with the medication inappropriate, even though the patient's medical notes directed to continue with IV antibiotics until a review the following day. Expressing concerns about potential harm and waste of resources, you emphasised the importance to establish the need for antibiotics to reduce adverse effects, resistance, infections, and reduce hospital costs and stays. You state that nurses play an important role in antimicrobial stewardship and the actions you took were in line with this duty. You said it was challenging to work with senior nurses who may not have received the same training as you but believe that they know better which you said could lead to mistakes or suboptimal care.

The panel considered the Datix report dated 10 February 2019, involving a patient with delirium secondary to a UTI, prescribed co-amoxiclav. The Datix report states:

> *"Patient is on oral co-amoxiclav and later on switched to IV co-amoxiclav. Last ward round with AMU consultant was 8/2/2019. WCC of 8.5 and DPR 17.2, condition still variable as per medics, so plan is to continue IV augmentin until*

10/2/2019. Nurse on the night shift of 10.2.19 refused to give IV augmentin after checking ICE results, thinks that the patient doesn't need it. Requests for urgent review from the on-call doctor. Explained to the nurse to give the last dose as per plan, nurse still unhappy to give it and omitted the last dose of IV augmentin. Nurse argues with senior nurses and goes on with what she thinks is right for her patient despite medical plan and senior nurses' advice."

Ms 15 told the panel that nurses do not possess the authority to decide when to discontinue a patient's prescribed medication.

The panel acknowledged your admission of not giving the medication and withholding it until review. However, the panel determined that withholding the last dose of a prescribed IV antibiotic until review when instructed by senior nurses to give the dose and where there is a plan authorised by a consultant in the medical notes, is equivalent to non-administration and is a refusal to administer. The panel determined that you had a duty to administer the medication in line with the prescription.

Therefore, the panel found charge 8) proved on the balance of probabilities.

Charge 9)

9) On 13 February 2019, failed and/or refused to administer Sando K on one, or more, occasions to a patient admitted to the Acute Medical Unit with hypokalaemia;

This charge is found proved.

The panel considered the witness statement of Ms 15, highlighting the incident involving the failure to administer Sando-K to a patient with hypokalaemia. Ms 15 states:

"*On 13 February, [Mr 7] reported that the registrant failed to administer two separate doses of Sando-K to a patient who had been admitted with hypothermia* [sic]*. Sando-K is a drug used to prevent potassium depletion. The registrant had advised the patient that as their blood potassium levels were within normal limits, they could have dietary sources of potassium as opposed to a medical dose.*

This is clearly not the registrant's decision to make. [Mr 7] challenged the registrant about this and they sought to advice from a consultant who said they wanted the patient to complete a short dose of the treatment…The registrant still refused to administer this and went over to the patient to 'discuss their options'. [Mr 7] called the registrant into the office to talk to her but she became confrontation saying 'I have my NMC Pin'. The medication had to end up being administered by [Mr 7]."

The panel also considered the Datix report dated 13 February 2019 submitted by Mr 7, which states that you omitted doses despite medical advice suggesting otherwise:

"*Staff Nurse omitted two doses of Sando K during the day because she is not sure to give it or not. Incoming night shift nurse asked her to give it, she requested for a medical review of the medication. Doctor on take was seeing a different patient but she ask him to review the medicine for her patient. SHO agreed and checked ICE result. Latest K level if 4.3. SHO explained to her its still on the border and its ok to give the medicine. The day team on the following day can review it again if they want to stop it or not. She still did not listen to the SHO and said "Doctor, I will give the patient options because Sando K has a bitter taste". She then went to the patient and explained lots of medical terms."*

Mr 7 told the panel that the regime for hypokalaemia is three days of medication and that although the patient's potassium had reached the normal range on the day of this incident, giving more would not cause harm. He said that he had to call the doctor on duty who was very busy.

In your response bundle, you explained the usual practice with Sando-K. You justified your decision based on the patient's normalised potassium levels and ability to intake orally. You asked the on-call doctor to review the patient's Sando-K. You said that the doctor looked at the patient's potassium level and was happy to discontinue the medication. The doctor was going to note this on the patient's drug charge when Mr 7 interrupted and told you in rather an aggressive manner that the medication should be given. You said you did not think it was appropriate to give the medication, so you did

not take Mr 7's instruction and explained that the reason for the omission had been fully documented in the patient's notes.

The panel determined that you made a clinical decision outside of your scope of practice by advising the patient to rely on dietary sources instead of administering the prescribed medication and by asking an on-call doctor for his opinion when he may not have been in possession of all the facts. The panel noted that although you stated that a doctor, not previously connected with the treatment of this patient, supported your choice to discontinue the medication, the panel found you had a duty as a nurse and not a prescriber to follow the prescribed treatment plan set out by the treating doctor. The panel acknowledged your attempts to seek justification for your actions but found the charge proved due to you failing to administer the prescribed treatment.

The panel therefore found charge 9) proved.

Charge 10a)

10) On 16 February 2019 administered IV Tazocin to a patient:

a) without ensuring that the dose and/or route was second checked before administration;

This charge is found proved.

The panel acknowledged your evidence that you had been IV trained in another hospital and were awaiting your IV training at this Trust, which was booked for 14 March 2019. You were therefore authorised to administer IV medicines pending your training as long as you had a second person to check prior to administration.

The panel considered Ms 15's witness statement, which detailed the incident on 16 February 2019 where you administered an IV Tazocin dose without a second check by another nurse. Ms 15 stated that Mr 6 had noticed a missing countersignature during handover, and that you could not recall who had second-checked it for you.

The panel also took into account the Datix report dated 18 February 2019, which states that upon taking over from the day nurse during the night shift, only one signature was found on the drug chart for a patient on Tazocin 4.5g iv TDS.

The panel also considered Mr 7's report dated 21 February 2019, emphasising the importance of following Medicines Policy 6.24h [6.26h]. It states:

> *"She decided not to let a second checker sign the IV tazocin and signed it by herself…"*

In addition, Mr 5's witness statement raised concerns about your premature administration of IVs without the required countersignature. He states:

> "*The registrant had gone to the patient given the IV and signed it…[without] obtaining a countersignature. I recall this being addressed with her on the ward and she became very agitated and said to the nurse who addressed this 'don't worry about it'."*

The panel considered Mr 6's account who was a direct witness, highlighting the absence of a countersignature for an IV Tazocin dose during handover and your dismissive responses when questioned by him about the oversight.

Your accepted that the second check of the IV Tazocin had not occurred. You attributed this to you being distracted at the time. You said in your response bundle that upon realising that the medication chart had not been signed by the senior nurse, you approached her to ask that she sign the chart showing her that the correct medication had been given to the patient. However, the senior nurse refused to sign the drug chart saying that the correct process had not been followed. You said that it was a one-off incident, but in all other instances you have been careful in ensuring that the correct process is followed. You also said that the approach the management took was draconian as they left you unsupported in this situation.

The panel considered that the purpose of second checking was to observe that the correct dose and type of medication was given to the correct patient. As the senior nurse had not witnessed all the correct steps, she was unable to countersign.

You told the panel that you accepted administering the IV Tazocin without ensuring a second check. Therefore, the panel found charge 10a) proved.

Charge 10b)

5) *On 16 February 2019 administered IV Tazocin to a patient:*

   b) *when not trained ~~and/or authorised~~ to do so by the Trust;*

The panel took account of the Datix report on 16 February 2019 which recorded the following:

> *'Staff involved does not have IV administration certificate on the Trust. No evidence of 2 trained nurse signing the drug chart. Staff will not be allowed to prepare IV medications without presence of IV trained nurse until certificate gained. Will be added to the agenda of the management meeting with involved staff this February'.*

It also had regard to the written statement of Ms 15 which set out:

> *'On 16 February 2019 … reported on datix that the registrant had administered an IV Tazocin dose but this was not second checked by another nurse. The registrant was not yet IV trained in this Trust although she was from her previous Trust. She was waiting for her booked IV training after completing her IV booklet supposedly on the 14 March 2019 but the registrant self-cancelled due to an unknown reason.'*

Ms 15 confirmed in her oral evidence that you were originally permitted to administer IV as you had undertaken IV training with your previous hospital.

In cross-examination, you confirmed Ms 15's position, that you had completed the training with a previous hospital. You said that Ealing Trust had authorised you to administer IV drugs whilst waiting to undertake the training with them, so long as a second checker was present.

In view of this evidence, the panel found it proved that you were not trained at the Ealing Trust and were awaiting your assessment and competency certificate from them.

This element of the charge is found proved.

Charge 11)

11) On 16 February 2019, failed to administer and/or sign for the administration of Lantus solostar to a patient;

This charge is found proved.

The panel considered 'LNWUHT Medicines Policy' dated February 2020, section 6.26 h) regarding the 'Process for administration of medication'. The policy outlines the importance of timely recording of medication administration to prevent duplicate doses:

> "*h) Once the medication has been administered, record actions by signing the prescription chart in the appropriate box at the time of administration; a delay in recording can result in one or more additional doses being given..."*

The panel was satisfied that you had a duty to sign for the administration of Lantus solostar.

The panel considered the Datix report dated 18 February 2019, which highlighted the incident involving the administration of Lantus solostar. The report detailed the incident

on 16 February 2019 where the medication was not properly documented despite being administered, leading to a discrepancy in the drug chart. The Datix report states:

> *"…I found that Lantus solostar was not given at dinner for the patient. Hence, I asked the day staff nurse to give it before she goes. Then, she prepared the Lantus solostar. I checked the medicine, signed the drug chart and then continued my work. After some time, When I went to the patient to give night medications, I could see only my signature on the drug chart. The day nurse had given the Lantus solostar but had not signed on the drug chart…I went to the patient and asked whether he had insulin. The patient replied that he received Lantus solostar by the day staff nurse and the nurse in charge."*

In your response bundle, you acknowledged the error in not signing for the administration of the patient's Lantus solostar injection. You clarified that it was an isolated incident triggered by distractions at the end of your shift. You said you have since taken steps to ensure that such an oversight does not occur.

The panel found that the Lantus solostar was administered to the patient, but you failed to sign for it.

The panel therefore found charge 11) proved.

Charges 12a) and 12b)

12) In relation to the administration of S/C Insulin Lantus to a patient on, or around, 16 February 2019:

a) failed to sign timeously for the administration;

b) on 18 February 2019, retrospectively signed for the administration;

This charge is found proved in its entirety.

The panel noted that charge 12a) appears to be a duplicate of charge 11). The panel therefore determined that charge 12a) is proved for the same reasons as given in charge 11).

In respect of charge 12b), the panel considered the detailed account provided by Mr 5, who described the incident on 18 February 2019 during a shift handover where he discovered that you had failed to sign for prescribed insulin given to a patient on 16 February 2019. Mr 5 raised this issue with you, and you signed retrospectively for the insulin you had given two days earlier but did not mark it as being retrospective. Mr 5's statement highlighted his concerns over the incident, prompting his report.

Furthermore, the panel took into consideration Mr 5's local statement from the same date, which outlined the incident about the unsigned Insulin Lantus and the subsequent signing of the drug chart by you after two days. The panel noted the gravity of Mr 5's concerns that led to his formal report.

In your oral evidence, you accepted your failure to sign for the medication promptly and accepted that you signed for this two days later after the medication had been administered.

Given your own acceptance that you signed the drug chart retrospectively, the panel found charge 12b) proved.

Charge 13)

13)On 18 February 2019, shouted at a colleague during a handover;

This charge is found proved.

The panel considered the evidence of Mr 5 who outlined the incident on 18 February 2019 where you confronted him about incomplete blood forms for a patient. Mr 5 described your aggressive questioning and a misunderstanding that led you to believe that Mr 5 had called you "dumb”. He explained that this escalated into shouting and unprofessional behaviour in front of patients. Mr 5 states:

"*The registrant started shouting at me saying I had called her dumb and that I was nasty. I was completely shocked by her reaction and tried to explain her that I did not say that…The registrant carried on and started screaming and shouting in front of patients, it was very unprofessional…The registrant carried on and was shouting at me to go away…"*

This prompted Mr 5 to report the incident to the nurse in charge. In addition to Mr 5's statement, the panel considered a more detailed local statement from the same day, providing additional context to the incident.

In your response bundle, you recalled a disagreement during a handover with Mr 5 over the use of a worksheet, mentioning hearing a word that you believed was "dumb." You described addressing Mr 5 calmly about his behaviour and attempting to walk away to de-escalate the situation.
In your closing statement you also said that you believed that Mr 5 had shown a lack of insight into how medication errors can happen and also into the appropriate way to support a colleague in such situations. You also said that Mr 5 did not seem to take responsibility for the conflict although you did accept that the conflict also reflected poorly on your professionalism.

While you acknowledged the conflict but denied shouting, the panel noted Mr 5's detailed report to the nurse in charge written on the day of the incident. The panel found him to be a credible and reliable witness and preferred his evidence.

Therefore, the panel found charge 13) proved on the balance of probabilities.

Charge 14)

14)On one, or more, occasion, used your own self- made handover sheet;

This charge is found proved.

The panel considered Mr 5's witness statement, in which he described your use of a self-made handover sheet. He said that despite having all the necessary information readily available in the patient's bedside folder, you opted to duplicate everything on your personal checklist which took 5 to 10 minutes per patient and significantly extended the 40-minute handover period. As a result, colleagues were left waiting at each patient's bedside while you completed this task which you justified as maintaining your 'high standard' of handover practice.

Furthermore, the panel considered the witness statement of Ms 15, who expressed concerns about your detailed but impractical method of record-keeping. Ms 15 states: *"…I believe she wasn't ready as she had her own method of record keeping that was detailed and didn't allow for timeliness. This meant the patients weren't always received the care they could have."*

In your response bundle, you said the use of your self-made handover sheet was to improve efficiency and help you prioritise tasks. You explained that the handover sheet allowed quick access to pertinent patient information without the need to return to the bedside or search for charts, which you said was especially beneficial in a paper-based system shared by multiple professionals. You also provided the panel with your handover sheet made up of two pages.

The panel acknowledged that you accepted you used your own self-made handover sheet which you asserted was for the purpose of enhancing efficiency.

Therefore, the panel found charge 14) proved.

Charge 15)

15) On one, or more, occasion, failed to act within the scope of your practice by refusing to undertake nursing duties and reasonable requests including:

a) Arguing with nursing and medical staff;

b) Challenging medical/patient decisions;

c) Refusing to assist colleagues on the Ward;

This charge is found proved in its entirety.

The panel accepted that challenging decisions could be part of a nurse's responsibilities. However, the panel heard from several colleagues who felt that you consistently exceeded the acceptable boundaries of such actions. The panel interpreted arguing as meaning challenging colleagues persistently without good reason but not necessarily involving raising of the voice.

In respect of charge 15a) the panel considered Ms 14's witness statement, which states:

> *"As nurses we are encouraged to challenge other medical practitioners when we are unsure or have concerns, but the registrant was consistently doing this. Often consultants would explain to her why they* [medication] *had been prescribed but she would continue to argue that it was incorrect; this was often in front of other colleagues and sometimes patients which was obviously very unprofessional…The registrant would also refuse to follow instruction and medical advice in other clinical aspects. This made it very difficult for others to work with her as she would openly question medical decisions and at times argue with colleagues in front of patients and their relatives."*

Ms 14 told the panel of your persistent tendency to challenge medical practitioners' decisions, even after explanations were provided. She said that this behaviour, displayed in front of colleagues and patients, was unprofessional and disruptive to the team's dynamics.

Mr 7 also told the panel about your confrontational demeanour, leading to instances where colleagues felt compelled to disengage from interactions with you. Mr 7 said: *"The registrant was very argumentative and I witnessed multiple occasions where staff had to walk away from her."*

Mr 6 told the panel about the difficulties in working with you, citing instances of perceived rudeness in your communication style and witnessing confrontations with

other medical professionals. Mr 6 said: *"…it was really difficult to work with her. I would also say the registrant would come across as quite rude in her communication. I never argued with her but overheard her being argumentative with the doctors when she wouldn't administer medication that was prescribed."*

The panel considered the Datix report dated 10 February 2019, which states: *"Nurse argues with senior nurses and goes on with what she thinks is right for her patient despite medical plan and senior nurses' advice."*

The panel also considered the list of concerns produced by Ms 15 which sets out a number of issues, including: "*Arguing with fellow nursing staff in front of patients in the clinical area."*

In your response bundle, you said that it was not in your nature to behave in such a way and denied engaging in unprofessional behaviour or refusing reasonable requests. You said that your actions were solely driven by a desire to ensure optimal care for your patients.

Although you denied it, multiple witnesses told the panel that they had seen your argumentative interactions with both nursing staff and doctors with regards to you refusing to undertake nursing duties or reasonable requests.

Therefore, the panel found charge 15a) proved on the balance of probabilities.

Regarding charge 15b), Mr 7 told the panel about concerns regarding your behaviour. Mr 7 recalled the initial positive experience with you but later noticed a pattern of excessive questioning. While acknowledging the importance of nurses questioning decisions for patient safety, Mr 7 pointed out that you went beyond appropriate questioning, challenging every decision, even basic nursing tasks. Despite numerous interventions from senior staff, you persisted in challenging instructions, making collaboration difficult and time-consuming. Mr 7 further stated that:

"*The registrant continued to challenge all our decisions and instruction and this made working with her hard at times as it took a lot of time. I felt that the registrant was trying to do her own job as well as the job of the prescriber and despite us explaining this to her over and over it didn't seem to change anything."*

Mr 7 also said: *"I cannot recall a single time when the registrant's challenging was justified or as a result of an error. That is why it was a concern."*

Although you expressed concerns about Mr 7 being biased against you, the panel noted his anticipation to work with someone from the same background as himself. Mr 7's statement reflected his positive attitude towards meeting you. In his statement, he states:

"*I was excited for the registrant to start because I am also from the Philippines and it's nice to meet others from your own country."*

He also said that he *"really wanted the registrant to do well. I know what it is like to come from the Philippines and how hard you have to work to be a nurse in the UK, to register with the NMC and adjust to a new way of living…I really tried my best with the registrant, I did everything I could think of and I gave her more chances than I probably should have."*

The panel rejected the suggestion that Mr 7 was biased against you.

Additionally, the panel considered Ms 15's witness statement, which echoed Mr 7's concerns. In her oral evidence, Ms 15 said nurses are entitled to challenge doctors. However, once a rationale for giving a medication had been provided, she said that you refused to accept this and wanted to go from one doctor to another to find support for your position. She said that this was unacceptable as it is the clinical decision of the prescribing doctor and that another doctor should not be involved.

The panel considered your response bundle. You state that the instances when you had to push back and step up to raise concerns about the treatment of your patients was for the purpose of ensuring that they received optimal care.

The panel noted your insistence on seeking multiple opinions and challenging prescribed treatments. However, the panel noted that this undermined the authority of the treating physician. The panel found that there were multiple instances where you challenged decisions of other medical professionals for no valid reason; this was beyond the scope of your practice.

Therefore, the panel found charge 15b) proved.

Concerning charge 15c), Mr 7 told the panel about the 15 February 2019 when Ms 16 asked you to assist a high-risk falls patient. Instead of providing assistance, you dismissed the situation by stating, "*don't worry, I will just datix it."* Mr 7 expressed concerns about your lack of professionalism and accountability in this incident. He noted that you failed to treat your colleagues with respect, showed reluctance to help fellow staff or HCAs, and avoided "*going the extra mile"* expected of a nurse. He stated that your tendency to refuse tasks such as assisting patients with toileting or changing, claiming to be too busy, contrasted with the collaborative behaviour expected among nursing staff. Mr 7 also stated that he observed instances where staff members had to disengage from interactions with you due to argumentative behaviour.

The panel also took into account Ms 16's witness statement regarding the same incident, confirming that you did not assist the patient and no fall occurred.

Furthermore, Mr 6's statement added weight to the concerns and indicated a general reluctance among colleagues to seek assistance from you due to the perception that you were always too busy.

Additionally, the panel took into account the report by Ms 15 dated 21 February 2019, emphasising the importance of teamwork. The report highlighted instances where you failed to support colleagues, refused to assist HCAs, and demonstrated poor

communication skills during handovers. Your focus on personal tasks, use of a non-standardised checklist, and disruptive behaviour during handovers negatively impacted team cohesion and patient care.

Given the consistent accounts from multiple witnesses regarding your refusal to assist colleagues, the panel found charge 15c) proved on the balance of probabilities.

Charge 16)

16) On one, or more, occasion, failed to preserve patient safety:

a) Failing to transfer patients in a timely manner;

b) Failing to complete documentation in a timely manner;

This charge is found proved in its entirety.

The panel considered the wording in the stem of the charge 'failed to preserve patient safety' and understood it to mean actions that put patients at risk.

Regarding charge 16a), the panel considered Mr 7's witness statement concerning an incident on 29th November 2018 where you were assigned two patient transfers during the shift. Despite receiving clearance for the transfers, you repeatedly delayed the process, citing being busy and having unfinished tasks as reasons. He states:

> "*The registrant was unable to transfer patients effectively. A Band 5 needs to have an understanding of the NHS goals and targets. When you are the nurse in charge this is an important part of the role to ensure the smooth running of the shift. The patients for transfer on the registrant's shift are either not transferred at all or their transfer is delayed for hours unnecessarily. The porters had to come back to the same patients several times and each time the registrant would say they aren't ready…*"

He further stated that you showed a lack of understanding of the urgency and impact of delayed transfers and referred to an instance where a patient missed a critical

procedure due to a delayed transfer, leading to rescheduling and patients not receiving the care they should have.

Additionally, Ms 16's statement highlighted several occasions where you would not transfer patients to other wards when asked and that when the porters arrived, you would say that you were not ready. She further states: "*I believe she wasn't ready as she had her own method of record keeping that was very detailed and didn't allow for timeliness. This meant the patients weren't always received the care they could have."*

An email from Mr 7 to Ms 15 dated 29 November 2018 outlined instances where porters had to return multiple times due to your unpreparedness for transfers. In oral evidence, Mr 7 emphasised that the responsibility for patient transfers rested with you and that you had disrupted bed flow and patient care.

In oral evidence, Ms 15 also emphasised the importance of timely patient transfers in an environment like the AMU with a high patient turnover rate.

In cross-examination, you said that "timely" can mean many things and suggested that patient transfers were a team effort. You said that if you were having difficulties, it was the whole team's responsibility.

Mr 7's evidence emphasised that while you were busy, others managed busier schedules and that the timely transfer of patients was ultimately your duty.

The panel accepted that managing bed flow is a team effort but considered that when you were requested to transfer a patient, you had a duty to do this in a timely manner. The panel found that you failed to do this in a timely manner on one or more occasions.

Therefore, the panel found charge 16a) proved.

In relation to charge 16b), the panel considered the witness statement of Ms 15, who states:

"…The registrant would normally stay 1-1.5 hours later on shift to complete her nursing documentation. Sometimes she was still on shift at 10pm doing this despite the shift ending at 7:20-08:00pm. The registrant had her own documentation that she used instead of the Trust documentation. This meant she would copy everything over from the patient's notes into her own form. This obviously took a substantial amount of time that could have been used for her contracted nursing duties. Sometimes the registrant would have to go to other wards where the patients had been moved from AMU to complete documentation she had forgotten or was unable to complete at the time. Of course there are always occasions where nurses will get behind with documentation but this was a daily occurrence…The Matron and I did speak to the registrant about this and she said she had made her own nursing checklist as it was more comprehensive. She actually showed us and we did say if it works for you that is okay but that this needed to be balanced with time-keeping. The nursing checklist in my opinion was tedious and unnecessary, she was duplicating the same records. As a result of the registrant's own clinical checklist being used at handover, her handovers would often take double the expected time delaying nurses from going home by 30-40 minutes each day."

Mr 7 also said:

"The registrant was also unable to prioritise clinical work, she would never finish on time, it would normally be between 22:00 to 23:00 before she finished her nursing notes. The ward should finish at 20:00 so it was usually 2-3 hours later than expected. This meant the night staff were unable to use the documentation as she would take it to compile all her own notes. I explained to her on many occasions that this was not acceptable and put patients at risks. There were also instances when she would have to go to other wards to locate patients who had been discharged because she had been unable to complete her documentation on time."

Mr 6 also highlighted to the panel the issue of poor timekeeping in handovers:

“I can’t recall any specific dates or incidents but I know her time-keeping was very poor. Handover should be kept simple and consistent but handover with the registrant was frustrating for everyone. The registrant used her own handover form and would go through lots of irrelevant information meaning they took much longer than they should have. We work in a busy department and we can’t be wasting time.”

Ms 14 reported concerns over time management and record-keeping, saying:

“*Another issue which was raised was poor time management re her record keeping; the registrant would stay up to an hour later after her shift to complete her notes. The registrant used her own documentation instead of the Trust wide standard system and this caused complications and delays during handover and contributed to the delay. The registrant was spoken to about this on multiple occasions by myself and others but continued to insist on doing things her own way…”*

The panel considered your response bundle and acknowledged your explanation for completing documentation post-shift, emphasising patient care priorities in a fast-paced environment. However, the panel noted that in its determination in charges 11) and 12) there were concerns raised regarding incidents such as administering medication without documentation and significant delays in documentation, which potentially compromised patient safety. There was a duty to ensure that patient notes were completed promptly in order to maintain patient safety, particularly given the nature of the unit on which you were working where matters could escalate quickly. The panel concluded that your frequent delays in completing notes, highlighted by many witnesses and in several incidents, indicated a lack of timeliness.

Therefore, the panel found charge 16b) proved.

Charge 19)

19)[PRIVATE].

Schedule 1 (private)

[PRIVATE].

This charge is found proved.

[PRIVATE].

Dr 1 was asked by the NMC to provide a further report following the conclusion of the primary evidence. [PRIVATE]. He was provided with the following material:

1. *Transcript of the Registrant's Substantive Hearing of the Fitness to Practise Committee – beginning Monday 9 October until Wednesday 11 October.*
2. *Registrant's witness statements.*
3. *Copy of the charges relating to both cases.*
4. *Copy of letter Registrant sent to the PSA, leading to the referral."*

After examining this evidence, Dr 1 updated his opinion and issued a report dated 5 November 2023, which states:

> ***"CONCLUSION:***
>
> *[PRIVATE].*

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

The panel considered your evidence including a PowerPoint presentation on [PRIVATE].

In your presentation you explained [PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

The panel therefore found charge 19 proved [PRIVATE].

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and/or lack of competence and, if so, whether your fitness to practise is currently impaired by reason of that and/or [PRIVATE]. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct and/or lack of competence. Secondly, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of misconduct and/or lack of competence (if the panel finds the facts found proved amount to either misconduct or lack of competence) and/or [PRIVATE].

Submissions on misconduct, lack of competence and impairment

Ms Nelson highlighted that a large number of the charges in your case had been found proved. She submitted that your conduct gave rise to regulatory failings, and set out the following five categories into which your conduct might be placed:

- That you failed to provide timely and appropriate care to patients.
- That you failed to assist patients appropriately in an emergency.
- Record keeping failures.
- That you failed to take instructions from senior colleagues and work in a collaborative manner.
- That you repeatedly worked outside the scope of your practice, particularly in relation to medicines management and administration.

Ms Nelson referred to the cases of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin). She invited the panel to find that the charges found proved and your clinical failings were not isolated incidents but instead were indicative of a pattern of poor behaviour and conduct. She submitted that individually, the issues would be regarded by fellow practitioners as deplorable and that collectively, there was no doubt that they amounted to misconduct.

Ms Nelson submitted that charges 1 – 4 of the those arising at the Hammersmith Trust, and all of the charges arising at the Ealing Trust, amounted to misconduct. However, if the panel did not agree that they amounted to misconduct, then she invited the panel to

find, in the alternative, that they arose due to lack of competence. Charge 6 arising from the Hammersmith Trust related solely to a lack of competence and Ms Nelson invited the panel to find that your performance was unacceptably low. She referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin).

Ms Nelson also referred the panel to the case of *R (Vali) v GOC* [2011] EWHC 310 (Admin) submitting that misconduct and lack of competence should be considered as alternative grounds, not simultaneously.

Ms Nelson identified the following standards within 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) (which was in place at the time of the Hammersmith Trust allegations) and which, in the NMC's view, your actions breached:

> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> > *To achieve this, you must:*
> >
> > *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
> >
> > *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
>
> ***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:*
> >
> > *6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services, and*
> >
> > *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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

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

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

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

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of 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

10.3 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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly,

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

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

Ms Nelson reminded the panel that the 2015 version of the Code was updated with effect from 10 October 2018. Therefore, the 2015 version is relevant to the Hammersmith charges and the 2018 version is relevant to the Ealing charges. However, she pointed out that the standards in each mirror one another.

In view of the nature of your behaviour, and the breaches of the Code, Ms Nelson invited the panel to take the view that the facts found proved amount to misconduct.

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

Ms Nelson referred to the test arising from the case of *Grant*, where in paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's “test” which reads as follows:

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

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

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

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

d) *…*

Ms Nelson submitted that in your case limbs a), b), and c) of the test were engaged. She submitted that much of your behaviour is indicative of a deep-seated attitudinal issue which is incapable of remediation. She further submitted that the misconduct in your case is so egregious that your fitness to practise is currently impaired despite any remediation you have put forward to the panel. On this basis, she invited the panel to find your fitness to practise currently impaired on the grounds of public protection as well as in the wider public interest.

[PRIVATE].

Ms Nelson submitted that you are liable in the future to put patients at an unwarranted risk of harm if allowed to practise unrestricted.

[PRIVATE].

You provided the panel with five detailed and comprehensive documents in addition to the reflective accounts and details of the training that you had previously provided. The first two documents addressed misconduct, lack of competence and impairment in relation to the charges found proved. [PRIVATE]. The fourth document specifically addressed the NMC's submissions in respect of misconduct, lack of competence,

[PRIVATE], and impairment. In addition, you provided copies of patient notes dating from 2017.

Within your written submissions you set out that the panel should not accept the volume of charges proven in your case as necessarily or automatically constituting a pattern of conduct. Instead, you said that each allegation must be thoroughly examined within its unique context, taking into account factors such as the circumstances surrounding each incident, the presence of any extenuating factors, the underlying motivations, and the overall demonstration of professional conduct.

You addressed the charges found proved individually and submitted that while certain actions may have indeed fallen short of ideal standards, attributing them solely to misconduct overlooks the nuanced realities of healthcare practice.

[PRIVATE].

You submitted that there was also evidence of self-awareness shown by your actions [PRIVATE]. You maintained that, where you had intervened in medical decisions, your actions were taken in the spirit of being a patient advocate and with the best intentions of your patients at heart. You submitted that misconduct should generally only be found if there was a deliberate act or gross negligence and pointed to your lack of intent.

Decision and reasons on misconduct and lack of competence

The panel accepted the advice of the legal assessor which included reference to a number of judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

In considering misconduct and the charges found proved, the panel kept in mind that you were working on the Heart Assessment Centre at Hammersmith, an initial assessment ward for patients arriving at the hospital with cardiac symptoms. This ward was the first port of call for emergency patients brought in by ambulance. The panel

kept in mind that the ward would have been an extremely pressurised environment, with a high and fast turnover of patients with serious and life-threatening issues. Therefore, any attitudinal issues and misconduct occurring in this setting, would have undermined the wider team, caused harm to patients, and also put patients at risk of serious harm.

Because of the large number of charges proved in this case, in her submissions, Ms Nelson grouped the facts into regulatory concerns. The panel considered each fact individually and decided that they fell into thematic groups. It decided on the following five themes, which slightly differ from the categories submitted by Ms Nelson:

- That you failed to provide timely and/or appropriate care to patients.
- That you failed to work collaboratively as part of a team including failing to assist patients appropriately in an emergency.
- Record keeping failures.
- That you failed to take instructions from senior colleagues.
- That you repeatedly worked outside the scope of your practice, particularly in relation to medicines management and administration.

The panel bore in mind that some of the facts fit within more than one of the themes set out above.

Within your written submissions you set out the following:

> *"…[the] allegations surrounding the failure to hand over responsibilities before breaks and non-participation in ward rounds underscore a lack of clear management expectations or established protocols regarding these tasks…"*

The panel recognised that it is unrealistic for every clinical situation or encounter to be covered by a policy or protocol. When looking at the facts proved, the panel held in mind the expectation that, as an experienced nurse, you need to adhere to standard nursing practice, common sense, and the Code to supplement any policies and protocols in place at the Trust. In this regard, the panel referred to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a

‘word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’

The panel noted your references to the context in each of the charges and acknowledged that in every charge there will always be contextual factors which influence behaviour. The panel heard your submissions and has taken them into account. Your submissions also referred to your failings being isolated incidents of human error. The panel acknowledged that occasional mistakes are unfortunately inevitable because of human error and a single or even a few instances may be excusable and may not amount to misconduct. However, given the number of errors and your level of qualified nursing experience, the panel is not able to take context as the reason for so many basic failures and falling below expected standards.

The panel also noted the deterioration in the relationship between you and Ms 1. You describe a hostile demeanour, frequent reprimands, and you being called into meetings unexpectedly. You also said that you felt pressured, scrutinised, and worried about your practice. The panel noted that you had said that you found it hard to approach management to communicate your concerns and felt misunderstood by them.

The panel noted that on several occasions, you explained that you needed to take extended breaks or remove yourself from the situation in order to calm down and regain your composure and you stated that there was no negative impact on patient care by you doing this. However, the panel considered that there would have been an impact on patient care and in a busy, pressurised environment such as the HAC, communication about your whereabouts, [PRIVATE], and conflict resolution skills are crucial. The panel noted that management at both Trusts had provided you with various additional supports, such as a mentor, a buddy, the support of a practice educator and a reduced caseload.

The panel noted your reference in your submissions to gross negligence and intention. You submitted that ‘Misconduct typically involves deliberate or grossly negligent actions’. The panel reminded itself that it is not necessary to find negligence or intent in determining whether an act or omission amounts to misconduct. The panel bore in

mind, however, the need for such conduct to be serious and to fall far below the standards expected of a registered nurse.

In addition to assessing failures and omissions, the panel assessed whether the facts proved caused not only actual harm, but also a risk of harm to patients.

The panel also bore in mind that acts or omissions which, in isolation, might not constitute misconduct, could amount to misconduct when considered collectively with other acts or omissions, particularly if together they demonstrate a pattern of conduct which falls seriously short of expected standards.

Theme one; that you failed to provide timely and/or appropriate care to patients.

The panel identified 25 charges which it considered give rise to a pattern of behaviour within this general theme. Specifically, those charges are:

- Arising at the Hammersmith Trust; 1a, 1b, 1cii, 1ciii, 1civ, 1d) i), 1d) ii), 1d) iii), 1e) i), 1e) ii), 1e) iii), 1e) iv), 1e) vi), 1e) viii) (first limb only), 1g), 3a), 3c), 3e), 3g), 3h), 3i), 4g).
- Arising at the Ealing Trust; 7), 16a), 16b).

Looking at charges 1c)iii and 1c)iv, these charges include failures relating to Patient B's diabetes review and a catheter insertion record. These two charges specifically serve as examples of conduct which the panel deemed to characterise a lack of efficiency and poor holistic care. They may sit at the lower end of the spectrum of seriousness, but they sit alongside more serious failings and indicate a pattern of behaviour.

Charges 1e)iv), 1g, 3c and 3g, illustrate more serious failings. You failed to tell a 'nil by mouth' patient that they could not eat, which resulted in their procedure being delayed. You failed to re-start a patient's infusion, subsequently failing to handover that it had not been done which meant that the patient's infusion was not administered for several hours. You failed to cross-reference a patient's electronic drug chart with their wrist

band and made a medication error by administering Amoxicillin to the wrong patient. You failed to check patient notes to find out if a cannula was still necessary. There was no need for the patient's cannula to be reinserted and the procedure would have caused them unnecessary discomfort.

The panel considered that the failings highlighted here relate to basic nursing tasks which would not necessarily be covered in a Trust policy.

There were no charges in this theme which individually or cumulatively did not amount to misconduct. The panel decided that they were all serious, to a lesser or greater degree, and all gave rise to a risk of harm to patients. It was of the view that all the facts found proved breached fundamental tenets of the nursing profession and that fellow practitioners would find your conduct deplorable.

Theme two; that you failed to work collaboratively as part of a team including failing to assist patients appropriately in an emergency.

The panel identified the following charges which it considered give rise to a second pattern of behaviour:

- Arising at the Hammersmith Trust; 1d) iv), 1d) v), 1e) v), 1j) i), 1j) ii), 3d).
- Arising at the Ealing Trust; 1), 3a), 3b),13), 14).

In the panel's view, a nurse caring for their patients should actively participate in ward rounds whenever possible and support the multi-disciplinary team with up-to-date information relating to their patients' condition. Charges 1d)iv) and 1d)v) illustrate you avoiding patient rounds and prioritising other tasks, which in the panel's view put patients at risk of harm.

In relation to charge 1j)i) the panel heard how you stood with folded hands when a patient suffered a cardiac emergency, and when asked to help you responded, "*I don't care*". You were working in an extremely pressurised environment, with a high and fast turnover of patients with serious and life-threatening issues. Your role was to support

your colleagues and assist directly in providing patient care. Instead, you prioritised administrative tasks, putting patients at a real risk of harm and increasing the pressure on your colleagues at critical times.

The panel determined that your lack of awareness of the situation around you and your insular way of working led to a failure to provide appropriate assistance in an emergency. Your conduct at charges 1j) i), 1j) ii) fell far below the standards expected of a registered nurse. Again, the panel considered that all these facts found proved breached fundamental tenets of the nursing profession and that fellow practitioners would find your conduct deplorable.

In relation to charge 3d, you refused to administer or allow a colleague to administer prescribed medication to Patient K (who had acute confusion and had attempted to leave the HAC). You raised your voice to Ms 4, the Nurse in Charge, stating that it was your own assessment that even though it was a small dose, it was not necessary. This was despite Ms 4, a senior colleague, judging the medication to be necessary. The panel recognised that appropriate challenge falls within a nurse's remit, but you went beyond reasonable challenge and did not respect your senior colleague's decision or work collaboratively taking into account her greater level of experience.

The panel considered Charge 1, arising from the Ealing Trust to strike at the heart of professional nursing behaviour and trust in nurses and the profession.

In the panel's view, your conduct in all the charges within this theme amounted to a serious breach of the following provisions of the Code (both the 2015 version, which covers the charges arising from the Hammersmith Trust, and the 2018 version which covers the charges arising from the Ealing Trust):

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

You failed to work collaboratively and frequently frustrated your colleagues. The panel considered these facts found proved, particularly Charges 1j)i), ii) and Charge 3d) to be at the higher end of the spectrum of seriousness, as they undermined the effectiveness of the team and the care provided to patients, consequently giving rise to a risk of harm.

The panel determined that your conduct in all the charges within this theme fell far below the standards expected of a registered nurse. Again, the panel determined that these facts found proved amounted to serious breaches of both the Code (both the 2015 and 2018 versions) and fundamental tenets of the nursing profession and that fellow practitioners would find your conduct deplorable.

Theme three; record keeping failures.

The panel identified the following charges which it considered give rise to a third pattern of behaviour:

- Arising at the Hammersmith Trust; 2a) i), 2a) ii), 2a) iii).
- Arising at the Ealing Trust; 11), 12a), 12b).

The panel determined that charges 2a) i), 2a) ii), 2a) iii), although at the lower end of the spectrum of seriousness, nevertheless represented a pattern of poor record keeping.

Making patient notes retrospectively could prevent colleagues from being able to monitor observations accurately at a glance, or remotely from other areas of the hospital, to establish worrying trends or a deterioration, and therefore puts patients at risk of harm. The panel heard that you recorded your observations on a piece of paper next to Patient B's bed and did not input them in real time.

Failing to mark notes as having been retrospectively made compounds the seriousness as the panel heard evidence that it is 'akin to falsifying records'.

These failings demonstrate not only a lack of attention to detail but also a failure to appreciate the need for an accurate, contemporaneous and effective record keeping system, and the impact of inaccurate records on patient care.

Looking at charges 11) & 12a) arising from the Ealing Trust, these charges fall at the higher end on the spectrum of seriousness. Lantus Solostar was administered to the patient, but you failed to sign for it. Your failure to sign that you had administered the drug gave rise to a clear risk of harm, in that the patient could potentially have been given a second dose of Lantus Solostar by a colleague unaware that a dose had already been given.

The panel determined that these failings, individually and cumulatively, fell far below the standards expected of a registered nurse and amounted to misconduct.

Theme four; that you failed to take instructions from senior colleagues.

The panel identified the following charges which it considered give rise to a fourth pattern of behaviour:

- Arising at the Hammersmith Trust; 3f) ii), 4b), 4d), 4f), 4g), 4h), 4i) i), 4i) iii),4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii).
- Arising at the Ealing Trust; 3c), 4a), 4b).

All the charges referred to above are examples of you failing to take instructions and disregarding the authority of your senior colleagues. For example, at charge 3c) arising from the Ealing Trust, you inappropriately and continuously challenged a doctor's decision regarding a patient's discharge. The final decision regarding patient medical discharge rested with the doctor, and you persistently failed to accept their clinical rationale. The panel noted that the doctor in this scenario was reportedly upset and distressed by your confrontational manner. The panel considered this to be a serious failure by you.

In relation to charge 4a and 4b arising from the Ealing trust, the medication was delayed and was not given at the time that the doctor had prescribed. Your delay in administering the medication potentially compromised the patient’s care. The physician responsible for the patient had issued clear instructions in the patient notes, which you overlooked in favour of guidance you had sought from the pharmacist without having checked the patient’s notes first or at any time before you handed over. The panel found that it was not your role to verify why a doctor had prescribed this commonly used drug to this patient. It was your duty to administer the medication as prescribed, which you failed to do by spending time seeking guidance from a pharmacist. This resulted in the drug being given much later than required.

Charges 4h), 4i) i), 4i) iii) represent a failure to comply with reasonable instructions to move a patient to a different ward (charge 4h) or move wards yourself to ensure a correct balance and safe staffing levels (charges 4i) i), 4i) iii)). The panel heard that it was common practice for nurses to be moved to various wards within the cardiac

directorate, and that this was part of your employment contract. This failure to comply resulted in unnecessary pressure being placed on other colleagues and an imbalance in staffing levels in wards across the directorate, which potentially put patients at risk of harm. The panel decided that this failure to comply with reasonable instructions constituted misconduct.

Charges 4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii) all occurred after a meeting in which you explained to management the reasons why you were unable to move to work on ward A7. [PRIVATE]. The panel also heard evidence that you had raised with other colleagues that you would work on other wards but not on A7. However, the panel also heard evidence that on one occasion you refused to move and sat down at the nurses' station on your phone and on another occasion, you stood with a stern look on your face and refused to move. It considered this to fall below the standard expected of a registered nurse. [PRIVATE]. The panel went on to consider if these charges arose due to a lack of competence. Taking account of all the surrounding circumstances, the panel was not satisfied that these failures represented an unacceptably low standard of performance. Therefore, it did not find these charges amounted to a lack of competence.

Charge 4c) arising from the Hammersmith Trust, and Charges 2), 6a), 6b), 9), arising from the Ealing Trust, all fit within both themes; namely, failing to take instructions from senior colleagues and acting outside the scope of your practice. The panel considered charge 4c) arising from the Hammersmith Trust, and charges 2), 6a), 6b), 9), arising from the Ealing Trust to be extremely serious and the examples of your conduct which best illustrate not only how you acted outside of the scope of your practice but also how you failed to take instructions from senior colleagues.

In charge 4c) arising from the Hammersmith Trust, despite a clear instruction from Mr 3 to administer Amiodarone to Patient B, you did not follow the instruction and did not administer the medication to Patient B. In charge 2) arising from the Ealing Trust, you refused to administer a prescribed dose of Tinzaparin to a patient with Pulmonary Embolism, causing a delay in treatment. In charge 6)a) and b) arising from the Ealing Trust, you unduly alarmed a terminally ill patient as to potential side effects of the drug

Celecoxib, when a consultant had deemed the drug to be the most appropriate in the circumstances. The consultant, who was described by witnesses as very experienced and competent, was best placed to conduct a risk-benefit analysis having taken account of the patient's condition and pain levels.

In charge 9) arising from the Ealing Trust, you also made a clinical decision outside of your scope of practice by advising a patient to rely on dietary sources of potassium instead of administering the prescribed medication for hypokalaemia and by asking an on-call doctor for their opinion unnecessarily when they may not have been in possession of all the facts.

The panel heard numerous examples of where you refused to accept the initial advice of senior colleagues and sought out further advice from other doctors or senior professionals to try to confirm your own view. The panel appreciates that there are situations when a challenge by a nurse of a more senior colleague may be appropriate and in the best interests of the patient. However, it did not find that this was the situation in the examples found proved in your case.

You undermined the smooth operating of a multi-disciplinary team and frustrated your colleagues, putting patients at risk of harm, causing unnecessary delays to patient care and taking other, often senior, professionals away from their work in critical care situations. Being able to follow instructions is a crucial and fundamental skill in safe nursing practice. Excluding charges 4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii), the panel found your conduct within this theme to be extremely serious breaches of the Code amounting to misconduct, specifically the following sections:

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

Theme five; that you repeatedly worked outside the scope of your practice, particularly in relation to medicines management and administration.

The panel identified the following charges which it considered give rise to a fifth pattern of behaviour:

- Arising at the Hammersmith Trust; 1d) ii), 1d) vi), 1f), 4c), 4e).
- Arising at the Ealing Trust; 2), 6a), 6b), 8), 9), 10a), 10(b) (first element), 15a), 15b), 15c).

As set out above charge 4c) arising from the Hammersmith Trust, and Charges 2), 6a), 6b), 9), arising from the Ealing Trust illustrate how you undermined the effectiveness of a multi-disciplinary team and frustrated your colleagues, putting patients at risk of harm.

The panel appreciated that you may have been advocating for your patients and trying to ensure that they were fully informed. However, the panel considered that you ought to have appreciated the limits of your knowledge, listened to advice from other professionals and respected the authority, knowledge, and experience of your senior colleagues. Being able to recognise your limitations is a crucial and fundamental skill in safe nursing practice, as is being able to follow instructions especially in critical care situations. Your failure to recognise your limitations put patients at risk of harm.

Looking at 1d) ii), 1d) vi) and 1f) in isolation, and at a superficial level, they may initially appear to be of limited concern. However, the underlying and recurring behaviours of thinking that you knew best are concerning and created situations which put patients at risk of serious harm.

The panel determined that your conduct at these charges, except for charge 10b), fell far below the standards expected of a registered nurse. Again, the panel considered

that these facts found proved amounted to serious breaches of both the Code, specifically section 13, which requires you to recognise and work within the limits of your competence. Your conduct also breached fundamental tenets of the nursing profession and fellow practitioners would find it deplorable.

The only charge in this theme where the panel did not find misconduct was Charge 10b. The panel accepted that you had not been trained by the Trust to administer IV medication but had been authorised by the Trust to do so with a second checker in place, pending your Trust training. The panel accepted that not doing this training was outside of your control as there were limited places available and a long waiting list. The panel also accepted your evidence that other nurses were in a similar position and determined that this did not amount to a serious falling below the standards expected.

Having not found misconduct for charge 10b, the panel went on to consider if this would amount to a lack of competence. It decided that this did not represent an unacceptably low standard of performance and therefore did not find that this amounted to a lack of competence.

Lack of competence.

The NMC had presented the following charges as relating to a lack of competence as they arose out of a failure to complete a formal management plan:

- Arising at the Hammersmith Trust; 6a), 6b), 6d), 6e), 6f).

Having considered the detail within these charges, the panel noted that these relate to areas which have already been addressed within the body of the misconduct charges. Charge 6a) relates to oral medication management, 6b) relates to IV medication management and administration, 6d) relates to the delivery of basic nursing care, 6e) covers your general attitude to managers and work colleagues and 6f) relates to your ability to follow reasonable requests from shift leaders and managers.

The charges set out here (6a, 6b, 6d, 6e and 6f) relate to conduct and behaviours which the panel has already found, in relation to other charges set out above, to have

constituted misconduct. The panel considered therefore, that it would not be fair or logical to find that they also amounted to a lack of competence.

Conclusion on misconduct and lack of competence

The panel had regard to the terms of the Code, and it accepted all of the breaches put forward by Ms Nelson.

With the exception of charges 4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii) arising from the Hammersmith Trust, and 10b) arising from the Ealing Trust, there were no charges found proved which the panel considered individually or cumulatively did not amount to misconduct. It decided that they were all serious, to a lesser or greater degree, and all gave rise to a risk of harm to patients. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel went on to consider whether your actions demonstrated a lack of competence in relation to Hammersmith Charge 6 (which was alleged to demonstrate lack of competence alone) and Charges 4i) iv), 4i) v), 4i) vi), 4i) vii), 4i) viii) arising from the Hammersmith Trust, and 10b) arising from the Ealing Trust (which were alleged to amount to misconduct or lack of competence and which the panel has found did not amount to misconduct either individually or in conjunction with other charges). The panel has found that these charges, for the reasons given above, do not amount to a lack of competence.

Decision and reasons on impairment

Panel's decision on impairment in relation to misconduct

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

In coming to its decision, the panel had regard to the Fitness to Practise Library (DMA-1), 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

d) *…*

The panel finds that patients were put at risk and may have been caused physical or emotional harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

There are wide ranging and concerning issues in your case, which in the panel's view both individually and cumulatively constitute misconduct. Many of the concerns are underpinned by attitudinal issues, which are extremely difficult to remediate, if at all.

You have engaged fully with the regulatory process, which the panel acknowledges. The panel had regard to a number of general training certificates and reflective accounts provided by you, including some pertaining to building relationships, communication and dealing with feedback. The panel was not satisfied, however, that you have taken an objective view of your behaviour and nursing practice from a more 'global' viewpoint. You have not demonstrated any insight into the impact that your behaviour has had on your colleagues, patients, and their care. The panel noted that you continue to blame colleagues for many of the incidents rather than fully reflecting upon the nature and impact of your own conduct. The panel was not satisfied that you

have appreciated the impact of your actions on the wider reputation of the nursing profession. It determined that you have no real insight into the regulatory concerns and the risks to which patients have been exposed. The panel considered that your working outside your scope of practice, failure to work collaboratively with colleagues, failure to recognise the limitations of your own knowledge, together with your failure to respect the greater authority, expertise and experience of senior colleagues demonstrate deep-seated attitudinal issues which are extremely difficult to remediate.

In these circumstances, the panel concluded that there remains a risk of repetition of the conduct relating to the facts found proved. In view of the wide-ranging misconduct in your case, and the risk of repetition, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required to mark the seriousness of your misconduct.

[PRIVATE].

Submissions on application to adjourn

After the panel handed down its decision on misconduct and impairment, you made an application for the hearing to be adjourned.

You submitted that you wish to obtain legal advice in advance of making any submission in respect of any sanction. You said, however, that your legal advisor was on a cruise and would be unavailable for the whole of next week. You submitted that in

the circumstances, it would be fair and just to adjourn the hearing for the entirety of next week until your legal advisor is available.

You informed the panel that you not being able to obtain legal advice would impact the fairness of the proceedings. You said that this adjournment is needed to uphold the principle of justice.

Ms Nelson opposed your application. She informed the panel that the hearing has been ongoing since October 2022, a period of over 18 months. She submitted that there is a strong public interest in concluding expeditiously. The hearing is scheduled to run until Friday 17 May 2024, and should it continue as scheduled, then the case will conclude on time.

Ms Nelson highlighted that it is not unusual for registrants to be unrepresented. She accepted that there is a general right to legal advice. She also highlighted that throughout these proceedings you have not been represented, and, in view of this, it is your availability that the panel needs to concern itself with, and not that of your legal advisor. Ms Nelson reminded the panel that the dates of this hearing were agreed in advance and that the onus was on you to ensure that your legal representative was available. She submitted that it would have been open to you to alert the hearing at an earlier stage to the fact that you may have had difficulty sitting for the last week of the hearing, but you had not done so. Further, she said that you are subject to an interim suspension order which has had to be extended before by an application to the High Court. Were this hearing adjourned, a further application would have to be made to the High Court to extend the interim suspension order again which would result in additional expense to the NMC.

Ms Nelson submitted that it is right to say that fairness to you should be balanced with the need to protect the public and the public interest. Balancing these factors, she submitted that the hearing should be concluded without further delay because at this late stage, it is not reasonable to request an adjournment.

In response to questions by the panel, you stated that you did not anticipate that the hearing would take the course it has done and therefore did not seek advice on sanction from your legal advisor in preparation. You highlighted that you are currently subject to an interim suspension order and therefore cannot pose a risk to the public.

The panel accepted the advice of the legal assessor who set out that there is no absolute right to legal advice and referred to the following cases: R *(on the application of Fleurose) v* Securities & Futures *Authority Ltd & Anor* [2001] EWHC 292 Admin and *Pine v Solicitors' Disciplinary Tribunal* [2001] All ER (D) 359 (Oct).

Decision and reasons on application to adjourn

The panel took account of the submissions of both you and Ms Nelson, and it bore in mind the advice of the legal assessor. It also had regard to the NMC's guidance on postponing and adjourning hearings (CMT-11).

The panel bore in mind that the hearing has been ongoing since October 2022 and that the dates for this tranche were agreed many months in advance, in consultation with you. The dates were chosen in the full anticipation of concluding the hearing within the generous timeframe agreed.

The panel considered that, in full knowledge of the dates of the hearing and the hearing process, you should have sought any legal advice required and fully prepared your case in advance, including as far as possible the preparation for any potential sanction stage.

You have been referred to the NMC's guidance and information on sanction. The panel considered it to be your failure to recognise that you may have needed legal advice at any point during the 13 days that the hearing has been scheduled for throughout April – May 2024. Furthermore, the panel considered that, if you had wanted to change the dates of this section of the hearing then you could have given notice of the dates being unsuitable in advance of the hearing restarting. The panel considered that a lengthy adjournment would be unfair to the NMC and the registrants they serve, and it was not prepared to misuse NMC time and resources by agreeing to a lengthy adjournment. In

addition, the panel considered that it would not be in the public interest, or indeed in your own interest, to continue to delay the conclusion of this case, as it may take many months to reconvene the hearing.

The panel considered that it has been generous in acceding to your various requests for delays throughout this hearing and has always given you additional time to prepare any submissions you may wish to make as a result of you being unrepresented.

The panel decided that it would be unfair to the NMC to adjourn the hearing for a considerable length of time. It did however consider that it would be reasonable to allow you some time to prepare submissions on sanction and obtain legal advice from an alternative source if you wish.

You have been referred to the NMC's guidance and information on sanction (SAN-1 and SAN-3) and were informed of your right to make further submissions and give evidence at this stage.

In all the circumstances, the panel decided to adjourn and resume on Tuesday 14 May 2024 to hear submissions from you and Ms Nelson in respect of any sanction.

The hearing resumed on Tuesday 14 May 2024 with a further application to adjourn.

Upon resuming the hearing, the panel received a 39-page document from you. The first 22 paragraphs contained a fresh application to adjourn the hearing to allow you the opportunity to secure "legal representation". In response to questions from the panel, you clarified that this meant that you wanted to seek legal advice on how best to present your case to the panel yourself. You stated that proceeding without obtaining guidance from your legal advisor would constitute an injustice, a misapplication of the law, violate of your rights to a fair hearing, and infringe upon your human rights.

Your document also extended to provide your submissions on sanction which you said were provided in case the application to adjourn was not successful. You stated these were prepared ‘hastily within the constraints of limited time and under immense pressure and without legal support’. Alongside the application and submissions, you also provided evidence of continued professional development (CPD) and a CPD log.

The panel acknowledged that this application was essentially the same as the one you made a few days ago, but, this time, you provided the panel with detailed written submissions setting out why it was imperative that you were able to express your concerns. You highlighted that your professional expertise is in healthcare and that you are not a legal professional. You said that the legal procedure around sanction and other legal complexities are unfamiliar to you. You noted the panel had adjourned for four days, inclusive of a weekend. However, as you previously explained, your legal advisor is unavailable until 17 May 2024 and it had been unreasonable to expect you to find an alternative legal professional in the Philippines who could sufficiently familiarise themselves with your case and provide you with legal advice in this short time.

You submitted that the imposition of a sanction carries significant ramifications which extend beyond mere procedural consequences. You said that a sanction may tarnish an individual's professional reputation, potentially leading to difficulties in securing future employment opportunities. [PRIVATE].

You submitted that any inconvenience an adjournment may cause to the NMC pales in comparison to the unjust repercussions that proceeding without affording you time to obtain legal advice would have on you. You accepted that you were made aware of the hearing dates in advance, but you did not anticipate the case taking this course or reaching the sanction stage. As a result, you said that navigating this stage of the proceedings is a challenge for you, primarily because you are not able to access legal support to address the complexities of the process and advocate for your position. You said that you needed time to take legal advice to do this. [PRIVATE].

Without sufficient time and opportunity to prepare for the sanctions stage, and without having obtained legal advice from your advisor, you said that the scales of justice would

be tipped to your detriment. You set out that your ability to effectively participate in the hearing would be compromised, ultimately undermining the integrity of the adjudication process. Therefore, granting an adjournment was essential to uphold principles of fairness and equity.

Ms Nelson opposed this second application for the hearing to be adjourned until after 17 May 2024. She highlighted that you have not been formally represented throughout this hearing and that it was surprising that you expect the hearing to accommodate your absent legal advisor at this stage. She submitted that the availability of your legal advisor should have been taken into account before now.

Ms Nelson submitted that an unrepresented registrant is a common occurrence in regulatory proceedings. She said that it is not usual for lengthy periods of time to be afforded to registrants to prepare for the sanctions stage of the hearing. [PRIVATE].

Ms Nelson submitted that you have provided sufficient submissions on sanction to enable the professional panel to impose the most lenient sanction possible.

Decision and reasons on application to adjourn

The panel accepted the advice of the legal assessor who directed the panel specifically to Rules 32(4)(a) to 32(4)(c) and, again, had careful regard to the NMC's guidance on postponing and adjourning hearings (CMT-11). The legal assessor agreed with the advice previously given to the panel that there is no absolute right to be legally represented, but pointed out that this application was not an adjournment for representation, but an adjournment to take advice on how the registrant could best represent herself. It was not a re-hearing of the previous application, but a fresh application based on further evidence and submissions given to the panel.

The panel accepted that despite some confusion in the language used in your submissions, your request to adjourn was in relation to your need to seek legal advice prior to making submissions on sanction and was not in relation to you seeking legal representation at this stage of the hearing.
The panel considered each of the following Rules.

Rule 32(4)(a); considering the public interest in the expeditious disposal of the case

The misconduct in your case dates back as far as 2017. There is clearly a public interest in concluding this long-running case expeditiously. However, given the late stage in proceedings, and the fact that only the sanction stage of the hearing remains, the panel accepted that the public interest in the expeditious disposal of your case is now less that it would have been at the opening of the hearing. Nonetheless, the panel recognised that although it remains in the public interest that your hearing is concluded expeditiously, the public interest is not sufficiently high to reject the application for an adjournment on this ground.

Rule 32(4)(b); considering any potential inconvenience to a party to the hearing

The dates for this hearing were scheduled, agreed and communicated to all parties well in advance. The generous timeframe given was intentional, so as to be fair to you in accommodating your need for more time to prepare in between the stages of the hearing as you have not been legally represented. It was also to ensure that the matter concluded within the allocated time.

In view of the fact that the hearing has been ongoing for over 50 days, from October 2022 until now, the panel recognised that there would be some inconvenience to the NMC in relisting the conclusion of this hearing for a future date. However, this is purely administrative inconvenience. The panel determined that any inconvenience to the NMC is not sufficient to reject the application for an adjournment on this ground.

Rule 32(4)(c); fairness to you

The panel bore in mind that the focus in this Rule is to ensure that the principle of fairness is upheld in relation to you, and that you are afforded a fair hearing. It took account of your detailed written submissions as well as your supporting documentation and oral submissions.

The panel understood that although you are not formally represented at this hearing, you now wish to obtain legal advice so that you are fully informed and prepared for the sanction stage in proceedings. The panel also understood that your legal advisor is

away on holiday, is not contactable, and is not expected to return until after 17 May 2024.

The panel was disappointed that the non-availability of your legal advisor was not communicated at an earlier stage in this tranche of the hearing. You stated in response to questions from the panel that you had not contacted your legal advisor on Friday 10 May 2024 after you received the panel's decision in relation to misconduct and impairment very late the previous evening (due to the time difference between the UK and the Philippines). You explained that this was because it took you some time to process the outcome, as this was unexpected for you, and you needed time to decide on an appropriate course of action. The panel found this delay to be regrettable.

In your application you set out that you consider it to be unreasonable for the panel to expect you to prepare for the sanction stage in only a few days. However, the panel does not accept this. It is normal and a customary expectation for both represented and unrepresented registrants to be ready to present their case within the time scheduled for the hearing. Lengthy adjournments between stages of proceedings are not customary.

The panel noted that you say that you have faced obstacles in preparing your defence alone. You said that you had not sought advice from your legal advisor before reaching this stage as you had not anticipated being in this position. Whilst it is not necessary for you to present a 'defence', you are entitled to provide mitigation and evidence of training and professional development, in addition to making any submissions that you wish. Decisions at the sanction stage are based upon a panel's professional judgement, taking account of all the circumstances and a range of aggravating and mitigating features.

This is an unusual case in that your fitness to practise has been found to be impaired on the grounds of both misconduct and [PRIVATE]. This is a particularly difficult situation for an unrepresented registrant to face.

Even more unusually, your adjournment application and submissions on sanction were included in the same document, which enabled the panel to see what your submissions

on sanction would be, were your application for an adjournment refused. This puts the panel in a very different position from your initial application to adjourn on Friday. The panel has read these submissions and has seen the evidence you provided of continued professional development. However, the panel noted and was concerned that there were no submissions at all relating to one of the grounds on which the panel found your fitness to practise to be impaired, [PRIVATE]. Therefore, the panel could not agree with Ms Nelson's submission that you had provided sufficient information in respect of sanction to enable it as a professional panel to impose the most lenient sanction possible.

The panel determined that given the complexities of your case, and the difficulties that you have outlined in your submissions, there would be unfairness to you in not being able to seek legal advice in advance of presenting your case on sanction in respect of both grounds on which your fitness to practise has been found impaired. Whilst this further delay is highly regrettable, the fairness to you outweighs the inconvenience to other parties and the public interest in concluding the case expeditiously.

In the specific circumstances of your case the panel decided to grant your application for an adjournment. A further two days will be scheduled in the firm expectation that your case will conclude within that timeframe.

The panel reconvened on 2 September 2024 having received and read your additional written submissions in a document dated 27 August 2024.

Decision and reasons on proceeding in the absence of Miss Samson

Ms Nelson informed the panel that you were not in attendance on this occasion and referred to your email to the NMC dated 27 August 2024 which sets out the following:

> *"Attached herewith is my written representations for the upcoming hearing on Sanction.*
>
> *I would greatly appreciate if you can kindly forward this to the panel ahead of the hearing.*

Due to a schedule conflict, I may be unable to attend the upcoming hearing but I am happy for the panel to proceed in my absence taking into account my written submissions. Likewise, I am happy to receive the outcome via email."

The panel had sight of an additional email from you on 29 August 2024 in which you confirmed that you would not be attending the resuming hearing. In view of this correspondence, Ms Nelson invited the panel to proceed in your absence.

The panel accepted the advice of the legal assessor.

The panel had regard to Rule 21 and heard the submissions of Ms Nelson. It noted its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21.

The panel decided to proceed in your absence. It noted that you are aware that the hearing is due to resume today, that you have now provided two written submissions in respect of sanction and have confirmed that you are content for the hearing to proceed in your absence.

In these circumstances, the panel has decided that it is fair to proceed in your absence.

Submissions on sanction

Ms Nelson's submissions related to the consideration of both your misconduct and your [PRIVATE]. She asked the panel to consider the issue of misconduct first. [PRIVATE]. Ms Nelson submitted that there are wide ranging and numerous instances of misconduct, and therefore all sanctions are available for the panel to consider. She submitted that the misconduct in this case was so pervasive and serious as to make it fundamentally incompatible for you to remain on the register. She set out that there were numerous concerns, including concerns about your attitude, which would be difficult if not impossible to put right.

Ms Nelson submitted that the following aggravating factors were present your case:

- There are wide ranging instances of misconduct spanning a prolonged period of time
- The misconduct occurred at two different NHS Trusts
- The misconduct put patients at risk of serious harm on a number of occasions
- You repeatedly undermined the effectiveness of the team
- You demonstrated a failure to recognise and work within the limitations of your nursing practice.

In respect of mitigating factors, Ms Nelson highlighted that you had provided detailed written submissions at each stage of the hearing and had provided evidence of training. Further, you fully engaged during the NMC's investigation and, until now, have been in attendance throughout this hearing, and always maintained a professional manner. Ms Nelson also highlighted to the panel that there have been no previous regulatory findings against you, and that you had only been qualified for approximately 18 months when you started working at Hammersmith Hospital.

Ms Nelson submitted that the misconduct identified in your case was indicative of a deep-seated attitudinal issue which persisted throughout your employment and at two different hospital Trusts. She submitted that the most serious of all the aggravating features was your persistent lack of insight into your misconduct and clinical failings.

The panel took account of both of your written submissions on sanction.

In your first set of written submissions on sanction you addressed themes which included the need for a rehabilitative approach to sanction, not taking a punitive approach, encouraging a sense of accountability and learning from mistakes. You also addressed the need for the panel to be proportionate and take account of the context in which the mistakes occurred. You raised issues such as the fast paced and demanding healthcare environment in which you were working, high patient volumes, resource constraints, intricate interpersonal dynamics and evolving clinical protocols.

You urged the panel to consider your strong educational background and your commitment to ongoing professional development. You also referred the panel to various testimonials and certificates from courses that you have undertaken.

In your initial submissions on sanction, you stated that a caution order, complemented by a recommendation to partake in professional undertakings [sic], would be an appropriate sanction.

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

You argued that as a result of the above, no sanction would be the correct course of action in your case. [PRIVATE].

Decision and reasons on sanction

Having, at the second stage of this process, found your fitness to practise to be currently impaired, the panel considered what sanction, if any, it should impose in this case.

The panel accepted the advice of the legal assessor.

The panel bore 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 concurred with and adopted the approach suggested by the NMC that the findings of misconduct could, and should, be addressed first when considering the appropriate sanction in this whole case.

In respect of misconduct, the panel identified the following aggravating features:

- There are wide ranging instances of misconduct spanning a prolonged period of time
- The misconduct occurred at two different NHS Trusts
- The misconduct put patients at risk of serious harm on numerous occasions
- You have failed to demonstrate insight into your failings and have persistently failed to recognise the impact of your behaviour on patients, colleagues, and the wider reputation of the nursing profession.

The panel was unable to identify any mitigating factors. You cited examples of factors which the panel should take into account, including the fast-paced and demanding environment you were working in. However, the panel did not consider this to be an unusual environment for nurses to be working in. The panel also noted that you had received considerable support in terms of access to training, mentorship and on occasion a reduced caseload, at both Trusts.

The panel noted the extensive number of training courses that you have completed and the certificates and reflective accounts that you provided in your bundle. However, many of these courses were completed whilst you were having problems at work, and your behaviour did not improve despite the training. The courses that you undertook have not addressed the underlying attitudinal issue identified by the panel.

Although it is not a mitigating factor, the panel appreciated that you have fully engaged and participated in these regulatory proceedings, providing clear and detailed written

submissions at each stage. It noted your professional and thorough approach to proceedings.

As required by Article 29(3) of the Nursing and Midwifery Order 2001, the panel first considered (pursuant to Article 29(4)) whether to undertake mediation or to take no further action. It considered that neither of these outcomes would be appropriate as neither would restrict your practice. The public would therefore not be protected, and the public interest would not be satisfied. The panel then moved on to consider the four available sanctions set out in Article 29(5) of the Order.

The panel first considered the imposition of a caution order but determined that, due to the wide ranging, serious and persistent misconduct in this case, and the resulting public protection concerns, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel has found that your misconduct was not at the lower end of the spectrum. There are wide ranging instances of misconduct spanning a prolonged period of time and at two Trusts. Further, the misconduct put patients at risk of serious harm on a number of occasions. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the diverse nature of the charges found proved in this case. The wide-ranging misconduct identified, and the issues around your attitude and ability to work as an effective team member, are not issues which can simply be addressed through retraining. The panel has identified a persistent lack of insight from you into the misconduct and its wider impact on patients, colleagues and the public, which would undermine the effectiveness of any conditions imposed. The panel therefore concluded that the placing of conditions on your registration would not adequately address the misconduct in this case, nor would it protect the public.

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

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

This case involved over 70 instances of wide-ranging misconduct. There was evidence of a deep-seated attitudinal issue. Further, the panel was not satisfied that you had insight into your misconduct, and therefore there is a risk of repetition. Your repeated misconduct continued, despite support, training and mentorship, over a significant period of time at two Trusts. This illustrates a serious failure to prioritise people, preserve patient safety, and promote professionalism and trust. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, the panel considered whether a striking-off order was the appropriate order to impose, taking note of the following paragraphs of the SG:

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

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the large number of findings involving widespread misconduct,

affecting many patients and colleagues in two different Trusts and over a number of years, clearly demonstrate that your actions and behaviour were extremely serious. To allow you to continue practising would put patients and members of the public at risk, and would undermine public confidence in the profession and in the NMC as a regulatory body.

After taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. No lesser sanction would provide the level of public protection needed in this case.

You submitted that the panel should focus on rehabilitation rather than punishment. The panel appreciates that this striking-off order may appear punitive to you. However, the overriding objective of the panel is to protect the public. The panel has ensured that the principle of proportionality is at the forefront if its mind. In the circumstances of this case, the panel found that a striking-off order to be necessary for the protection of the public.

Having regard to the effect of your misconduct in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case. The panel considered that this order is necessary to mark the seriousness of your misconduct and to signal the importance of maintaining public confidence in the profession, sending a clear message to the public and the profession about the standards of behaviour required of a registered nurse.

[PRIVATE].

The panel directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that your name has been struck-off the register.

Decision and reasons on interim order

As the striking-off 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 has taken account of the submissions made by Ms Nelson and accepted the advice of the legal assessor. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the striking-off sanction takes effect.

The panel was satisfied that an interim order is necessary for the protection of the public. 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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.