Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 7 May 2024 – Friday, 17 May 2024
Wednesday, 26 March 2025 – Friday, 4 April 2025
Tuesday, 15 April 2025 – Wednesday, 16 April 2025

Virtual Hearing

Name of Registrant:	**Grace Okanlawon**
NMC PIN:	06H2890E
Part(s) of the register:	Nurses Part of the Register – Sub Part 1 RNMH: Mental Health Nurse, Level 1 (1 March 2007)
Relevant Location:	West Northamptonshire
Type of case:	Misconduct/Lack of Competence
Panel members:	Melissa D'Mello (Chair, Lay member) Alison Thomson (Registrant member) David Boyd (Lay member)
Legal Assessor:	John Caudle (7 May 2024 – 17 May 2024) John Bassett (26 March 2025 – 4 April 2025) Graeme Henderson (15 - 16 April 2025)
Hearings Coordinator:	Hamizah Sukiman (7 May 2024 – 17 May 2024 and 26 March 2025 – 4 April 2025) Samantha Aguilar (15 – 16 April 2025)
Nursing and Midwifery Council:	Represented by Uzma Khan, Case Presenter (7 May 2024 – 17 May 2024 and 26 March 2025 – 4 April 2025) Represented by Alastair Kennedy, Case Presenter (15 - 16 April 2025)
Mrs Okanlawon:	Present and represented by Julia Flanagan, instructed by Royal College of Nursing (RCN)
Facts proved by admission:	Charge 7a

Facts proved:	Charges 1, 2 (in relation to 25/26 September 2022 only), 3a, 3b, 3c, 3d, 3e, 4b, 4c (in relation to medication only), 5a)i), 5a)ii), 5a)iii), 5b)i), 6 (in relation to 5 October 2022), 7b)i), 7b)ii), 7b)iii), 8a, 8b, 8c, 9, 10 and 11
Facts not proved:	Charges 2 (in relation to 6 September 2022 only), 4a, 5b)ii) and 8d
Fitness to practise:	**Impaired (by reason of misconduct only)**
Sanction:	**Conditions of practice order with review (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

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

At the outset of the hearing, Ms Khan, on behalf of the Nursing and Midwifery Council ('NMC'), made a request that this case be held partially in private on the basis that, [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended ('the Rules').

Ms Flanagan, on your behalf, indicated that she has no submissions to make in relation to this application.

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

The panel determined to go into private session as and when references to [PRIVATE] in order to protect the privacy [PRIVATE].

Details of charge (as amended)

That you, a registered nurse:

1) Between 6 September 2022 and 3 October 2022 on one or more occasion failed to check and/or record Patient H's blood glucose/sugar.

2) On 6 September 2022 and/or 25 September 2022 and/or 26 September 2022 failed to document handover notes in respect of one or more patient/s on the electronic system.

3) On 31 August 2022 in respect of Patient A:
    a) Failed to carry out a second check of their blood pressure.
    b) Failed to monitor their blood pressure.
    c) Failed to escalate their high blood pressure to a General Practitioner.
    d) Failed to handover their high blood pressure reading.

e) Failed to record any comment/rationale for the high reading.

4) On 13 September 2022 in respect of Patient B:
   a) Failed to record their details on the electronic care plan system.
   b) Failed to record their medication on the electronic care plan system.
   c) Did not raise with your clinical lead/colleague that you were unable to record details and/or medication on the electronic care plan system.

5) On 21 September 2022:
   a) in respect of Patient C;
      i) Turned off the PEG feed pump/machine.
      ii) Did not change the feeding tube.
      iii) Failed to escalate their feed had occluded.

   b) In respect of Patient D;
      i) Did not close the wound review on the system.
      ii) Did not update their treatment plan to say the wound had healed.

6) Between 4 October 2022 and 5 October 2022 on one or more occasion failed to check and/or record Patient E's blood glucose/sugar.

7) On 28 September 2022:
   a) In respect of Patient C stopped their feeding tube early/disconnected their feeding tube before the feed was finished.
   b) In respect of Patient E;
      i) Did not follow up when they refused to have their wound checked.
      ii) Failed to record that they required their wound to be checked.
      iii) Failed to handover that they had refused to have their wound checked.

8) On or about 2 October 2022 in respect of Patient F;
   a) Were unable to take their blood pressure.
   b) Did not attempt to use the manual blood pressure machine.
   c) Contacted 111 unnecessarily without attempting to use the manual machine.

d) Failed to document your discussions with 111.

9) On 5 October 2022 in respect of Patient G failed to record on their MAR chart that their medication, Gabapentin and/or Diazepam, had been administered.

10) On an unknown date wrongly identified a Covid test as negative.

11) On an unknown date did not carry out the Covid testing procedure correctly.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Khan to amend the wording of charges 5b)ii), 8c), and 11. The proposed amendment was to correct the grammatical and typographical errors found in those charges.

Ms Khan submitted that the proposed amendment would provide clarity. She further submitted that, as these proposed amendments are not substantive in nature, these amendments are not prejudicial to you.

The proposed amendments are as follows:

"That you, a registered nurse:

5) On 21 September 2022:
   a) …
      i) ...
      ii) …
      iii) …
   b) In respect of Patient D;
      i) …
      ii) Did not update their treatment plan to say **the** wound had healed.

6) …
7) …
   a) ...
   b) …
      i) …
      ii) …
      iii) …
8) On 2 October 2022 in respect of Patient F;
   a) …
   b) ...
   c) ~~Contact~~ **Contacted** 111 unnecessarily without attempting to use the manual machine.
   d) …
9) …
10) …
11) On an unknown date did not carry out **the** Covid testing procedure correctly.

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

Ms Flanagan submitted that she agreed with the NMC position with regard to these amendments and stated she did not object to the submissions.

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 these amendments, as applied for, seek to correct grammatical and typographical errors. The panel was satisfied that, as these amendments are not substantive in nature, no prejudice or injustice would be caused to either party by the proposed amendments being allowed. The panel took into account that both parties agreed with the proposed amendments. It was therefore appropriate to allow the amendments, as applied for, to ensure the clarity and accuracy of these charges.

Decision and reasons on application to allow Ms Flanagan to take instructions on the matter of adjourning the hearing to allow the NMC to obtain additional documentation

On the seventh day of proceedings, whilst you were giving evidence, the panel considered that it might be beneficial to its decision-making process to obtain further documents from the NMC. Ms Khan made submissions on this matter, which are detailed in the following section of this determination.

Ms Flanagan, in response to Ms Khan's submission on asking for time for the NMC to obtain further documentation, requested that the panel permit her to speak to you at this stage to take instructions on this discrete point only, and on her undertaking that she would not discuss your evidence with you. She submitted that, as the panel considers this set of documents relevant to their decision-making process, and as you have been taken by surprise by this application, she should be given the opportunity to explain to you the relevance of these documents. She stated that you may have instructions to give to her in relation to the application on obtaining further documentation, and she submitted that you should be entitled to give those instructions to your legal representative now, as this matter has arisen unexpectedly.

Ms Flanagan informed the panel that no parties object to her being allowed to speak to you in relation to this discrete point. Ms Khan confirmed that the NMC does not object to this application.

The panel heard and accepted the advice of the legal assessor, who reminded the panel that the norm, whilst a party is giving evidence, is that they do not speak to their legal representative unless leave to do so is granted by the panel. He further reminded the panel to consider that this leave can be granted in exceptional circumstances, and the panel should consider whether it would be fair and just to allow Ms Flanagan to speak to you with the sole purpose of taking instruction on this specific point.

The panel considered submissions from both Ms Flanagan and Ms Khan. It noted that the application is not objected to, and the matter has arisen unexpectedly. The panel concluded that it would be fair to all parties, and it would be in the interests of justice, to allow Ms Flanagan to speak to you on this discrete point.

Decision and reasons on consideration of adjourning proceedings on Day 7 due to [PRIVATE]

Within her submissions on the NMC's application to adjourn proceedings whilst the NMC makes inquiries on obtaining further documentation, Ms Flanagan informed the panel that [PRIVATE], and [PRIVATE]. You confirmed this to the panel, and you also told the panel [PRIVATE].

The panel heard your remarks as well as Ms Flanagan's submissions and invited both Ms Khan and Ms Flanagan to make submissions in relation to the fairness of continuing with the proceedings today in light of [PRIVATE] you have expressed to the panel.

Ms Khan indicated to the panel that she is content for Ms Flanagan to take instructions from you in respect of this application only. The panel heard and accepted the advice of the legal assessor, and it determined that it was content for Ms Flanagan to take instructions in relation to this application on the same basis as before.

Ms Khan informed the panel that the NMC remains neutral on this application, and she does not wish to make any submissions, as this is a matter for the panel to consider.

Ms Flanagan submitted that you indicated that you would like to proceed. [PRIVATE]

In response to panel questions regarding [PRIVATE].

[PRIVATE].

The panel heard and accepted the legal advice. He drew the panel's attention to Rule 32 of the Rules, and he reminded the panel of the lack of an application from you to adjourn, and that this matter was raised of the panel's own volition.

The panel considered submissions from both Ms Khan and Ms Flanagan, as well as remarks you have made to the panel. The panel raised this concern following your response to cross-examination, as well as the information it received from Ms Flanagan [PRIVATE]. Notwithstanding the panel's concern, [PRIVATE]. The panel determined that, to continue the proceedings today, would cause no injustice to you or to the NMC. The panel concluded it would be in the public interest to continue with the hearing at this stage.

In all the circumstances, and in particular your indication that you wish to continue with the hearing, the panel was satisfied that it would be fair to all parties not to adjourn, but to continue with the hearing.

Decision and reasons on application to adjourn proceedings whilst the NMC makes inquiries on obtaining further documentation

As detailed above, the panel identified a collection of documents which it felt might be of assistance in its decision-making process with regard to some charges. The panel invited both Ms Khan and Ms Flanagan to make submissions regarding obtaining the documents.

Ms Khan submitted that, in light of the identification of these additional documents, it would be appropriate to adjourn for a short period to enable her to make inquiries on whether the documents can be retrieved and placed before the panel. She submitted that the dispute pertaining to the dates on which you were working at the Home did not emerge until you began giving evidence under oath at this hearing. Ms Khan submitted that the NMC was satisfied that there is sufficient evidence within the existing bundles that you were working on the dates in question.

Ms Khan acknowledged that you clearly dispute the authenticity and accuracy of the documents within the existing bundle. Accordingly, she submitted that it would not be fair to continue your cross examination without any supporting evidence indicating that the existing documents are true and accurate as otherwise there might be a danger that she is conducting her cross examination on a false and misleading basis. In the event that this documentation can be obtained, Ms Khan submitted that it is only fair that all parties, including yourself and Ms Flanagan, have the opportunity to review it. Ms Khan also submitted that it would be unfair to you, as the current line of questioning may invite you to incriminate yourself or admit, deny or provide an inaccurate account based on your beliefs or understanding of the current documentation.

Ms Khan asked the panel for an opportunity to speak to the NMC to establish whether these documents can be retrieved and placed before the panel to consider, in the interest of fairness for all the parties involved.

When asked by the panel, Ms Khan outlined that the documents referred to are as follows:

- MAR Charts for Patient H on the dates as outlined in Charge 1;
- MAR Charts in relation to any dates as outlined in Charge 2;
- Rotas for dates as outlined in all the charges;
- Documentation indicating your attendance at the Home between 16 August and 6 October 2022, such as ‘clocking in and clocking out’ records;
- Any documentation indicating the hours you were working in the Home;
- Care Plans for Patients H & E in relation to the care provided, specifically in relation to blood sugar levels; and
- The Home’s policy, at the time of the incidents, in relation to what should be done if blood sugar levels fall below 5 or above 15.

Ms Flanagan submitted that she agreed with Ms Khan only in so far as, if there is the possibility of further relevant documents being obtained and these documents are to

be relied upon, it is fundamental that both you and your legal representative have sight of those documents before you continue giving evidence.

She submitted that, in any event, it remains for the NMC to prove its case on the balance of probabilities.

Accordingly, she further submitted that, if these documents are to be produced and relied upon by the NMC, no further questions should be posed to you until you and your representative have had the opportunity to have sight of the documents, in fairness to you.

Notwithstanding the above, Ms Flanagan invited the panel to reconsider its decision on requesting additional documents, as this would cause inevitable delay to your evidence. She submitted that you have been waiting for the proceedings to commence, and you are currently in the middle of giving evidence under oath. She further submitted that these documents could, and should, have been obtained before the hearing, and it is not your responsibility to inform the NMC of weaknesses in their case. She reminded the panel that the burden of proof remains with the NMC. She submitted that any delay now in obtaining these additional documents is a failure on the NMC's part to obtain these documents in the first place.

Ms Flanagan submitted that [PRIVATE]. For these reasons, Ms Flanagan submitted that a further delay by days – or months in the worst-case scenario – would be against your interest.

Ms Flanagan further submitted that not only is it in your interest to proceed with the remainder of your evidence to make swift progress and complete the facts stage within the allocated hearing timeframe, but it is also in the public interest to have the expeditious disposal of this part of the case. She reminded the panel that evidence should be concluded when matters are as fresh in witnesses' minds as possible.

Ms Flanagan invited the panel to proceed with the documents currently available, as seeking to obtain these further documents would cause significant delay.

In response to a panel question regarding the Case Management Form ('CMF'), Ms Flanagan informed the panel that there has been no CMF submitted on your behalf, and there is no CMF which can be presented before the panel. Ms Khan informed the panel that the CMF was sent out to you, but no response was received.

The panel was told that, only at this hearing, was the NMC made aware that you do not accept that you were in the Home at the relevant dates, and you do not accept the validity of the existing documents.

In response to a panel question regarding whether you were aware this matter may go part-heard, and that the current proposed resuming dates are in March 2025, Ms Flanagan informed the panel that your understanding is that facts, in terms of giving evidence, would be concluded within this time frame, but the fact-finding stage would not conclude until March 2025.

The panel heard and accepted the advice of the legal assessor, who reminded it that justice must not only be done but be seen to be done. He further reminded the panel to consider fairness to all parties.

In reaching its decision, the panel considered submissions from both Ms Khan as well as Ms Flanagan. The panel acknowledged that this situation had arisen from the panel being of the view that the documents requested would assist them in their decision-making process. The panel considered, in light of the evidence you have given regarding not working at the Home on specific dates, as well as the doubt you have raised over the accuracy of the existing documents, that obtaining these additional documents would be of assistance to it in determining facts.

The panel was reassured that all reasonable steps would be taken to secure these additional documents in a timely manner, if they are procurable.

With regard to whether to adjourn the matter to allow the NMC time to obtain these documents, the panel decided to allow the NMC appropriate time to ascertain whether these documents are procurable, and if relevant, to obtain them. The panel determined that it does not wish to place Ms Khan in a position where she is

potentially misleading you and the panel with her cross-examination. The panel accepted that the NMC was not aware, prior to you giving evidence, that you were disputing the relevant dates on which you were working at the Home, or that you are suggesting the documents were false for the purposes of this hearing. Accordingly, the panel determined that it would be in the interest of justice for the proceedings to be adjourned to allow Ms Khan to make these initial inquiries.

Decision and reasons on allowing Ms Flanagan to take instructions on the additional documentation and proposed resuming dates

On the eighth day of proceedings, Ms Khan updated the panel on the status of her enquiry regarding the further documentation requested by the panel. She told the panel that Witness 1, at 07:44 this morning, had emailed the NMC that he is able to obtain the documents by the end of the working day. Ms Khan confirmed that, by mid-afternoon, the NMC sent him an email to follow up on this matter, and Witness 1 confirmed that he had sent the documents at approximately 12:00, and he resent the documents at approximately 15:21. She informed the panel that the NMC has still not received this email, and that there may be an issue with the size of the files. However, Ms Khan confirmed that the NMC is aware and is currently attempting to resolve it. She also confirmed that this matter is being expedited, and that the Case Coordinator and Reviewing Lawyer are aware of the urgency of the request, and that both will prioritise the anonymisation and redaction of these documents as appropriate. Ms Khan also assured the panel that she would send the unredacted documents to both Ms Flanagan and the Legal Assessor as soon as possible.

The panel invited both Ms Khan and Ms Flanagan to make submissions regarding Ms Flanagan taking further instructions from you when these documents are obtained, as well as Ms Flanagan speaking to you regarding the proposed resuming dates.

Ms Khan informed the panel that she has discussed the matter with Ms Flanagan, and she confirmed that she has no objection to Ms Flanagan taking instructions on the new documents in the interest of fairness to all parties.

Ms Flanagan agreed with Ms Khan.

The panel heard and accepted the legal assessor's advice.

The panel considered submissions from both Ms Flanagan and Ms Khan. It noted that the request is not objected to. The panel determined it would be fair, in these circumstances, to allow Ms Flanagan to take instructions on this discrete point when the documents arrive. The panel further determined that Ms Flanagan should be permitted to speak to you regarding the proposed resuming dates in March 2025 today on the same basis.

The panel also noted that, on the sixth day of the hearing, you informed the panel that you have a [PRIVATE] on Friday, 17 May 2024. You told the panel that you thought that the hearing was scheduled to conclude by Thursday.

On the seventh day of proceedings, the panel informed you that it is entirely your choice as to whether [PRIVATE] it to attend this hearing.

As part of its decision to allow Ms Flanagan to speak to you regarding the matters above, the panel determined to allow her to speak to you on whether you have decided [PRIVATE]. Subsequently, the panel was informed that you have chosen to cancel it.

Admissibility of the additional documentation

On the last scheduled day of the May 2024 proceedings, Ms Khan updated the panel on the status of the additional documentation requested. She told the panel that she was in receipt of an unredacted and anonymised version of the documents following the conclusion of the hearing on Thursday, 16 May 2024. She informed the panel that she received the redacted and anonymised version soon after, but she was unable to access the documents and had informed the coordinator responsible. However, the coordinator had left work, and Ms Khan told the panel that the matter

was resolved the following morning. She subsequently shared the documents with Ms Flanagan and the legal assessor as soon as she could.

Ms Khan submitted that there are no admissibility issues with the additional documentation, and further redactions would not be necessary. She submitted that she has no application to make in association with this document.

Ms Flanagan submitted that she accepted that the relevance was considered by the panel, as it was not the NMC who sought the additional documents. She further submitted that she could not argue that the additional documents are not relevant nor do the materials require further redactions.

She informed the panel that she has not received instructions from you regarding the additional documents, so these submissions are made without specific instructions and that she will take instructions from you when you are in a position to give them.

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

The panel noted that no objections were taken on admissibility. Therefore, the additional documents will be sent to the panel in advance of this hearing resuming.

Decision and reasons on the application to adjourn the hearing until March 2025

Ms Flanagan informed the panel that she was granted access to the document at approximately 11:00 today, and she took approximately 30 minutes to read and discuss them with Ms Khan and her instructing solicitors. She told the panel that, at approximately 14:00, she contacted both Ms Khan and the legal assessor to update parties on her progress.

Ms Flanagan informed the panel that there would be no opportunity to reopen examination-in-chief today, given the lateness of the time. She submitted that it would be unfair to proceed today, as you have not been able to access the additional documentation, nor have you been [PRIVATE] to give instructions to her. Ms

Flanagan further submitted that she would need further time to cross-reference the additional documents to existing documents and take further instructions as necessary. She invited the panel to adjourn matters at this stage.

Ms Khan did not oppose the application and submitted that you are entitled to review these documents, and Ms Flanagan should have the time to cross-reference as necessary. Ms Khan confirmed that the documents were sent to you by the Case Coordinator at 10:50.

On releasing you from your oath until the matter resumes, Ms Khan submitted that it is the sensible solution in light of the time period between now and March 2025. Ms Flanagan submitted that she agreed and releasing you from your oath would give her the opportunity to take instructions when you have received a hard copy of the additional documentation.

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

The panel accepted that, in light of the lateness of the day, the matter is going part-heard in any event. Therefore, the matter of adjournment does not arise in these circumstances.

The parties have agreed that a further eight working days would be appropriate to conclude this matter. It was informed by the Hearings Coordinator that the tentative resuming dates, which have been sent to the NMC, are:

- Wednesday, 26 March 2025 to Friday, 28 March 2025; and
- Monday, 31 March 2025 to Friday, 4 April 2025.

The panel proposes that a further two working days are listed, in order to ensure that this hearing does not go part-heard for a second time. The panel directs that the NMC seeks and lists promptly further dates following the close of the hearing.

Decision and reasons on allowing Ms Flanagan to reopen examination-in-chief

Ms Flanagan submitted that she wishes to make an application to reopen examination-in-chief when we return to your evidence under oath, notwithstanding that she has been unable to receive specific instructions from you regarding the additional documentation at this time.

Ms Khan did not object to the application, and indicated that in the circumstances, it would be fair to all parties to permit Ms Flanagan to do so.

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

The panel determined that, in light of the additional documentation arriving whilst you are giving evidence, it would be appropriate for Ms Flanagan to reopen examination-in-chief, subject to your instructions to her, as neither you nor Ms Flanagan has the documents before. The panel has given leave to Ms Flanagan to take instructions from you in relation to these additional documents. The panel determined that it would be inappropriate for you to be cross-examined without hearing your evidence-in-chief on these documents first.

Decision and reasons on an interim order

The panel heard from Ms Khan that an interim order is currently in place and has been extended by the High Court until 20 August 2024. She informed the panel that there would be no application made for an interim order today.

Ms Flanagan confirmed that she has no submissions in relation to this matter.

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

The panel was informed than an interim order has been extended by the High Court until August 2024 and determined that it did not need to consider matters concerning an interim order today.

Decision and reasons to amend the stem of Charge 8

Following the conclusion of your evidence under oath, the panel, of its own volition, considered amending the wording of the stem in Charge 8. The panel heard from the legal assessor, pursuant to Rule 28(1), that it may amend any charge prior to its decision on facts.

The panel took into account that you accept that there was one occasion on which you contacted 111 because you were unable to take Patient F's readings, albeit you deny this charge and its sub-charges. The panel noted that, at this stage, it is not making any findings of fact.

The panel also noted the documentary evidence before it – namely Patient F's observation record and the nurses' rota at the Home in September/October 2022 (indicating that you may have been working a night shift on 1 October 2022) – and it considered that all the evidence before it reflected that this alleged incident may have occurred on or about 2 October 2022.

Thus, the panel considered the following proposed amendment:

"That you, a registered nurse:

8) On **or about** 2 October 2022 in respect of Patient F;
   a) …
   b) ...
   c) …
   d) …

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

The panel took into account that any potential amendment to the date in the stem of Charge 8 would not impact your account or the NMC's case of the disputed matters within sub-charges a) to d).

The panel invited submissions from both Ms Khan and Ms Flanagan on its observations.

Ms Khan submitted that the proposed amendment would more accurately reflect the evidence before the panel. She further submitted that the proposed amendment is not substantive in nature, and that there is a certain degree of acceptance on your part that this 111-incident occurred, albeit you dispute the details of the incident. She submitted that the NMC does not object to the proposed amendment.

Having taken instructions from you, Ms Flanagan submitted that she did not object to the proposed amendment.

The panel accepted the advice of the legal assessor in relation to its powers within Rule 28(1) of the Rules.

The panel was of the view that the identified amendment seeks to more accurately reflect the evidence before it. The panel was satisfied that, as this amendment is not substantive in nature, no prejudice or injustice would be caused to either party by the proposed amendment being made. The panel also considered that both parties agreed with the proposed amendment. It was therefore appropriate to make the amendment to ensure the evidence before it is reflected in the charge.

Decision and reasons to amend the charges

Prior to its deliberations on facts, the panel, of its own volition, considered further amending the wording of the charges upon the legal assessor's observations. The panel heard from the legal assessor, pursuant to Rule 28(1), that it may amend any charge prior to its decision on facts.

The panel heard from the legal assessor that the charges as presently drafted allege that, by virtue of the facts set out in the charges, your fitness to practise is impaired by your misconduct. The panel heard that, if it was to find any of the charges proved, when it moves on to consider your fitness to practise in the next stage of these proceedings, it may consider that some of the charges amount to lack of competence, rather than misconduct. The legal assessor advised the panel that, as you are not on notice that you are facing lack of competence charges, were the panel to determine that the charge admitted by you and any other charges found proved did not amount to misconduct, this would be the end of the matter at that stage, and the panel could not move on to consider sanction for these charges. The panel heard that this may not properly serve the public interest.

The panel, at this stage, has not made its decision on this matter or on any of the charges. However, it considered amending the charges to reflect this possibility and not restrict the panel in its decision-making in due course.

Thus, the panel considered the following proposed amendment:

"That you, a registered nurse:

1) …
2) …
3) …
    a) …
    b) …
    c) …
    d) …
    e) …
4) …
    a) …
    b) …
    c) …
5) …
    a) …

i) …
ii) …
iii) …

b) …
i) …
ii) …

6) …
7) …
a) …
b) …
i) …
ii) …
iii) …

8) …
a) …
b) …
c) …
d) …

9) …
10) …
11) …

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

The panel invited submissions from both Ms Khan and Ms Flanagan on this matter.

Ms Khan reminded the panel of its powers to amend the charges at any point prior to its decision on facts, pursuant to Rule 28(1), provided the amendment can be made without causing injustice to any party. She submitted that late-stage amendments to charges may be permitted where they do not fundamentally change the nature of the allegations or cause undue prejudice to the registrant in the proceedings.

Ms Khan submitted that the proposed amendment better reflects the evidence before this panel and ensures that the charges encapsulate your alleged conduct. She further submitted that the proposed amendment does not introduce new allegations, and that it particularises the existing allegations against the evidence before the panel. She submitted that you and your representative have both had the opportunity to hear and respond to the evidence. She further submitted that it would not be prejudicial to you if this proposed amendment was made, as it would be foreseeable for you that these allegations do concern your lack of competence, based on the evidence throughout these proceedings. Consequently, Ms Khan submitted that there is no disadvantage or material unfairness to you if the amendment was allowed.

Ms Khan reminded the panel of its overarching objective to protect the public, maintain professional standards and uphold the public confidence in the nursing profession. She submitted that ensuring the charges accurately reflect the evidence is essential to fulfilling this duty. Accordingly, she invited the panel to accept the proposed amendment.

Having taken instructions from you, Ms Flanagan submitted that she resisted the proposed amendment made at this late stage. She submitted that you have been dealing with this matter for a number of years, and your approach to these proceedings – and the NMC's case throughout – has been on the basis that you were facing charges which amounted to misconduct. She submitted that this is not something you could have foreseen.

Ms Flanagan submitted that she has addressed her questions to witnesses and you have given evidence with the perception that you are dealing with charges of misconduct. She submitted that all of the NMC's witnesses were questioned on this basis. She further submitted that, whilst none of the factual matters change, the approach to the witnesses would have, had you known you were also facing lack of competence charges. Ms Flanagan submitted that, for example, questions would have been asked regarding your training or your colleagues' work practices, to help demonstrate that you were no less competent than other nurses. She further submitted that, from the small sample of papers before this panel, there appears to

be issues more broadly with the [PRIVATE] Nursing Home, which would have been explored had these charges been lack of competence charges.

Ms Flanagan submitted that the prejudice to you cannot be remedied, given the considerable amount of time which has been spent on the analysis of the evidence and that written submissions have been submitted for the panel's consideration. She further submitted that any amendment at this stage could not be made without causing injustice to you.

The panel accepted the advice of the legal assessor in relation to its powers within Rule 28(1) of the Rules.

In reaching its decision, the panel considered the submissions from both Ms Khan and Ms Flanagan. It reminded itself that it was not making any findings of fact at this stage.

The panel considered that all of the NMC witnesses have been questioned by Ms Flanagan on the basis that you were facing misconduct charges. The panel also considered that you have been preparing for these proceedings over a number of years, and it recognised that your approach to the allegations may have been different had it included an allegation of lack of competence. The panel acknowledged that some injustice may be caused to you if the proposed amendment was allowed, given the lateness of the proposed amendment in the proceedings.

However, the panel recognised its statutory duty to protect the public and maintain public confidence in the profession. The panel considered that if it was to find any of the charges proved and that in its consideration at the impairment stage that they may amount to a lack of competence rather than misconduct, it may fail its duty to protect the public and not be in the public interest. The panel reminded itself that it has not made any decision on facts at this stage, but it recognised the possibility of these circumstances emerging in later stages of these proceedings.

Taking all of the above into account, the panel was of the view that the identified amendment may reflect the evidence before it. The panel recognised that some

prejudice to you may be caused by the proposed amendment being made, but it determined that this was outweighed by the need to protect the public and maintain public confidence in the profession. The panel was mindful that any such prejudice may be mitigated as either party may choose to call further evidence at later stages in these proceedings.

The panel concluded that it was therefore appropriate to make the amendment, given it potentially more accurately reflects the evidence before it, and to not restrict the panel in its overarching duty to protect the public and uphold the public interest.

Background

You have been a registered nurse since 2007. These charges arose whilst you were employed as a registered nurse at [PRIVATE] Nursing Home ('the Home'). You started working in the Home on 16 August 2022. The regulatory concerns arose between August to October 2022, during your probation period, and broadly concern your clinical practice and documentation.

On 27 October 2022, the NMC received a referral from Witness 1, the Deputy Manager at the Home. It is alleged that the Home raised a safeguarding referral on 12 October 2022 as a result of your medication error, namely you had failed to sign for medication that you administered, which allegedly resulted in the medication being administered twice.

It is further alleged that there were concerns with your medication management. It is alleged to you failed to document a new patient's medication onto the electronic system, which allegedly resulted in the patient not being administered their evening medication that day. The Home also alleged that you have failed to adequately record your documentation on the electronic system, and this allegedly led to handover notes not being completed.

The Home also raised concerns in relation to your management of percutaneous endoscopic gastrostomy ('PEG') feeds, namely that you allegedly discontinued a

PEG feed before it had completed, and you failed to raise that a PEG feed had occluded.

It is further alleged that, with regard to your clinical practice, you failed to check and record patients' blood glucose/sugar, that you were unable to take a patient's blood pressure, that you did not follow up with patients' wound care and that you inaccurately identified a patient's COVID-19 test result as negative when it was positive and that you did not carry out the COVID-19 testing procedure correctly.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Flanagan, on your behalf, who informed the panel that you have made full admissions to charge 7a).

The panel therefore finds charge 7a) proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by both Ms Khan and Ms Flanagan.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Deputy Manager of the Home
- Witness 2: Clinical Lead at the Home (at the time of the incident)

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

In the course of your evidence and in the submissions made on your behalf by Ms Flanagan, reference was made to the alleged failings of other nurses and staff at the Home. In reaching its findings on facts, the panel has reminded itself that it is concerned only with your alleged conduct at the relevant times.

The panel also had regard to the fact that the witnesses who gave oral evidence were relating matters that occurred between approximately 18 months and 2.5 years ago. In these circumstances, it made appropriate allowance for the possibility that memories had faded over time.

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

Charge 1

"That you, a registered nurse:

1) Between 6 September 2022 and 3 October 2022 on one or more occasion failed to check and/or record Patient H's blood glucose/sugar."

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement, which stated:

"Grace had failed to document that Patient H … bowel movements were documented … This ties in with the shift handover notes not being

documented as if she wasn't able to get onto the electronic system then she wouldn't have been able to record these observations. The potential risk with this is that bowl [sic] *monitoring documentation is really important as we need to have a record to identify and clinical changes. Grave* [sic] *said that this was down to the system not working. I asked her to show me how she was trying to log onto the system and she just kept using the wrong password."*

The panel also had sight of Witness 1's supplementary witness statement:

"Moreover, and with regard to my original statement, I remarked that Patient Pnt. H … bowel movements were not documented … To clarify, this should have been in relation to blood glucose monitoring, not bowel movements. Pnt. H was having QDS recordings before meals and bed …, when their blood sugars were outside of normal ranges."

The panel noted Witness 1's evidence that he was not referring to bowel movements, but instead Patient H's blood sugar. The panel determined that, taking both statements together, Witness 1's evidence related to this charge.

The panel considered Patient H's care plan, which was dated 10 August 2022, following an assessment from a diabetic nurse on 9 August 2022. The plan detailed:

"Nurses are required to monitor his blood sugars 5 times per day – prior to each meal and prior to bedtime.

…

Pnt H can experience the following:
Hypoglycaemia - blood sugar less than 4mmols/l. Pnt H may present as unwell, symptoms including fatigue, heart palpitations, irritability, sweating, shaking and anxiety.
If there are identified changes in Pnt H conscious levels Nurses are to record a full set of observations every 15 minutes and call 999.

…

Hyperglycaemia- blood sugar above 15mmols/l
Pnt H may present with increased thirst, increased micturition, tiredness, blurred vision, nausea.
If there are identified changes in Pnt H conscious levels Nurses are to record a full set of observations every 15 minutes and call 999."

The panel acknowledged that Patient H's care plan is dated 10 August 2022, which is outwith the dates in this charge. However, the panel considered that the following care plan for Patient H was dated 3 October 2022, following the dates in this charge. Accordingly, the panel was satisfied that, at the relevant time, this care plan was in place for Patient H.

The panel was satisfied, based on the care plan, that Patient H's blood sugar had to be monitored and recorded five times a day, and that, if the reading was below 4mmols/l or higher than 15 mmols/l, a set of observations had to be conducted every 15 minutes and, where relevant, 999 had to be called. The panel was further satisfied that, if you were the nurse responsible for Patient H's care on any given shift, these duties as outlined in Patient H's care plan were your responsibility.

The panel next considered whether you, on one or more occasion between 6 September 2022 and 3 October 2022, did fail to check and/or record Patient H's blood sugar levels. The panel's approach was to consider a significant sample of the dates, chronologically, that you were allegedly working according to the rota/roster. The panel was aware, however, that there were other shifts within this relevant time period when you worked.

The panel made the findings below.

<u>6 September 2022</u>

The panel had sight of the "*Nurses – August/September 2022*" rota. On this rota on Tuesday, 6 September 2022, you appear to have worked an "*EL*" shift. The panel

heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that another nurse, Ms 1, was working the early shift that day, and Ms 2, an agency nurse, was working an EL shift alongside you.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "06/09/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

Furthermore, the panel also considered Patient C's MAR chart, particularly on 6 September 2022. The panel accepted that Patient C is not the relevant patient on this charge. However, the panel took into account that, within the MAR Chart, the initials "*GO*" appear on the administration of Citalopram at 09:20 on 6 September 2022. The same initials appeared on Patient T's MAR chart at 09:23 on 6 September 2022. The panel accepted that the '*Users*' key indicated '*GO: Grace'*.

The panel took into account that you deny working the shift on 6 September 2022, and that you challenge the reliability of the rota and roster documentation. The panel also noted that you have brought it to its attention that the documentation was not made available at the start of these proceedings, and that it could have been altered.

However, taking all the information before it, the panel was satisfied that you did work a shift on 6 September 2022. The panel inferred that what is recorded in the "*Roster/Work/Pay Hours*" document is likely to reflect the times you clocked in and clocked out. The document indicated that you worked an early late shift for 14.25 hours on 6 September 2022, which was consistent with the rota. Furthermore, the panel was satisfied, based on other patients' MAR charts, that you did attend the Home for a shift, given your initials on the charts. The panel acknowledged that the rota was not made available at the start of the proceedings, but it was of the view

that, given the number of documents which would have had to be altered to show you were working when you were not, it was not plausible that the MAR charts referred to, the rota or "*Roster/Work/Pay Hours*" document had been altered. Accordingly, it was satisfied that there is sufficient information to support that you did work a shift on 6 September 2022, as the rota suggested.

The panel then considered Patient H's blood sugar records on 6 September 2022. There are four entries on 6 September 2022, which are:

- At 01:58, by Ms 3, with a reading of 7.3;
- At 06:56, by Ms 3, with a reading of 9.6;
- At 08:30, by "GRACE", with a reading of 11.4; and
- At 17:33, by "GRACE", with a reading of 5.9.

The panel considered that four entries is one short of the five required, as per Patient H's care plan. The panel further considered that, as you took the reading at both 08:30 and 17:33, it was more likely than not that you were the nurse responsible for taking Patient H's blood sugar reading in the hours between 08:30 and 17:33, for the continuity in care. The panel took into account that Patient H's blood sugar, pursuant to their care plan, ought to have been taken before mealtimes and before bedtime, and that there is an absence of a mid-afternoon reading (one taken prior to lunchtime).

The panel took into account that you assert that you did not make those entries in Patient H's blood sugar records, and that other colleagues would have had access to your login and password. However, the panel was not satisfied that there is any reason as to why other colleagues would have needed to sign into your account, and it did not accept your assertion that it could not have been your entry on account that you would never have written your name is capital letters. Further, the panel found that you had written your name in capital letters in respect of other entries which you accepted in oral evidence as being yours. For example, in respect of your entries in Patient B's medical records on Tuesday, 13 September 2022 at 20:18 and in Patient F's medical records on Sunday, 2 October 2022 at 06:51 and 07:22.

The panel considered that this is an electronic record, with a date and time associated with the entry. It was of the view that it would be improbable for other colleagues to have deliberately accessed your account to only make two entries on 6 September 2022 in relation to Patient H. The panel also considered Witness 1's oral evidence, where he explained to the panel that whilst management at the Home can enter into the electronic system, it can also see all the entries within it. Witness 1 told the panel that management can also see if any entry is deleted. The panel heard that, during the probationary meeting, you raised the concern that people were gaining access to your login and changing your entries. Witness 1 told the panel that, given his ability to access the entries in this way, there was nothing to suggest that the electronic systems have been manipulated.

The panel considered that this is confirmed by the decision letter (dated 13 October 2022) from the Home manager regarding your probationary review meeting held on 11 October 2022, which stated:

> *"When asked for an explanation, you stated that someone is manipulating the system, you stated that someone had a vendetta against you because you had completed all the tasks stated …*
>
> *[REDACTED]*
>
> *I have checked VCare and once medication has been listed and administered, it cannot be un done* [sic] *so no one could go and manipulate the system."*

Taking into account all of the above, the panel was also of the view that to alter all the electronic records before these proceedings (including MAR charts, fluid intake charts, and other similar clinical records) to be consistent with each other would be a substantial task, and is therefore improbable. Accordingly, the panel rejected your assertion that the electronic records have been manipulated.

Accordingly, the panel found this charge proved in relation to 6 September 2022.

<u>10 September 2022</u>

The panel had sight of the "*Nurses – August/September 2022*" rota. On this rota on Saturday, 10 September 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that Ms 1 was working the early shift that day. The panel acknowledged that an early shift would mean Ms 1 would have concluded her shift in the afternoon.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "10/09/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift. You also told the panel that you would never work weekends, as you lived far away. Subsequently, in your oral evidence, you conceded that you had worked one early shift on a Saturday.

Further, the panel had sight of the shift handover notes for 10 September 2022, where observations for some 20 residents were logged by "*GRACE*" between 19:11 and 20:34. The panel determined that, based on the evidence before it, it was more likely than not that you were working the early late shift on 10 September 2022.

The panel then considered Patient H's blood sugar records on 10 September 2022. There are five entries on 10 September 2022, which are:

- At 07:27, by Mr 1, with a reading of 17.3;
- At 08:00, by "GRACE", with a reading of 19.5;
- At 12:30, by "GRACE", with a reading of 10.7;
- At 17:30, by "GRACE", with a reading of 20.8; and
- At 23:25, by Ms 3, with a reading of 8.4.

The panel took into account that, pursuant to Patent H's care plan, blood sugar readings above 15mmols/l constituted hyperglycaemia, and in those circumstances, "*nurses are to record a full set of observations every 15 minutes*". The panel considered that between 08:00 and 17:30, you were the nurse in charge of taking and recording Patient H's blood sugar levels. Furthermore, the panel considered that at both 08:00 and at 17:30, Patient H's hyperglycaemia care plan ought to have been followed, as the readings were 19.5 mmols/l and 20.8 mmols/l respectively (both above the 15mmols/l as stated in the care plan). The panel determined that, at this stage, Patient H's observations should have been conducted and recorded every 15 minutes, and that you had failed to do so.

The panel adopted its findings above in relation to your assertion as to the reliability of these documents.

Accordingly, the panel found this charge proved in relation to 10 September 2022.

13 September 2022

The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Tuesday, 13 September 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that Mr 2 was working the early shift that day.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "13/09/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

Further, the panel had sight of Patient G's MAR chart, which indicated that you administered Diazepam at 16:47 and Patient T's MAR chart, which indicated that you administered Levetiracetum at 19:00 on 13 September 2022. The panel considered that the initials on the MAR chart is "*GO*" and, given that the "*Users*" key indicated "*GO: Grace*", it was satisfied that this indicated that you administered to Patient G and Patient T at the time. The panel also considered Patient O's MAR chart, which indicted that you administered Macrogol, under the same initials, at 17:19 on 13 September 2022. The panel determined that, based on the evidence before it, it was more likely than not that you were working the early late shift on 13 September 2022.

The panel then considered Patient H's blood sugar records on 13 September 2022. There are five entries on 13 September 2022, which are:

- At 06:28, by Ms 3, with a reading of 15.5mmol;
- At 08:30, by "GRACE", with a reading of 14.8;
- At 12:00, by "GRACE", with a reading of 16.2;
- At 15:30, by "GRACE", with a reading of 16.9; and
- At 17:30, by "GRACE", with a reading of 16.9.

The panel took into account that, pursuant to Patent H's care plan, blood sugar readings above 15mmols/l constituted hyperglycaemia, and in those circumstances, "*nurses are to record a full set of observations every 15 minutes*". The panel considered that between 08:30 and 17:30, you were the nurse in charge of taking and recording Patient H's blood sugar levels. Furthermore, the panel considered that at 12:00, 15:30 and 17:30, Patient H's hyperglycaemia care plan ought to have been followed, as the readings were 16.2 mmols/l, 16.9 mmols/l and 16.9 mmols/l respectively (all above the 15mmols/l as stated in the care plan). The panel determined that, at this stage, Patient H's observations should have been conducted and recorded every 15 minutes, and that you had failed to do so.

The panel adopted its findings above in relation to your assertion as to the reliability of these documents.

Accordingly, the panel found this charge proved in relation to 13 September 2022.

19/20 September 2022

The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Tuesday, 13 September 2022, you appear to have worked an *"N*" shift. The panel heard evidence from you that this stood for a "*night*" shift, namely working from the late evening (at approximately 21:00) to the early morning the next day (at approximately 08:00). The panel noted that you were the only night shift nurse on duty.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "19/09/2022", you were planned to work for 10.50 hours, between 21:00 to 07:30. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

The panel also had sight of Patient T's MAR chart, which indicated that you administered Atorvastatin at 22:36 and you administered Hypomellose eye drops at 22:36 on 19 September 2022. The panel found that the initials on the MAR chart are "*GO*", and, given that the "*Users*" key indicated "*GO: Grace*", it was satisfied that this indicated that you administered this to Patient T at the time. The panel also considered Patient L's MAR chart, which indicated that you administered Lansoprazole, under the same initials, at 06:15 on 20 September 2022. The panel noted that these patients are not the relevant patients in relation to this charge. However, the panel was satisfied that this is consistent with a night shift, and indicated that you were working in the evening of 19 September 2022 to the early morning of 20 September 2022.

The panel determined that, based on the evidence before it, it was more likely than not that you were working the night shift on 19 September 2022, which would have concluded on 20 September 2022.

The panel then considered Patient H's blood sugar records on 19 September 2022. There are three entries on 19 September 2022, which are:

- At 06:59, by Ms 3, with a reading of 14.7;
- At 12:15, by Witness 2, with a reading of 13.3; and
- At 17:00, by Witness 2, with a reading of 10.1.

The panel also considered that there is only one entry, made by you, on 20 September 2022, at 23:00, with a reading of 4.8.

The panel noted that this is two short of the five entries required by Patient H's care plan. The panel found that there are missing entries both in the late evening of 19 September 2022 and the early morning of 20 September 2022. The panel determined that, as you were the only night nurse on shift, it would be your responsibility to take these blood sugar readings at these times. The panel was satisfied that, in the absence of any entry, you have failed to do so.

The panel adopted its findings above in relation to your assertion as to the reliability of these documents.

Accordingly, the panel found this charge proved in relation to 19/20 September 2022.

<u>25/26 September 2022</u>

The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Sunday, 25 September 2022, you appear to have worked an *"N*" shift. The panel heard evidence from you that this stood for a "*night*" shift, namely working from the late evening (at approximately 21:00) to the early morning (at approximately 08:00) the next day. The panel noted that you were the only night shift nurse on duty.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "25/09/2022", you were planned to work for 10.50 hours, between 21:00 to 07:30. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

The panel also had sight of Patient Q's MAR chart, which indicated that you administered Atorvastatin at 21:27 on 25 September 2022. The panel considered that the initials on the MAR chart is "*GO*", and, given that the "*Users*" key indicated that "*GO: Grace*" it was satisfied that this indicated that you administered this to Patient Q at the time. The panel also considered Patient T's MAR chart, which indicated that you administered Lansoprazole, under the same initials, at 07:36 on 26 September 2022. The panel noted that these patients are not the relevant patients in relation to this charge. However, the panel was satisfied that this is consistent with a night shift, and indicated that you were working in the evening of 25 September 2022 to the early morning of 26 September 2022.

The panel determined that, based on the evidence before it, it was more likely than not that you were working the night shift on 25 September 2022, which would have concluded on 26 September 2022.

The panel then considered Patient H's blood sugar records on 25 and 26 September 2022. There are five entries on 25 September 2022, which are:

- At 07:30, by Ms 6, with a reading of "hi";
- At 09:30, by Ms 6, with a reading of 22.9;
- At 11:45, by Ms 6, with a reading of 12.9;
- At 16:30, by Ms 6, with a reading of 15.9; and
- At 22:00, by "GRACE", with a reading of 24.9

The panel also considered that none of the entries made on 26 September 2022 were by you, and the first entry was made at 06:00 by Ms 6.

The panel took into account that, pursuant to Patent H's care plan, blood sugar readings above 15mmols/l constituted hyperglycaemia, and in those circumstances, "*nurses are to record a full set of observations every 15 minutes*". The panel considered that at 22:00, Patient H's hyperglycaemia care plan ought to have been followed, as the reading was 24.9mmols/l. The panel determined that, at this stage, Patient H's observations should have been conducted and recorded every 15 minutes, and that you had failed to do so.

The panel adopted its findings above in relation to your assertion as to the reliability of these documents.

Accordingly, the panel found this charge proved in relation to 25/26 September 2022. In the light of the foregoing, the panel found proved on the balance of probabilities that you, between 6 September 2022 and 3 October 2022, on one or more occasions failed to check and/or record Patient H's blood glucose/sugar.

Charge 2)

"That you, a registered nurse:

2) On 6 September 2022 and/or 25 September 2022 and/or 26 September 2022 failed to document handover notes in respect of one or more patient/s on the electronic system."

This charge is found proved in relation to 25/26 September only.

In reaching this decision, the panel took into account its findings in relation to charge 1 above. It noted that you were more likely than not on shift at the Home both on 6

September 2022 and on a night shift on 25 September 2022 (which concluded on 26 September 2022).

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

> *"Every day the nurses are responsible for completing handover notes which is done electronically. From as early as after the induction Grace came to me saying that she couldn't get into the system and that it wasn't working but we were all in the system so we knew it was working. As a consequence of this there were days when she wasn't logging into the system and documenting her handover notes."*

The panel also had sight of Witness 1's supplementary statement, which stated:

> *"At paragraph 17 of my original statement I make reference to incident(s) concerning Grace not documenting handover notes on the electronic system. The specific dates that relate to this allegation are 6 and 25-26 September 2022. On these dates, Grace did not complete handover notes for all residents. On the days where Grace did complete handover notes, there were no issues with her notes."*

The panel also considered the probationary meeting notes, dated 11 October 2022, which stated:

- *"Use of IT systems and documentation*

Constant inability to log into the system, No night shift handover notes recorded on 09.10.2022."

The panel heard oral evidence from Witness 1, where he told the panel that it is possible for nurses to complete handover notes on a piece of paper and upload them to the system at a later time. The panel was satisfied that Witness 1's evidence was clear and consistent with his witness statement and the contemporaneous probationary meeting notes in relation to electronic handovers, and the panel found that his account was cogent and credible.

The panel considered the two dates in turn.

6 September 2022

The panel had sight of the "*Nurses – August/September 2022*" rota. On this rota on Tuesday, 6 September 2022, you appear to have worked an "*EL*" shift. The panel considered that another nurse, Ms 1, was working the early shift that day, and Ms 2, an agency nurse, was working an EL shift alongside you.

The panel considered the handover notes from the Home on 6 September 2022. The panel had sight of the handover notes completed by Ms 3 (who was working the night shift the evening prior) between 02:28 and 07:29. The panel was satisfied that this was consistent with a night shift.

The panel did not have sight of any other electronic handover notes after 07:29. The panel considered Witness 1's evidence that handover notes could be completed on paper and later transferred onto the electronic system, but the panel determined that it has not had sight of any paper handover indicating that you completed this handover.

The panel took into account that there were two nurses – namely Ms 2 and you – who were working the same shift on 6 September 2022. However, the panel was unable to establish, given that there were two nurses on shift, whether the responsibility to complete the handover notes lay with Ms 2 or with you. The panel determined that the NMC has not discharged the burden of proof to demonstrate, on the balance of probabilities, that the duty to complete the handover notes was your duty.

Accordingly, the panel found this charge not proved in relation to 6 September 2022.

25/26 September 2022

The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Sunday, 25 September 2022, you appear to have worked an "*N*" shift, namely a night shift. The panel considered that you were the only nurse working the night shift.

The panel considered the oral evidence it heard from you, whereby you confirmed that it was the night shift nurse's responsibility to complete the handover notes for the nurse on shift the following morning. Accordingly, the panel was satisfied that you had the responsibility of completing the handover notes for this shift, given you were the only nurse on duty.

The panel considered the handover notes from the Home. The panel had sight of the handover notes completed by Ms 6 (who was working the early late shift following yours on 26 September 2022).

The panel did not have sight of any other electronic handover notes from 25 September 2022. The panel took into account that, it can be inferred by other entries made by other nurses on a night shift, that you would have had sufficient time throughout the night shift to complete the electronic handover notes. The panel considered its findings above in relation to your assertion as to the reliability of electronic documents from the Home, per charge 1.

Taking all of the above into account, the panel was satisfied that you had a duty to complete the electronic handover notes for the night shift of 25 September 2022, and in the absence of these handover notes, you had failed to do so.

Accordingly, on the balance of probabilities, the panel found this charge proved in relation to 25/26 September 2022.

Charge 3a), b), c), d) and e)

"That you, a registered nurse:

3) On 31 August 2022 in respect of Patient A:
    a) Failed to carry out a second check of their blood pressure.

b) Failed to monitor their blood pressure.
c) Failed to escalate their high blood pressure to a General Practitioner.
d) Failed to handover their high blood pressure reading.
e) Failed to record any comment/rationale for the high reading"

These charges are found proved.

The panel had sight of the "*Nurses – August/September 2022*" rota. On this rota on Wednesday, 31 August 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to early evening (approximately 21:00).

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "31/08/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

The panel also had sight of the numerous handover notes completed by "*GRACE*" for various patients, including Patient A, between 19:47 and 21:28. The panel also had sight of the Enteral Feed Record for Patient C, dated 31 August 2022, where you had initialled, at 17:30, for giving "*Meds + H20 250*". Accordingly, the panel determined that, based on the evidence before it, it was more likely than not that you were working the early late shift on 31 August 2022.

In reaching this decision, the panel took into account Witness 1's witness statement, which stated:

"The first incident was on 31 August 2022. It was either the clinical lead or another nurse who brought the incident to my attention. I was told that Grace had recorded s blood pressure observations as being high and then it was not followed up or handed over. The blood pressure was recorded as being 177/144. If an observation is recorded and its high, then we would expect it to be checked again and then either record that more regular checks are needed or escalate it to a GP. With this recording, if it was correct, there is a risk of potential stroke. The patients blood pressure readings were normally within normal range so this was an unusual reading for this patient. If a reading is outside of the normal range then the machine shows the numbers as red and you are asked to put in the rationale for the reading in the comments section for that patient but there wasn't anything recorded in the comments. We take the patients blood pressure readings weekly unless they are abnormal so as Grace didn't follow this up the next reading wasn't done until the 8 September 2022. The next reading was done by an agency staff so they might not have realised what had gone on. The nurse had noticed the recording was high and hadn't been followed up. Unless we go into the system to look at the recordings then we wouldn't know that it was high or hadn't been followed up."

The panel also heard oral evidence from Witness 1, who told the panel that, at this stage, you were no longer in your shadowing period at the Hone. The panel considered your oral evidence, where you told the panel that you were still shadowing at this stage. The panel had sight of the "*Nurses – August/September 2022*" rota, where a different text colour was used to indicate your shifts until 25 August 2022. At the bottom of the rota, in the same colour text, read "*Grace – Induction/Shadowing*". The panel was satisfied that this indicated all of your shifts in this different colour were shifts whereby you were on your induction or shadowing another member of staff, and that all of your shifts following 25 August 2022 were shifts undertaken independently.

The panel also had sight of Patient A's patient records. On the "*31/08/2022*" entry, at 11:14, as logged by "*GRACE*", the panel had sight of Patient A's BP Systolic reading as 177 (with a red dot appearing next to the number) and their BP Diastolic reading as 144 (with a red dot appearing next to the number). Within the "*Comments*"

column, the comment "*from assessment '09 Vital Observations'*." appears.

The panel had sight of the handover notes for Patient A, completed by you, which stated:

> *"Patient A spent sometime in the lounge with other resident supported with all personal, inconsistent, food and fluid carem* [sic] *medications given, all clinical and safety checks maintained."*

The panel then considered each of the sub-charges in turn.

Charge 3a)

In relation to sub-charge a), the panel considered all of the above alongside your oral evidence, where you told the panel that an abnormally high blood pressure reading would require a follow up. The panel also considered Witness 1's evidence, and it determined that there is a responsibility on the part of the nurse to follow up and carry out a second check following a high blood pressure reading. The panel determined that Patient A's reading of 177/144 would be considered a high reading, and consequently, it was satisfied that there was a duty for you to follow up on this reading.

The panel then considered Patient A's patient notes, where you only logged the one reading (at 11:14) on 31 August 2022 and no other readings were logged until 8 September 2022. The panel determined that there is nothing before it to suggest that you took a second reading of Patient A's blood pressure following the reading at 11:14, despite your duty to do so.

Accordingly, the panel found charge 3a proved on the balance of probabilities.

Charge 3b)

The panel took into account all of the evidence above. The panel considered Witness 1's statement, whereby if a patient's blood pressure was high, there was an

expectation that the patient's blood pressure was "*checked again and then either record that more regular checks are needed or escalate it to a GP."*

The panel considered that following your entry on Patient A's records at 11:14 on 31 August 2022, no other entries were made in relation to Patient A's blood pressure. The panel was satisfied that this indicated that you did not monitor Patient A further following this reading. It also considered that, in your handover notes, Patient A's high blood pressure was not mentioned for the other nurse to monitor and, if necessary, follow up on in the next shift.

Accordingly, the panel found charge 3b proved on the balance of probabilities.

Charge 3c)

The panel took into account all of the evidence above. The panel considered Witness 1's statement, whereby if a patient's blood pressure was high, there was an expectation that the patient's blood pressure was "*checked again and then either record that more regular checks are needed or escalate it to a GP."*

The panel considered that following your entry on Patient A's records at 11:14 on 31 August 2022, no other entries were made in relation to Patient A's blood pressure. It also considered that, in your handover notes, Patient A's high blood pressure, and the possibility of needing to escalate it to a General Practitioner, was not mentioned. The panel did not have sight to any reference of escalation to a General Practitioner in either document, indicating that you failed to do so.

Accordingly, the panel found charge 3c proved on the balance of probabilities.

Charge 3d)

The panel considered the handover notes you completed, as detailed above. The panel was satisfied that the handover notes did not reference Patient A's high blood pressure.

The panel took into account that, in your oral evidence, you stated that this was not your handover notes as you did not write your name in capital letters. The panel reminded itself of its findings in relation to you using capital letters, per charge 1. Further, you told the panel that in any event, you were not doing handovers at the time.

The panel determined that there is no evidence before it that other members of staff would have fabricated your handovers in relation to Patient A. The panel therefore rejected your account in relation to this. It appeared to the panel that, as with much of your evidence, you were attempting to avoid your responsibilities and seeking to transfer them to others.

Accordingly, the panel found charge 3d proved on the balance of probabilities.

Charge 3e)

The panel considered Patient A's patient notes, and the comment as it appears under the "*Comment*" column. The panel determined that this comment appears on other entries. It determined that this was more likely than not an automatic comment generated by the blood pressure machine. The panel was not satisfied that this amounted to a comment or rationale entered by you, per the wording of the charge.

The panel did not have sight of any additional comment or rationale made by you in relation to Patient A's high blood pressure reading.

Accordingly, the panel found charge 3e proved on the balance of probabilities.

Charge 4a) and b)

"That you, a registered nurse:

4) On 13 September 2022 in respect of Patient B:
    a) Failed to record their details on the electronic care plan system.

b) Failed to record their medication on the electronic care plan system."

Charge 4a) is found NOT proved, but charge 4b) is found proved.

The panel first considered whether you were on shift on 13 September 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Tuesday, 30 September 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that Witness 2 was also working a shift that day, which was confirmed in her witness statement.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "13/09/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift. The panel reminded itself of its findings in relation to Patients G, T and O's MAR charts, per charge 1. The panel determined that, based on the evidence before it, it was more likely than not that you were working the early late shift on 13 September 2022.

In reaching this decision, the panel took into account Witness 1's witness statement, which stated:

> *"There was an incident on the 13 September 2022 where a lady had come to us for respite care, Patient B, and Grace had not recorded her medication onto the system. I was on holiday this week but [Witness 2] had taken over my responsibilities while I was away and informed me of the incident. The resident came in the afternoon around lunchtime. Normally when we have a new resident that comes to The Home their medication is uploaded onto the electronic care plan system so they are then shown on the MAR charts to be dispensed.*

[Witness 2] told me that these hadn't been recorded on the day she came to The Home. [Witness 2] said that she had asked Grace if she needed help uploading the medication and Grace had told her that she would be fine. Grace would have been on the day shift that day. As a result of it not being uploaded onto the system the resident didn't get their medication on the day they came to The Home. The medication that was missed was an iron tablet and Omeprazole which was for acid reflux. … I'm not sure which nurse was on the night shift but if it was an agency nurse then we wouldn't expect them to know how to put medication onto the system. The resident wasn't on any night time medication so this would have been left to the day staff to administer the next dose in the morning."

The panel also heard oral evidence from Witness 1. He explained the process of admitting a new patient into the Home's system, and that it consisted of two steps, namely to set up a patient profile – with the patient's name, date of birth and NHS number – before moving on to add all the medication that the patient was prescribed.

The panel took into account Witness 2's witness statement, which stated:

"On the 13 September 2022 Patient B came to [PRIVATE] *and the registrant took the handover from the* [PRIVATE] *regarding her medication. I asked the registrant if she was okay with putting the resident's details onto the electronic system and she said "Yes I'm fine, I can do it". I left at about 16:00 that day. The following day I was working on the floor as a nurse so I got the handover from the night nurse. The night nurse said that the residents details weren't on the electronic system. This meant that the resident missed two medication administrations. One was an iron tablet and one was Omeprazole. There was not a big risk of the patient missing a dose of these medications. I think the resident was on Omeprazole for acid reflux. [REDACTED]. The registrant was not working the following day but I met with her a few days later and I asked her why she hadn't inputted the details onto the system. She said that the system had stopped working. I told her that she should have called the manager for help and she said that she thought she could only call the manger* [sic] *for emergencies."*

The panel also considered the handover notes, completed by you, at 20:16 on 13 September 2022, which stated:

> *"Patient B arrived at the home this afternoon, round about lunch time accompanied by the paramedics and* [PRIVATE]*. Pat B is bed bound, unable to mobilise or communicate. Pat B is on pureed diet, fluids thickend* [sic] *with 2 scoops.* [PRIVATE] *brought a luggage of various items, medications and a metal straw. Pat B has got a pressure sore on back of right elbow, scratches on left side of neck – self inflicted injury"*

The panel also had sight of Patient B's MAR chart.

The panel then considered each of the sub-charges in turn.

Charge 4a)

In relation to sub-charge a), the panel considered Witness 2's evidence. She told the panel that you had failed to record Patient B's details in the electronic system. The panel also heard evidence from you, where you told the panel that the inputting of information in relation to setting up the patient profile was the responsibility of management or the clinical lead. The panel took into account that, in this situation, the clinical lead would have been Witness 2 (who appeared to have left her shift in the afternoon).

The panel was satisfied, based on Witness 1's evidence, that there was a duty on you to record Patient B's details into the electronic system. The panel was of the view that it was implausible, and impractical in a clinical setting, for every new patient's records to be the responsibility of the clinical lead or management. The panel determined that Witness 1 and Witness 2's evidence were clear and consistent with each other, in that the responsibility for inputting Patient B's information rested on you, as you received Patient B into the Home.

However, the panel also noted that you completed a shift handover note for Patient B at 20:16. The panel considered that, based on Witness 1's evidence, this would only be possible if the patient profile was set up, based on the two-step process he described. The panel determined that, irrespective of whether the patient's profile was accurate or complete, the patient's profile was set up in order to enable you to have made this entry.

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

Charge 4b)

The panel considered both Witness 1's and Witness 2's evidence in relation to this charge. The panel acknowledged that Witness 1's evidence on this incident is derived from Witness 2's account. However, the panel was satisfied that both witnesses were consistent with their evidence that, in the event of a new patient being admitted to the Home, the responsibility of setting up their profile and inputting their medication rested on the nurse.

The panel also heard oral evidence from you. You firstly expressed to the panel that you had the competencies to complete all the tasks alleged in these charges, but you also told the panel that you were unsure as to how to input the patient's information on the electronic system and that the responsibility ought to have been with the night shift nurse. The panel was of the view that there were shifting explanations from you in relation to these charges, and it did not accept your account.

The panel was therefore satisfied that there was a duty on you, as the nurse who received Patient B on the day she was admitted to the Home, to input the medication onto the electronic system.

Having established that you had a duty to input Patient B's medication, the panel next had sight of Patient B's MAR charts. The panel took into account that no medication was administered to Patient B on 13 September 2022.

The panel considered Patient B's handover notes which were completed by Ms 5 the following day. At 01:57, Ms 5 wrote:

> *"Pat B appeared to be asleep, she did not wake when spoken too* [sic]*, due to the late hour medications omitted will hand over to day staff"*

At 03:57:

> *"Pat B appears to have slept well, handover includes need for drug chart on MARS to enable drug administration, RISK assessments and resuscitation status to be updated"*

The panel took into account Witness 2's signed, local statement, dated 29 September 2022, which stated:

> *"The medications were not added onto the system until the following day resulting in no evening medications being administered on the day of admission. When this was followed up with Grace the following day she said that she was unable to access the system and that she had not informed any management."*

The panel determined, based on Ms 5's two handover notes and Witness 2's witness statement, her sufficiently contemporaneous local statement and her oral evidence, that it was clear that Patient B's medications were not administered because the MAR charts had not been set up by you. The panel was satisfied that this was due to your failure to input the medication into the electronic system.

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

Charge 4c)

> "That you, a registered nurse:
>
> 4) On 13 September 2022 in respect of Patient B:

c) Did not raise with your clinical lead/colleague that you were unable to record details and/or medication on the electronic care plan system."

This charge is found proved.

In reaching this decision, the panel took into account its findings in relation to charges 4a and 4b above. The panel considered that, given charge 4a was found not proved, this charge is in relation to Patient B's medication records only (charge 4b).

The panel bore in mind that the clinical lead, in these circumstances, would have been Witness 2, pursuant to Witness 1's evidence. The panel took into account that the "*colleague*" referred to in this charge could be Witness 2, but could equally be Ms 5, who was on the night shift following your shift that day.

The panel considered Witness 2's witness statement, which stated:

> *"I asked the registrant if she was okay with putting the resident's details onto the electronic system and she said "Yes I'm fine, I can do it". I left at about 16:00 that day … The registrant was not working the following day but I met with her a few days later and I asked her why she hadn't inputted the details onto the system. She said that the system had stopped working. I told her that she should have called the manager for help and she said that she thought she could only call the manager for emergencies."*

The panel also considered Witness 2's local statement, dated 29 September 2022, which stated:

> *"On 13.09.2022 new admission Pat B arrived for respite care, [Witness 2] asked Grace if she required any assistance in setting up the medication on the system and Grace declined".*

The panel also considered that, in your oral evidence, you denied the responsibility of inputting Patient B's information into the electronic system in any event. However,

the panel also had regard to your evidence – as referred to in charge 4b above – that you were unsure as to how to input the patient's information on the electronic system. The panel has taken your evidence together with Witness 2's account (including her contemporaneous local statement) which indicated that you told Witness 2 you were unable to input the medication information. The panel has placed weight on Witness 2's account, particularly given its sufficiently contemporaneous nature, and it determined that this was consistent with part of your oral evidence, albeit it noted that there were shifting explanations from you in relation to this charge.

Taking this together with all the other information before it, the panel was satisfied that you therefore did not raise with either Witness 2 or Ms 5 that you were unable to input Patient B's medication information on the electronic care plan system.

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

Charge 5a)i)

"That you, a registered nurse:

5) On 21 September 2022:
    a) in respect of Patient C;
        i. Turned off the PEG feed pump/machine."

This charge is found proved.

The panel first considered whether you were working a shift at the Home on 21 September 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Wednesday, 21 August 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that Mr 2 was working the early shift that day, which would have concluded by the afternoon.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "21/08/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

The panel further considered Patient C's Enteral Feed Record, dated 21 September 2022, in which the handwritten entries between 08:00 and 17:30 have your signature. The panel found that you accepted, in your oral evidence, that this was your signature. Accordingly, the panel was satisfied that you were working an early late shift on 21 September 2022.

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

> *"On the 21 September 2022 Grace discontinued Patient C's PEG feed before it had completed. [Witness 2] told me that she had witnessed this and told Grace to reconnect the feed which she did …"*

The panel considered that Witness 1's account relied on Witness 2's account. The panel accepted Witness 2's witness statement, which stated:

> *"On the 21 September 2022 I was doing paperwork in the office and I went down to do the covid tests for the residents when a carer told me that the PEG feed for one of the residents had been switched off. I went to see what had happened and the pump had stopped. I saw the registrant and I asked her why PEG feed had stopped and she said that the machine was bleeping so she switched it off. This isn't the correct thing to do, if it has occluded then we have to find out why and see if there is anything wrong with the machine or if it is the pump. Sometimes the machine bleeps if there is something wrong with the sensor or it needs a new pump so then we contact the supplier. I looked at the machine and I could see that the tube was blocked so*

I changed the tube and switched it back on. The bleeping stopped after this. The registrant should have changed the tube herself, she is competent enough to do this and she was the one who started the feed. I was not made aware of the issue by the registrant. I don't know what time she switched off the machine but from memory I think that only 3/1000ml of feed had been given. The resident was nil by mouth so by stopping the feed it meant that they didn't get any food from morning until lunch time."

The panel placed weight on Witness 2's signed local statement, dated 29 September 2022, and considered this to be a sufficiently contemporaneous account, given it was documented eight days after the alleged incident:

"[Witness 2] also detailed that on 21.09.2022 at around 13.00hrs Staff informed [Witness 2] that feed was not working, when checking [Witness 2] identified that the Pump was completely switched off. [Witness 2] asked Grace why stopped and she indicate that this was due to it becoming occluded. On checking the pump only 3mls of feed had been administered. [Witness 2] changed tubing and feed commenced. Grace had not raised this with [Witness 2] throughout the morning."

The panel also heard oral evidence from both Witness 1 and Witness 2. The panel heard from Witness 1 that you had discontinued a PEG feed which you administered, and that this account was based on his recollection of Witness 2's account to him.

The panel considered your oral evidence. You told the panel that you do not deny the PEG feed had occluded, but that it was Mr 2's responsibility, as he had administered the PEG feed in the first place. You told the panel that you attempted to assist Mr 2 when he asked you to do so, but you did not take responsibility for Patient C. You expressly denied the version of events given by Witness 2.

The panel considered Patient C's MAR chart. The panel had sight of the administration of Generic Jevity Promote liquid, which was done at 08:02 by the initials "*MM*". The panel was satisfied that this referred to Mr 2. The panel therefore

determined that Mr 2 administered the PEG feed at 08:02 on 21 September 2022, and not you.

The panel also considered the probationary meeting notes, dated 11 October 2022, which stated:

- *"Management of PEG feeds.*

Reported that on 21.09/22 at 17.00 Pat Cs PEG feed had not completed yet it was taken down, clinical lead raised.

Also reported that feed was occluded and was not addressed until lunchtime resulting in feed being late. Assistance of Clinical lead not asked by yourself."

The panel noted the inconsistencies in the timings as reported in this contemporaneous record. The panel was satisfied that there appears to be two incidents involving PEG feeds (namely, charge 7a and this charge). The panel considered that Witness 1 did not witness these incidents directly, and that Witness 2 (who did witness these incidents) was not present at the probationary meeting notes. The panel found that Witness 1 likely conflated the two incidents relating to PEG feeds (outlined in both this charge and charge 7a) in his account. Accordingly, the panel accepted the evidence of Witness 2 in relation to this charge, namely that you stopped the PEG feed.

The panel also had sight of Patient C's Enteral Feed Record. The panel found that there are five entries on this chart, and three of them – namely at 08:00, 13:30 and 17:30 were signed by you.

Taking all the above into account, the panel considered that, irrespective of Mr 2 starting the PEG feed, you had interactions with Patient C at three points in the day, namely at 08:00, 13:30 and 17:30. In these circumstances, the panel was satisfied that you had responsibility for Patient C's PEG feed. Furthermore, the panel accepted Witness 2's evidence regarding what she says you told her and rejected your account of this incident. Consequently, the panel was satisfied, on the balance

of probabilities, that you did turn off Patient C's PEG feed pump/machine.

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

Charge 5a)ii)

"That you, a registered nurse:

5) On 21 September 2022:
    a) in respect of Patient C;
        ii. Did not change the feeding tube."

This charge is found proved.

In reaching this decision, the panel took into account its findings in relation to charge 5a)i) above.

The panel determined that Witness 2's witness statement, oral evidence and local statement (as detailed above) were cogent and compelling. The panel heard that, having turned off the machine, you did not change the feeding tube, and that Witness 2 changed the tube at a later stage. The panel accepted Witness 2's evidence in relation to this.

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

Charge 5a)iii)

"That you, a registered nurse:

5) On 21 September 2022:
    a) in respect of Patient C;
        iii. Failed to escalate their feed had occluded."

This charge is found proved.

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

> *"I was not made aware of the issue by the registrant. I don't know what time she switched off the machine but from memory I think that only 3/1000ml of feed had been given."*

Further, in Witness 2's signed local statement, dated 29 September 2022, she stated:

> *"[Witness 2] asked Grace why stopped and she indicate that this was due to it becoming occluded. On checking the pump only 3mls of feed had been administered. [Witness 2] changed tubing and feed commenced. Grace had not raised this with [Witness 2] throughout the morning."*

The panel determined that Witness 2's evidence is clear and consistent on this matter. The panel was of the view that you did not raise the matter with Witness 2 at the time, and the panel accepted Witness 2's evidence in relation to this charge.

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

Charge 5b)i)

"That you, a registered nurse:

5) On 21 September 2022:
    b) in respect of Patient D;
        i. Did not close the wound review on the system."

This charge is found proved.

In reaching this decision, the panel took into account its decision in charge 5a) above, in relation to you working a shift on 21 September 2022.

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

> *"On the same day, Grace had documented that Patient D was all clear but their wound review hadn't been closed down on the system and the treatment plan wasn't updated. This was an issue with her documentation on the system. The task came up on the system for the wound to be reviewed and if the wound is healed then you close the task down on the system so there is no further treatment. Grace hadn't closed it down on the system so it was then flagged again as needing to be reviewed so another nurse reviewed the resident when it wasn't needed."*

The panel heard oral evidence from Witness 1. He told the panel that when a wound had healed, the procedure that was meant to be followed at the Home was that the nurse responsible should "*close down*" the wound monitoring task, giving a rationale for why they had done so. The task would then be archived in the electronic system, as to not appear as an active task which needed to be followed up by other nurses.

The panel also considered your oral evidence, where you told the panel that you did not close down the review as it was not the practice to do so at the Home.
The panel then considered Patient D's body map summary. The panel took into account that the entry on "21/09/2022" at 14:23, by "*GRACE*" stated:

> *"Treatment note for Pressure Sore located on Back, buttocks .*
> *All cleared"*

The panel took into account that you denied making this entry as this would not have been language you would have used in patient notes. However, the panel considered that this entry was made in your name, and there is no evidence before it that other members of staff accessed your account to make this entry, particularly with its findings that you were working on shift that day. The panel was therefore satisfied that this was your entry.

The panel noted that, following your entry on 21 September 2022, there were more entries by other members of staff, indicating that the wound review was not closed on the system.

The panel noted your own account that you did not close the wound review on the system, owing to the practices at the Home. Notwithstanding the possible practices of other staff members within the Home, the panel determined that you did not close the wound review on the system following your entry on 21 September 2022.

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

Charge 5b)ii)

"That you, a registered nurse:

5) On 21 September 2022:
    b) in respect of Patient D;
        ii. Did not update their treatment plan to say the wound had healed."

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings in relation to charge 5b)i) above, particularly on its findings that you worked a shift on 21 September 2022, and your care of Patient D on that shift.

The panel considered Patient D's patient records, including their body map summary. The panel took into account the entry, dated 21 September 2022, by "*GRACE*". The panel noted your evidence that you deny this was your entry on account of the wording used. However, the panel was satisfied this was your entry, pursuant to its findings in charge 5a)i) above.

Your entry, dated 21 September 2022, stated:

"Treatment note for Pressure Sore located on Back, buttocks .
All cleared"

The panel noted that this entry does not refer to the wound being "*healed*", as per the wording of the charge. However, the panel was of the view that the phrase "*all cleared*" is synonymous with "*healed*", namely, it tells the reader that Patient D's skin was intact at that time. The panel was therefore satisfied that the phrase "*all cleared*" sufficiently indicates that the wound had healed.

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

Charge 6

"That you, a registered nurse:

6) Between 4 October 2022 and 5 October 2022 on one or more occasion failed to check and/or record Patient E's blood glucose/sugar."

This charge is found proved.

In reaching this decision, the panel considered the two dates outlined in turn.

<u>4 October 2022</u>

The panel first considered whether you were on shift on 4 October 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Tuesday, 4 October 2022, you appear to have been scheduled for an "*EL*" shift, but this has been crossed out in annotation.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "04/10/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15.

However, the document showed you were not paid for those hours, indicating that you did not work that shift. The panel determined that, based on the evidence before it, it was more likely than not that you were not working the early late shift on 4 October 2022.

The panel also noted that there is no further documentation before it evidencing that you worked on 4 October 2022. Accordingly, the panel was satisfied that, on the balance of probabilities, this charge cannot be found proved in relation to this date.

5 October 2022

The panel next considered whether you were on shift on 5 October 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Wednesday, 5 October 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00). The panel noted that Ms 7 was working the early shift that day, and that you were the only nurse working the late shift before the night nurse's shift.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "05/10/2022", you were planned to work for 14.25 hours, between 07:00 to 21:15. The document indicated that you did work these hours, and that you were subsequently paid for this shift. The panel took into account your evidence under oath, where you told the panel that, when attending for work, you "*clocked in*" and "*clocked out*" at the end of your shift.

The panel had sight of Patient G's MAR chart. The panel noted that this is not the patient relevant to this charge. However, the MAR chart indicated that you administered Apixaban and Evacal D3 at 17:17 on 5 October 2022 and Paracetamol at 17:34 on the same date. The panel considered that the initials on the MAR chart are "*GO*", and given that the "*Users*" key indicated "*GO: Grace*", it was satisfied that this indicated that you had administered these to Patient G on that date. The panel

also had sight of Patient A's blood pressure records. The panel noted that this is not the patient relevant to this charge. However, the records indicated that you made an entry on 5 October 2022 at 19:25. The panel determined that, based on the evidence before it, it was more likely than not that you were working the early late shift on 5 October 2022.

Having established that you were on shift on 5 October 2022, the panel next considered whether you were under a duty to check and/or record Patient E's blood sugar levels. The panel considered Patient E's care plan, evaluation date 13 August 2022, which stated:

> *"Her blood sugars are currently being monitored tds to ensure we have an understanding how her blood sugars are running on a daily basis.*
>
> *Currently there is are no plans in place should have Pnt E have Hyper or Hypo glycaemia attacks, on admission to the home she is to be reviewed by the GP and blood test requested for HBa1c."*

The panel noted that this care plan was evaluated on 13 August 2022, a date prior to this charge. However, the panel considered that the next care plan for Patient E was evaluated on 14 October 2022, which is outwith this charge. Accordingly, the panel was satisfied that this care plan was in place at the relevant time.

The panel also considered Witness 1's witness statement, which stated:

> *"Grace had failed to document that … Patient Es bowel movements were documented…. This ties in with the shift handover notes not being documented as if she wasn't able to get onto the electronic system then she wouldn't have been able to record these observations. The potential risk with this is that bowl* [sic] *monitoring documentation is really important as we need to have a record to identify and clinical changes. Grave* [sic] *said that this was down to the system not working. I asked her to show me how she was trying to log onto the system and she just kept using the wrong password."*

The panel also considered Witness 1's supplementary statement, which stated:

> *"To clarify, this should have been in relation to blood glucose monitoring, not bowel movements. … Pnt. E was having TDS recordings before meals, when their blood sugars were outside of normal ranges."*

The panel also heard oral evidence from Witness 1, who confirmed that "*tds*" as referred to in the care plan indicated that Patient E's blood glucose should be checked three times a day. The panel was satisfied that Witness 1's evidence was cogent and consistent, and the panel determined that Patient E's blood sugar needed to be checked three times a day prior to mealtimes.

The panel then considered Patient E's blood sugar records on 5 October 2022. The panel noted that only one entry has been made at 11:36, and this was made by Ms 7, who was on early shift on that day. The panel was of the view that, as this entry is close to midday, there are two missing entries for Patient E's blood glucose, namely one in the morning (at breakfast) and one in the early evening (at dinner).

In relation to the morning reading, the panel took into account that there were two nurses – namely Ms 7 and you – whose shifts would have overlapped on 5 October 2022. The panel noted that, as Ms 7 was on an early shift, she likely would have finished her shift in the afternoon, at approximately 14:15. However, the panel was unable to establish, given that there were two nurses on shift in the morning, whether the responsibility to take Patient E's morning blood sugar reading lay with Ms 7 or with you. The panel determined that the NMC has not discharged the burden of proof to demonstrate, on the balance of probabilities, that the duty to take Patient E's morning blood sugar reading was your duty.

However, the panel found that you were the only nurse on duty in the late afternoon and early evening, as Ms 5 was working a night shift that evening, and not due to arrive until approximately 21:00. Accordingly, the panel was satisfied that you were responsible for monitoring and recording Patient E's blood glucose levels prior to dinner, and you have failed to do so.

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

Charge 7b)i)

"That you, a registered nurse:

7) On 28 September 2022:
    b) In respect of Patient E;
        i. Did not follow up when they refused to have their wound checked."

This charge is found proved.

In reaching this decision, the panel took into account your admission to Charge 7a. The panel was therefore satisfied that you were working a shift on 28 September 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Wednesday, 28 September 2022, you appear to have worked an "*EL*" shift. The panel heard evidence from you that this stood for an "*early late*" shift, namely working from the morning to late evening (approximately 21:00).

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

"On the 28 September 2022 Grace did not follow up when a resident, Patient E, had refused to have a wound checked. The nurses do daily tasks that the electronic care plan system generates. If there are any residents with a wound then you need to check on this. Grace had not recorded the task as completed as the resident had refused to have a wound on their hand checked and didn't hand this over that it still needed checking. We do audits on all wounds each month so this was how I saw that the wound had not been followed up. If a resident refuses then it should be reported to another nurse to check the resident again later as Grace was on the early shift that day. Grace did write on the system that the check was refused but she hadn't rescheduled the task or handed it over to another colleague to check later. The wound wasn't serious, it was a bruise. The

resident had dementia and could become quite aggressive during personal care and has been known to hit out. The resident had very thin skin and was known for having cuts and bruises on her hands so it needed to be monitored. The next time the wound was checked was on the 30 September 2022."

The panel also heard oral evidence from Witness 1. He told the panel that a wound could be anything "*from a bruise to skin tattoo a* [sic] *pressure sore*". He told the panel that, in the event a patient refused, the nurse should try again at a different time, or hand over this information for another nurse to try on the next shift. The panel determined that Witness 1's evidence was clear and consistent in relation to this charge.

The panel considered your oral evidence. You told the panel that this patient was not resisting, and that, in any event, you were able to see the patient's bruise on their hand. You asserted to the panel that, in these circumstances, there was no need to follow up on Patient E's wound/bruise. It appeared to the panel that this was another occasion where you were attempting to avoid your responsibilities. The panel therefore rejected your account in relation to this charge.

The panel also considered Patient E's body map and patient notes. The panel noted there was only one entry made at 18:54 on 28 September 2022, by "*GRACE*", which stated:

"Patient E refused her hand to be checked, she was resistive"

The panel was satisfied, having found that you were working a shift at the Home on 28 September 2022 and that this entry was made in your name, that you made this entry. The panel reminded itself of its earlier findings in relation to electronic records.

The panel was of the view that this entry adequately documented that Patient E refused her hand to be checked. However, the panel considered that there is an absence of any further entries in relation to following up with Patient E and checking their wound at a different time. The panel considered Witness 1's evidence that, if a patient refused, the nurse should try again at a different time. The panel took into

account that there were no further entries from you on the same day indicating that you attempted to recheck Patient E's wound, and that the next entry was dated two days later, on 30 September 2022. The panel determined that the absence of further entries recording either a wound check or an attempted wound check is indicative of you not following up after Patient E refused to have their wound checked at 18:54.

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

Charge 7b)ii)

"That you, a registered nurse:

7) On 28 September 2022:
    b) In respect of Patient E;
        ii. Failed to record that they required their wound to be checked."

This charge is found proved.

In reaching this decision, the panel took into account its findings in relation to charge 7a and 7b)i) above.

The panel considered Patient E's care plan, which outlined their treatment plan as:

"Monitor for pain, swelling or any other deviations"

The panel also considered Witness 1's evidence (as detailed above) in relation to the responsibilities of a nurse in Patient E's care, including when the patient resists. The panel heard that, in such circumstances, the nurse should return at a later time to assess the wound. If this was not possible, the nurse should detail the attempts and whether any action is needed to be taken by another nurse on a future shift. The panel was satisfied that the care plan, in conjunction with Witness 1's evidence, establishes a duty for you to record if Patient E's wound needed to be checked.

The panel had sight of the entry made by you, dated 28 September 2022, as detailed in charge 7b)i) above.

The panel took into account that this was the only entry made on this date. The panel considered that, whilst you detailed that Patient E resisted, you did not record that the wound needed to be checked by another nurse. The panel was therefore satisfied that you failed to do so.

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

Charge 7b)iii)

"That you, a registered nurse:

7) On 28 September 2022:
    b) In respect of Patient E;
        iii. Failed to handover that they had refused to have their wound checked."

This charge is found proved.

In reaching this decision, the panel took into account its decision in charges 7a, 7b)i) and 7b)ii) above.

The panel considered Witness 1's evidence, where he detailed that it is the responsibility of a nurse to handover that a patient has refused to have their wound check. He told the panel that this would be to keep the patient safe, as it would signal to the next nurse on shift that they should attempt to check the wound if possible. The panel was therefore satisfied that there was a duty on you to handover the information that Patient E has refused a wound check.

The panel took into account that the handover notes have not been made available to it in these proceedings.

The panel heard evidence from you that, because the wound was not dressed, there was nothing to follow up on. The panel found this inconsistent with Patient E's care plan, which stated, "*No dressing to be applied as it can cause skin tear*" and that the "*Treatment Plan*" required you to *"monitor for pain, swelling or any other deviations"*, irrespective of whether it was dressed.

However, the panel had sight of Witness 1's witness statement, which stated:

> *"We do audits on all wounds each month so this was how I saw that the wound had not been followed up. If a resident refuses then it should be reported to another nurse to check the resident again later as Grace was on the early shift that day … The resident had very thin skin and was known for having cuts and bruises on her hands so it needed to be monitored."*

The panel found that the error came to light as a result of Witness 1's monthly wounds audit, and the panel accepted Witness 1's evidence in that regard. Witness 1 also told the panel that there was no evidence before him to confirm that you did hand this information over to the next nurse.

The panel considered that a handover may be verbal or documentary at the Home, and it considered whether it was more likely than not that you gave a verbal handover instead. In this regard, the panel took into account that the next entry following your entry on 28 September 2022, the next entry was also made by you on 30 September 2022. The panel was of the view that, if you had done a handover to another nurse to review Patient E's wounds, then they would have done so sooner than 30 September 2022 (namely on the next shift). The panel considered that, in the absence of any documentation indicating that such a review took place, it is more likely than not that no other nurse reviewed Patient E's wound. The panel was satisfied that this was because you failed to handover that Patient E refused their wound check (and would consequently need to have their wound reviewed) to the next nurse.

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

Charge 8a)

"That you, a registered nurse:

8) On or about 2 October 2022 in respect of Patient F;
    a) Were unable to take their blood pressure."

This charge is found proved.

The panel next considered whether you were on shift on or about 2 October 2022. The panel had sight of the "*Nurses – September/October 2022*" rota. On this rota on Saturday, 1 October 2022, you appear to have worked an "*N*" shift. The panel heard evidence from you that this stood for an "*night*" shift, namely working from the evening (approximately 21:00) until the following morning.

The panel also considered the "*Roster/Work/Pay Hours*" document from the Home, indicating the hours any staff member was planned to work, alongside the hours they did work and were subsequently paid for. The panel considered that under the row "02/10/2022", you were planned to work between 21:00 to 07:30. However, the panel considered that the document indicated you were not paid for these hours.

The panel took into account that you accept that there was an occasion involving a 111 call.

The panel further considered an unknown patient's MAR chart, which indicated that you administered Mirtazapine to the patient at 21:32 on Saturday, 1 October 2022. Further, the panel also had sight of Patient T's MAR chart, which indicated that you administered Lansoprazole at 07:51 on Sunday, 2 October 2022. The panel noted that neither of these patients is relevant to this charge. However, the panel was satisfied that this information, taken into account alongside the rota, indicated that you more likely than not worked the night shift on 1 October 2022, which ended on 2 October 2022. The panel was satisfied that this is within "*on or about 2 October 2022*", as per the wording of the charge.

In reaching this decision, the panel took into account Witness 1's witness statement, which stated:

> *"On the 2 October 2022 Grace called 111 as she was unable to take Patient F's blood pressure reading. I can't remember who reported this to me. Sometimes these machines aren't reliable so we do have back up manual ones but 99% of the time the electronic machine does given an accurate reading. Grace had recorded in the resident's daily notes that she was unable to get a blood pressure reading so she called 111.*
>
> *…*
>
> *I asked Grace about this incident in the probationary meeting on the 11 October 2022 and she said that she couldn't get a reading on the electronic machine ... I asked Grace if the resident appeared clinically well as I was trying to understand why she called 111 and Grace said that she called them as she couldn't get a reading. The resident had a history of seizures so we were monitoring her blood pressure as it could go low. There is no documentation of what was discussed with 111. If Grace couldn't get a reading on the electronic machine then she should have tried repositioning the arm or using a manual machine. Grace knew that we had manual machines at The Home as we showed her during her induction and she knew how to use these as she had been a qualified nurse for 17 years. I've never known a nurse not to know how to use a manual blood pressure machine. If the resident was breathing and had a pulse, which she did, then she would have had a blood pressure reading. Grace should have known that it would be impossible to have a reading of 0 if the patient was alert and breathing. We know the patient was breathing as Grace recorded her saturation level as 94, her repository rate was 18 and her pulse was 105."*

The panel considered the probationary meeting notes, dated 11 October 2022, which stated:

- *" Leadership and Clinical oversight on shift.*

02/10 — Called 111 and unable to record blood pressure."

The panel considered that the probation notes were sufficiently contemporaneous and were dated less than two weeks following this incident. The panel was satisfied that Witness 1's witness statement and oral evidence were clear and consistent with this contemporaneous note.

The panel also had sight of Patient F's handover notes. On Sunday, 2 October 2022, two entries were made by "*GRACE*", one at 06:51 and the other at 07:22. The first entry stated:

"Pat F remains in isolation, vitals taken but blood pressure was not readable after several attempts, 111 informed, waiting a call back"

The entry at 07:22 stated:

"Pat F had a very high temperature and pulse during the night, 1 tablet of prn paracetamol given"

The panel bore in mind that you were working a night shift and would have likely concluded your shift by the next morning, at approximately 08:00.

The panel also considered that, in your oral evidence, you acknowledged that you failed to take Patient E's blood pressure and could not locate the manual blood pressure machine to take a blood pressure reading, which led to your call to 111 in the first place.

Taking all the above into account, the panel was satisfied that you failed to take Patient F's blood pressure.

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

Charge 8b)

"That you, a registered nurse:

8) On or about 2 October 2022 in respect of Patient F;
    b) Did not attempt to use the manual blood pressure machine."

This charge is found proved.

In reaching this decision, the panel took into account its findings in relation to charge 8a above, particularly in relation to Witness 1's evidence. The panel also took into account the probationary meeting notes, dated 11 October 2022, which stated:

> *"Grace was asked whilst she found it necessary to ring 111 when she was unable to take somebody's blood pressure, Grace stated that she had tried numerous times but couldn't get a reading, [Witness 1] asked if she tried to complete it manually but she said she didn't know how."*

The panel considered that Witness 1 detailed, in his oral evidence, that manual blood pressure machines were always available in the Home, and there were two in the medication room at the relevant time. The panel determined that Witness 1 is consistent with his account that manual blood pressure machines were at the Home, and the panel accepted that it was more likely than not that there were manual blood pressure machines in a care home. The panel placed weight on your induction notes, which indicated that you were shown the location of the manual blood pressure machines (sphygmomanometers) as part of your training.

The panel took into account that you said you could not find a manual blood pressure machine at the time, and consequently, you did not use a manual blood pressure machine. Having accepted Witness 1's evidence in relation to this and taking into account your evidence, the panel was satisfied that you did not attempt to use the manual blood pressure machine.

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

Charge 8c)

"That you, a registered nurse:

8) On or about 2 October 2022 in respect of Patient F;
    c) Contacted 111 unnecessarily without attempting to use the manual machine."

This charge is found proved.

In reaching this decision, the panel took into account its findings in relation to charge 8a and 8b above.

The panel determined that you accept that you contacted 111 following your inability to get a blood pressure reading (per charge 8a) and that you could not find the manual blood pressure machine (per charge 8b). The panel considered that the patient had a history of seizures and was having their blood pressure monitored. Within these circumstances, you admitted to calling 111.

The panel considered Witness 1's oral evidence, where he told the panel that he would never question a nurse calling 111 if they felt like they needed to and there was clinical justification to do so.

However, the panel considered the circumstances in relation to Patient F. The panel accepted Witness 1's evidence that the blood pressure machines were regularly checked and tested, and that in any event, manual blood pressure machines were available in the Home. The panel was of the view that the 111 call was unnecessary in the circumstances, given the manual blood pressure machines were available, albeit that you stated that you could not find any. The panel reminded itself that, as part of your training, you were shown the location of all the equipment in the Home. In these circumstances, the panel was satisfied that you did make the call to 111 unnecessarily, without attempting to use the manual blood pressure machine.

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

Charge 8d)

"That you, a registered nurse:

8) On or about 2 October 2022 in respect of Patient F;
    d) Failed to document your discussions with 111."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's evidence as well as the entries you made, as detailed above.

The panel also considered your account that you were awaiting a callback from 111, before concluding your shift.

Taking into account all of the information before it, the panel determined that you have sufficiently recorded that you contacted 111. The panel was of the view that, at this stage, no further information needed to be recorded, as no callback had yet been received from 111.

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

Charge 9

"That you, a registered nurse:

9) On 5 October 2022 in respect of Patient G failed to record on their MAR chart that their medication, Gabapentin and/or Diazepam, had been administered."

This charge is found proved.

In reaching this decision, the panel took into account its decision in charge 6 above, in relation to you working an early late shift on 5 October 2022. The panel was satisfied that you were on shift this day.

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

> *"On the 5 October 2022 Grace didn't sign that she had given Patient G's night medication which resulted in it being administered again by the night staff … This came to my attention when the night nurse reported it to me the following morning. The resident had capacity and she used to self-medicate but as her condition deteriorated physicalyl* [sic] *she preferred the nurses to give the medication. The resident liked to have all of her medication at night before she went to sleep at around 19:30-20:00. The normally routine is that the day staff are on shift until 21:00 and then the night staff take over. The resident always had her medication administered by the day staff. On this day Grace was on the day shift. Grace had given her her medication but it wasn't signed for on the electronic system. The resident knew she had had her medication with Grace but when the night staff came on shift it showed on the system that the medication hadn't been given so they administered it again. The resident said that she thought the doctor had changed the medication to an increased dose so she didn't question why it was being given again.*
>
> *…*
>
> *We reported this to safeguarding and it was a learning point for us. … We have since changed the system so that if any medication is down to be administered at 20:00 then it comes up in the night staff's tasks so it shouldn't come up on the system again that it was due at night and during the day. When administering the medication most of the medication boxes have bar codes on and in order to dispense them you have to scan it in on the electronic system or if they don't have a bar code you can click on the medication on the system. Once you had administered it you have to press that it had been given on the system. Grace either didn't log the medication into the system or she didn't press that she had administered it."*

The panel also heard oral evidence from Witness 1, who confirmed this account and told the panel that a stock count of the Diazepam and Gabapentin was done, which allowed him to reach the conclusion that you had administered the medication to Patient G, and had not recorded it. The panel was satisfied that Witness 1 is cogent and consistent in his account in relation to this charge.

The panel also had sight of the Safeguarding Notification to the Care Quality Commission ('CQC'), dated 12 October 2022, which stated:

> *"Resident takes her night time medications at 20.00hrs prior to going to bed. This consists of Gabapentin 100mg and Diazepam 2mg. These are administered by the day nurse … between 7-7:30pm … On 05.10.2022 resident was given her medications at the normal time by the day nurse. The day nurse omitted to sign the medications as being given. The Night nurse commenced shift at 21.00, she saw that the medications were showing as being due, they administered and dispensed and took them to the resident. She woke resident who took the tablets thinking that the Dr had increased the doses to help her sleep."*

The panel also considered the probationary meeting notes, dated 11 October 2022, which stated:

- *"Medication Management.*

05/10/2022 - Did not sign Patient G's night medications and this resulted in them being administered by the night staff. Resulting in medication error and safeguarding."

The panel also had sight of Patient G's MAR chart. The panel considered that, for Diazepam 2mg and Gabapentin 100mg, an entry was made at 22:26 and 22:34 respectively, both by the initials "*LR*". The panel was satisfied that, according to Witness 1's evidence, the CQC safeguarding notification and the rota, these are Ms 5's initials, who was the nurse working the night shift.

The panel additionally considered that your initials "*GO*" appear in Patient G's MAR charts, on 5 October 2022, at the following times and that the "*Users*" key indicated "*GO: Grace*":

- At 17:17, for the administration of Apixaban;
- At 17:17, for the administration of Evacal;
- At 17:18, for the administration of Ferrous fumarate;
- At 17:18, for the administration of Insulin isophane human;
- At 17:34, for the administration of Paracetamol; and
- At 17:19, for the administration of Pramipexole.

The panel also considered your oral evidence. You told the panel that you had initially forgotten to sign that you had administered Diazepam and Gabapentin to Patient G but later denied this account, suggesting that the electronic records had been altered. The panel reminded itself of its findings in relation to the reliability of the electronic records, per charge 1.

Taking into account all the above, the panel was satisfied that you, more likely than not, administered Diazepam and Gabapentin, and did not sign for it. The panel was satisfied that Patient G appeared to have received their other medication in accordance with their MAR chart at in and around 17:30 in the evening, with the exception of Diazepam and Gabapentin. The panel accepted Witness 1's evidence, namely that a stock count for both medications were conducted, which indicated that you had these administered these medications (alongside the other medications for Patient G), but that you had not signed for them on the MAR chart. In the absence of your initials on the MAR chart for both medications, the panel was satisfied that you had failed to record the administration of Diazepam and Gabapentin on Patient G's MAR chart.

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

Charge 10

"That you, a registered nurse:

10) On an unknown date wrongly identified a Covid test as negative."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, which stated:

"There were incidents involving Covid-19 testing and identifying positive tests. During Covid we had a resident that was positive at The Home and we were classed as an outbreak so we did regular testing following the correct procedures. There were two nurses working in the morning and one would go round to do the lateral flow tests or PCR's if we needed to submit these. On one occasion I met Grace in the corridor and I asked her how the testing was going and whether anyone had tested positive. She showed me a test that was positive but told me that the resident was negative. She said that the test had two lines but one was faint so that meant that it was negative. I told her that this was not the case and if there were two lines then it meant the test was positive and it didn't matter how bold the line was. We were two years into Covid at this point and we had been testing the residents regularly. The resident had just had Covid and was tested the day before and was negative so I thought maybe there was an issue with the test kits that Grace was using so I tested the resident myself and I used the same test kit that Grace did and I also tried two other kits in case the one she used was faulty. I did three tests and they all came back as negative so I don't know how Grace got a positive test as we both tested on the same day. I thought she had maybe got them mixed up with another resident but there was no documentation done so we had to start the testing from the beginning to see if something had gone wrong. I met with Grave after and we went through how she was taking the tests and I showed her how to do it and she was adamant that she was doing it properly. The only thing she said she was doing differently was instead of adding 2-3 drops of the fluid as instructed she said she was tipping all of it onto the test which isn't right. Because of this we then made sure that all of the other nurses were doing the tests correctly."

The panel also heard Witness 1's oral evidence. He told the panel that he remembered this incident "*quite clearly*" and outlined his concern for the resident being COVID-19 positive, as they would need to be isolated; he gave the panel an account which was consistent with his witness statement. It was put to him that he may have misremembered or misunderstood the situation, to which he responded that if your version of events was true, then it would have been a lot more information to remember, making it harder to forget. The panel was satisfied that Witness 1 was cogent and consistent in his evidence in relation to this charge.

The panel also had sight of the probationary meeting notes, dated 11 October 2022, which stated:

- *" Infection control management and COVID testing.*

Inability it identify positive Covid testing, and ..."

The panel was of the view that this sufficiently contemporaneous record was consistent with Witness 1's account.

The panel considered your oral evidence. You told the panel that you deny misidentifying a positive COVID-19 test, and that you brought the test to Witness 1 because you have identified a problem with the "*T line*" on the COVID-19 test. You told the panel that you informed Witness 1 that the sample was not reaching the "T line" as it should. You asserted that Witness 1 had misremembered the conversation, and that COVID-19 tests were, at times, faulty.

Taking all the above into account, the panel considered both your evidence and Witness 1's evidence. The panel was of the view that the two accounts sufficiently differ, and that it would be improbable that Witness 1 was fabricating the information in relation to this charge. The panel considered that Witness 1's evidence was supported by contemporaneous records from your probationary meeting notes, and this issue was brought up at the meeting with you. On the balance of probabilities, the panel concluded that it was more likely that you went to Witness 1 and misidentified a positive COVID-19 test as negative.

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

Charge 11

"That you, a registered nurse:

11) On an unknown date did not carry out the Covid testing procedure correctly."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, as referred to in charge 10 above.

The panel also heard oral evidence from Witness 1. He told the panel that you were tipping out all of the testing fluid into the COVID-19 test, instead of the 2-3 drops of fluids as per the procedure. When challenged about this incident in cross-examination, Witness 1 maintained his account. He told the panel that, due to his concern regarding potentially faulty COVID-19 tests, he asked you to demonstrate your COVID-19 testing procedures. The panel was satisfied that Witness 1 was clear and consistent in his evidence in relation to this charge.

The panel also had sight of the probationary meeting notes, dated 11 October 2022, which stated:

- *" Infection control management and COVID testing.*

[…] and not taking samples correctly."

The panel was of the view that this sufficiently contemporaneous record was consistent with Witness 1's account.

The panel considered your oral evidence. You told the panel that you deny not carrying out the testing procedures correctly, and that you know that only 2-3 drops of the testing fluid were needed for the COVID-19 tests.

Taking all the above into account, the panel accepted Witness 1's evidence. The panel placed weight on the evidence that the Home then took action to ensure that all nurses knew the proper testing procedures following this interaction between you and Witness 1, and that this was not targeted at you. The panel was of the view that Witness 1 would not have done so if you had demonstrated the correct COVID-19 testing procedures, and instead reached the conclusion that the test kits were faulty. On the balance of probabilities, the panel concluded that it was more likely than not that you did not carry out the COVID-19 test procedures properly.

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

Fitness to practise

The panel bore in mind that these charges brought by the NMC are "*and/or*" charges, in that any of the facts found proved may amount to misconduct, lack of competence or both.

The panel bore in mind that misconduct and lack of competence are distinct grounds and took care to not conflate the two when deciding whether a charge found proved amounted to misconduct or lack of competence. The panel noted that some charges found proved may amount to both. The panel determined to first consider whether the facts found proved amounted to misconduct before considering whether they amounted to a lack of competence.

The panel noted that its decision on current impairment must be considered in stages, namely it must consider whether the facts found proved amounted to misconduct and/or a lack of competence. If so, the panel must then consider whether your fitness to practise is currently impaired by way of your misconduct and/or lack of competence.

The panel considered both in turn below.

Misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct and impairment

Ms Khan invited the panel to take the view that the facts found proved amount to misconduct. She reminded the panel of the decision in *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".* She reminded the panel that not all lapses in practice would amount to misconduct, and that the panel should consider whether the facts found proved amounted to a significant departure from the standards expected of a registered nurse. She drew the panel's attention to the decision in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Khan submitted that the facts found proved demonstrated a pattern of your repeated failings in fundamental areas of nursing, which impacted vulnerable patients in the Home. She submitted that this occurred over multiple shifts, and involved several areas of nursing practice, including a failure to check patients' blood glucose levels, failure to check and escalate a high blood pressure reading as appropriate, medication errors, failure to escalate and the turning off of patients' PEG feed, poor communication and documentation practices, poor wound care management, and improper following of infection control procedures, in relation to COVID-19.

Ms Khan referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). She submitted that the facts found proved amounted to a breach of paragraphs 1.1, 1.4, 1.5, 6.1, 6.2, 10.1, 10.3, 13.1, 15.1, 16.1, 18.2, 19.1, 20.1, 20.2 and 20.4 of the Code.

Ms Khan submitted that these failings are serious and were not a one-off incident or a difficult shift. She submitted that these failings demonstrate a consistent pattern of unsafe, substandard patient care, involving fundamental elements of nursing practice. She further submitted that you had access to the care plans, clinical systems and support staff at the Home, and these failings still occurred despite a period of induction, supervision and support.

Ms Khan further submitted that, pursuant to *NMC v Thompson* [2005] EWHC 405 (QB), one-off errors may not reach the threshold for misconduct, but when the errors are repeated and impact patient safety, it might. She submitted that these failures do amount to misconduct, as your failings placed patients at the Home at avoidable risk of harm and undermined the public confidence in the nursing profession. She further submitted that these are serious departures from the standards expected of a registered nurse.

Ms Khan 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.

Ms Khan referred the panel to the four 'limbs' outlined in the decision of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council and (2) Grant* [2011] EWHC 927 (Admin) as well as the guidance before the panel per the decision in *R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin).*

Ms Khan submitted that the failings are serious, wide-ranging and remain unresolved. She submitted that, whilst you have provided training certificates to this panel, there is no evidence of a safe return to clinical practice, the completion of any structured retraining programme or an independent assessment of your safe clinical practice. She further submitted that these training certificates are not specific to the failings identified, and that the panel cannot be reassured that this demonstrates your safe clinical practice.

Ms Khan further submitted that, despite your reflective statement, your insight remains limited and theoretical. She submitted that you have failed to address the specific concerns that this panel has found proved, and that despite [PRIVATE], you nonetheless failed to escalate diabetic patients, per their care plans. Ms Khan further submitted that whilst the reflective piece expresses support for good record keeping, it lacked your reflection as to why your record-keeping practices were poor. She reminded the panel that insight goes beyond apologising, and the panel should consider the measures you have taken to ensure that your failings will not be repeated.

Ms Khan submitted that you have also failed to address the root cause of your failings. She acknowledged that you have engaged with these proceedings and have made some reflection into your failings. However, she submitted that there is insufficient evidence to demonstrate your clear insight into the gravity and seriousness of your failings and the cause of your conduct. Accordingly, she submitted that the panel could not be satisfied that the risk of repetition is low.
Ms Khan further submitted that your failings spanned essential and basic nursing duties and were breaches of fundamental tenets of the nursing profession. She submitted that, without compelling evidence of remediation, a lack of finding of impairment would undermine the public confidence in the nursing profession and the

NMC as its regulator, pursuant to the decision in *Yeong v General Medical Council* [2009] EWHC 1923 (Admin). She submitted that a finding of impairment is necessary on both public protection and public interest grounds, and she invited the panel to do so.

Ms Flanagan submitted that the threshold for misconduct has not been met in this case, and she invited the panel to consider whether it wishes to consider if any of the facts found proved amounted to a lack of competence instead. She reminded the panel that the amendment to incorporate a lack of competence was made to the charges at the later stages of these proceedings, and she submitted that this may be indicative of the relevance of a lack of competence consideration.

Submissions on lack of competence and impairment

Ms Khan reminded the panel that lack of competence is a separate, though overlapping, consideration before this panel in light of its decision on facts. She invited the panel to consider whether there is a persistent underperformance across a representative sample of your work, and whether you are able to safely and effectively fulfil the role of a registered nurse. She referred the panel to the decision in *R (on the application of Dad) v GMC* [2010] EWHC 3053 (Admin), where the court stated that lack of competence means "*a standard of professional performance which is unacceptably low and which has been demonstrated by reference to a fair sample of the practitioner's work*."

Ms Khan submitted that the evidence before this panel is a fair representation of your work over a sustained period of time, namely between August to October 2022. She submitted that, in this time, you were responsible for a wide range of tasks across several fundamental areas of nursing practice. She submitted that these were not complex, specialist functions, and were instead routine responsibilities expected of a registered nurse.

Ms Khan drew the panel's attention to paragraphs 6.1, 6.2, 10.1, 13.1, 19.1 and 20.1 of the Code, and she submitted that these paragraphs are engaged in this case.

Ms Khan further submitted that the facts found proved demonstrate a consistently poor standard of practice, despite your wealth of experience as a registered nurse and the training you received from the Home. By way of example, in relation to charges 1 and 6, Ms Khan submitted that you failed to monitor the patients' blood glucose levels over multiple shifts, despite this being stated in their care plan. She further drew the panel's attention to your failure to record or escalate a patient's high blood pressure reading, despite Witness 1 confirming that escalation is basic accepted practice in these circumstances.

Ms Khan submitted that your actions demonstrated a lack of both practical nursing skill and clinical judgment. She submitted that your use of electronic systems was consistently poor, despite record keeping being a fundamental element of day-to-day practice, and despite other staff members not experiencing the technical issues you reported. She submitted that none of these failures occurred in isolation or in the context of inadequate support. She reminded the panel that you completed a two-week induction programme and benefited from a shadowing period, and that you had access to the relevant policies and procedures at the Home. She further submitted that you had completed your online modules. Ms Khan submitted that, despite this, the concerns began almost immediately at the Home, and there did not appear to be any sustained improvement in your performance during that time period.

Ms Khan further submitted that, in the absence of sufficient remediation or evidence of safe practice, the panel could not be assured that your previous poor practice has been addressed. She reminded the panel that sufficient remediation must be more than theoretical reflection and should include real-life considerations. She submitted that you have not engaged with the seriousness of your own failings, and there remains a risk of repetition.

Ms Khan submitted that, when your performance has consistently been substandard despite the support you have received, a finding of lack of competence is necessary in these circumstances.

In response to a question asked by the panel as to which of the facts found proved amounted to misconduct, which amounted to lack of competence and if any

amounted to both, Ms Khan indicated that charge 1 amounted to both misconduct and lack of competence, charge 2 amounted to misconduct, charge 3 amounted to lack of competence, charge 4 amounted to lack of competence, charge 5 amounted to lack of competence, charge 6 amounted to both, charge 7 amounted to misconduct, charge 8 amounted to lack of competence, charge 9 amounted to both, and charges 10 and 11 amounted to misconduct. She reminded the panel that this is a matter for the panel's professional judgement.

The panel reminded itself of Ms Flanagan's submissions on misconduct, as detailed above.

Ms Flanagan reminded the panel that breaches of the Code do not automatically lead to a finding of misconduct or lack of competence. She submitted that there is nothing to suggest that you were anything but a hardworking nurse, and no patients were harmed by your actions or omissions.

Ms Flanagan invited the panel to consider the circumstances you were facing at the time. She submitted that this concerned a five-week period in the context of a 16-year unblemished career as a registered nurse, and the charges predominantly related to the Home's electronic systems which you had difficulty with. Ms Flanagan submitted that you raised these difficulties at the time with Witness 1, but no further formal training in relation to the electronic systems were given to you.

Ms Flanagan further submitted that the issues tended to arise towards the end of you working a long shift, where you were more likely to be tired. She submitted that the Home, pursuant to Witness 1's evidence, was moving towards having two nurses on a day shift due to an increase in patient numbers, which it had not yet achieved at the time you were working there. She submitted that you were working long hours in an understaffed environment.

In relation to your training, Ms Flanagan submitted that following your basic training and a period of supervision, you received no further training in relation to the issues you raised. She drew the panel's attention to the working practices at the Home, citing charges 1 and 5b, whereby other nurses acted in a similar way to you.

However, you were the only person to be reprimanded for the Home's poor working practices.

Ms Flanagan submitted that the issues raised at the probationary meeting, dated 11 October 2022, took you by surprise. She submitted that you were a hardworking nurse working within an environment which was busy and where other staff members did not work to the standards expected of them.

Ms Flanagan further submitted that you did not have a dangerous attitude towards patient safety, as evidenced by you calling 111 when you were unable to obtain a blood pressure reading. She submitted that these incidents occurred within a short period in a difficult working environment and should be taken in context of your years of unblemished nursing practice.

In relation to whether your fitness to practise is currently impaired, Ms Flanagan reminded the panel that you have no previous regulatory history with the NMC since you entered into the register in 2007. She submitted that your fitness to practise is not currently impaired, and you would not put patients at risk of unwarranted harm.

Ms Flanagan submitted that it has been a few years since the events at the Home and you have since been able to demonstrate you can work safely, kindly and professionally in a clinical environment, both as a nurse and as a healthcare assistant. She submitted that you have strengthened your practice, and outlined your employment history. She told the panel that you worked as a registered nurse at [PRIVATE] NHS Foundation Trust from April 2023 to March 2024, that you then had a period of unemployment and that you are currently working as a healthcare assistant (via an agency) at [PRIVATE], a role you started on 12 February 2025. She submitted that there have been no concerns in relation to your work, and that your employers were satisfied that you pay attention to detail in all areas of work allocated to her. She submitted that you have also taken the time to observe registered nurses in your role to strengthen your practice.

Ms Flanagan submitted that you have also undertaken further training in the relevant areas of clinical practice. She submitted that you have completed mandatory

training, as part of your current role, in diabetes awareness, fluids nutrition, infection prevention and control, as well as training on wounds, specifically, sepsis awareness.

Ms Flanagan drew the panel's attention to your curriculum vitae ('CV') and the testimonials received from your colleagues. She submitted that your colleagues at [PRIVATE] NHS Foundation Trust were aware of the charges you faced and had a ward meeting and discussion in relation to this. She also submitted that you discussed your charges with your colleagues who had written a testimonial for you, and that these are written with that knowledge.

Ms Flanagan also submitted that you have completed four of the six training sessions on Excel, to help strengthen your knowledge.

Ms Flanagan submitted that you have had two periods of employment since the Home with no issue, which demonstrates that you can work kindly, safely and professionally. She submitted that you have reflected on all the issues identified in your reflective piece, and you show insight into the charges found proved against you. She submitted that you are a caring and devoted practitioner, and that the evidence before this panel indicates that it is highly unlikely that the conduct would be repeated. She submitted that the risk to patients is low, and that the Home was an isolated, short period of time whereby you were working long shifts in a poorly run care home. She further submitted that, given the passage of time, you have since demonstrated safe clinical practice. She invited the panel to find that your fitness to practise is not currently impaired.

In response to questions asked by the panel, Ms Flanagan confirmed you were working on an acute psychiatric ward at [PRIVATE] NHS Foundation Trust, but you were dealing with other health issues suffered by the patients on the ward, such as diabetes and medication administration. She further confirmed that, where it stated in your CV that you were working as a lead nurse, you were working alongside a Band 6 nurse, and you were directly supervised in respect of medication administration. She submitted that you have been assessed, and passed, on medication administration, but you have not received your certificate. She confirmed that you

also engage in blood monitoring or taking blood pressure readings with patients. At the time, you were employed by [PRIVATE] NHS Foundation Trust directly, and you worked full-time (37.5 hours a week). She clarified the time and nature of further roles between February 2020 until now, as detailed in your CV.

Ms Flanagan outlined your current role at [PRIVATE], whereby you work three or four long shifts a week but, prior to these proceedings, you undertook a week of short days. She told the panel that your role encompasses work common for healthcare assistants, such as monitoring patients' care and nutrition and managing patients' blood pressure.

In relation to your expired training certificate on safe medications, you told the panel that you undertook another course as part of your mandatory training for your current role on 27 September 2024. This course encompassed, amongst other things, training on medication management.

The panel accepted the advice of the legal assessor, who referred the panel to the NMC Guidance on both misconduct (FTP-2a) and lack of competence (FTP-2b).

Decision and reasons on misconduct

In reaching its decision, the panel had regard to the definition of misconduct, as outlined in the case of *Roylance.* The Panel had regard to Lord Clyde's speech where he defined misconduct as:

> *"…..a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by [medical] practitioner In the particular circumstances."*

The panel considered whether there had been a departure from the standards expected of you in the particular circumstances. The panel next had regard to the terms of the Code. The panel was of the view that your actions did fall short of the

standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

8.6 share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

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 … harm and the effect of harm if it takes place.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It was not enough for there to be a falling short. In order for there to be misconduct there had to be a serious falling short or a significant departure from the standards expected.

The panel considered whether each of the charges and sub charges found proved amounted to misconduct.

The panel made its findings below.

Charges 1 and 6

The panel was satisfied that both charges are sufficiently similar and can be considered together. The panel took into account that these charges involved highly vulnerable patients who lived in the Home, and your failure to check or record the patients' blood sugar levels in accordance with their care plan. The panel determined that the failure to follow a patient's care plan – particularly when they are highly vulnerable – was a significant departure from the standards expected of a registered nurse.

Accordingly, the panel found that this amounted to misconduct.

Charge 2

The panel considered that this charge involved your failure to document handover notes in respect of patients within the Home. The panel took into account that handovers are essential in the maintenance of patient safety, as it outlines the necessary information (and any follow up tasks) to other nurses following your shift. The panel determined that the failure to work co-operatively with other colleagues in the Home and communicate information essential to patient care – particularly when patients are highly vulnerable – was a significant departure from the standards expected of a registered nurse.

Accordingly, the panel found that this amounted to misconduct.

Charge 3

The panel considered Witness 1's evidence that Patient A was at risk of suffering from a stroke, and that their blood pressure was monitored to prevent this from happening. The panel also heard that a blood pressure reading of 177/144 was high,

and intervention would have been necessary.

The panel determined that your failure to monitor, escalate or handover any information in respect of Patient A's high blood pressure reading falls significantly short of the standards expected of a registered nurse in these circumstances. The panel was of the view that these were basic and essential tasks outlined in Patient A's care plan. Accordingly, the panel found that this amounted to misconduct.

Charges 4b/4c

The panel considered that Patient B did not receive their medication as a result of your failure to record their medication onto the electronic system. The panel acknowledged that, based on Witness 1's evidence, in this particular case, this would have caused limited harm to Patient B. However, the panel was of the view that missed medication inherently carries a risk of harm.

The panel further considered Witness 1's evidence. The panel determined that there was a clear requirement for you to record Patient B's medication, and you failed to do so or raise the issue with other colleagues. The panel found that this was a significant departure from the standards expected of a registered nurse, as you failed to adhere to the Home's procedures, leading to Patient B missing their medication for one evening. Accordingly, the panel found that this amounted to misconduct.

Charge 5a/7a

The panel was satisfied that both charges are sufficiently similar and can be considered together. In relation to charge 5a, the panel considered that you turned off the PEG feed machine, and did not change the feeding tube or escalate that the feed had occluded to another colleague. The panel reminded itself of its findings that, at this stage, you were involved in Patient C's care on at least three occasions on that day.

The panel also considered Witness 2's evidence that this led to Patient C not receiving feed until lunchtime. The panel determined that your failure to change the

feeding tube or escalate the matter fell short of the standards expected of a registered nurse, as it led to Patient C not receiving the feed they needed for several hours.

In relation to charge 7a, the panel determined that to turn off a PEG feed and take no remedial action before the feed has completed was a significant departure from the standards expected of a registered nurse. The panel considered that this would have led to Patient C receiving less feed than they should have.

Accordingly, the panel found that your actions in charges 5a and 7a amounted to misconduct.

Charge 5b

The panel considered Witness 2's evidence that to keep a patient's wound review open on the electronic system was good clinical practice, particularly as the wound could recur. The panel noted Witness 1's evidence that the wound review should be closed on the electronic system.

The panel also considered the thoroughness of all of the Home's electronic systems, and the common practices at the Home in relation to wound management.

Taking all of the above into account, the panel was satisfied that you acted as a reasonable registered nurse would have acted, in light of Witness 2's evidence and the apparent practices at the Home. The panel determined that your actions in relation to this charge did not amount to misconduct.

Charge 7b

The panel was satisfied that, pursuant to Witness 1's evidence, you should have followed up at a later time, based on the Home's procedures. The panel found that you failed to follow up after Patient E refused to have their wound checked. The panel determined that your failure to follow clearly documented procedures on wound management fell below the standards expected of a registered nurse.

The panel considered that this charge also involved your failure to document relevant information in relation to Patient E's refusal in your handover notes. The panel took into account that handovers are essential in the maintenance of patient safety, as it outlines the necessary information, and, in this scenario, follow up tasks to other nurses following your shift. It noted that the next review on Patient E's wound was not until two days later. The panel determined that the failure to work co-operatively with other colleagues in the Home and communicate information essential to patient care – particularly when patients are highly vulnerable – was a significant departure from the standards expected of a registered nurse.

Taking all the above into account, the panel found that your actions amounted to misconduct.

Charge 8

The panel considered your evidence that you were a registered nurse with 16 years' experience, and that you were fully competent to take blood pressure reading. Despite this, you failed to do so. The panel determined that, given your experience as a registered nurse, you should have been able to obtain a blood pressure reading. The panel also considered that, based on its findings that the manual blood pressure machines were in the Home at the relevant time, your inability to locate and subsequently use the machines, despite this having been covered in your induction training at the Home, fell short of the standards expected of a registered nurse.

The panel acknowledged that you rang 111 due to your inability to take a blood pressure reading and following your failure to locate and use a manual blood pressure machine.

Taking all the above into account, the panel found that your actions amounted to misconduct.

Charge 9

The panel considered that the administration of Diazepam and Gabapentin twice to Patient G carried a risk of harm to the patient. The panel acknowledged that, based on the information before it, no actual harm came to Patient G as a result of the double administration of the medication.

However, the panel considered that medication administration is a fundamental aspect of nursing practice. It consequently determined that your failure to record the administration of Diazepam and Gabapentin to Patient G was a significant departure from the standards expected of a registered nurse. Accordingly, the panel was satisfied that this amounted to misconduct.

Charge 10

The panel considered that, by 2022, two years had passed since the beginning of the COVID-19 pandemic. The panel was of the view that, at this stage, registered nurses should be able to identify that two lines on a COVID-19 test – even faded lines – are indicative of a positive test result, rather than negative. The panel determined that you, as a registered nurse working throughout the COVID-19 pandemic, should have known this.

Notwithstanding this, the panel considered that you brought the COVID-19 test to Witness 1's attention to seek clarity and advice. The panel determined that, whilst you should have known that two lines were indicative of a positive test, your approach to Witness 1 and your acceptance of his advice do not amount to misconduct. The panel was also satisfied that this appeared to be an isolated incident, and that you corrected your COVID-19 testing procedure upon Witness 1's advice.

Therefore, the panel determined that your actions in relation to this charge did not amount to misconduct.

Charge 11

The panel took into account that, akin to its findings in relation to charge 10 above,

this incident occurred nearly two years from the advent of the COVID-19 pandemic. The panel was of the view that your lack of knowledge in relation to the Home's correct COVID-19 testing procedure was indicative of your poor clinical practice.

However, the panel considered that, even by your own account, you brought the patient's COVID-19 test to Witness 1 to seek additional clarification and advice. The panel considered that you followed Witness 1's advice on this occasion, and you accepted the change to your testing procedure as recommended by the Home. The panel was therefore not satisfied that your actions in relation to this charge amounted to misconduct.

The panel noted that, for the charges found proved in which it did not find amounted to misconduct, it is open for it to find those charges amounted to a lack of competence only. This was considered separately.

Lack of Competence

Having reached its determination on misconduct, the panel then moved on to consider whether those facts it found proved amount to a lack of competence.

The panel bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

Decision and reasons on lack of competence

The NMC has defined a lack of competence as:

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

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonably competent registered nurse of equal grade or employment and not by any higher or more demanding standard.

The panel accepted the definition set out in the case of *R (on the application of Dad) v GMC* [2010] EWHC 3053 (Admin), where the court stated that lack of competence means "*a standard of professional performance which is unacceptably low and which has been demonstrated by reference to a fair sample of the practitioner's work*."

As with misconduct it was not enough for there to be a departure from the standards expected of a registered nurse.

The panel considered that although the charges of misconduct and charges of lack of competence were framed as an 'and / or', the panel did not consider it appropriate to determine whether the misconduct charges also involved a lack of competence. Misconduct is a far more serious charge than lack of competence as it can result in a striking-off order. This order is not available in respect of lack of competence charges. It is unusual for the NMC to frame charges in respect of both of these gateways to impairment as an alternative. The panel did not consider the misconduct charges to also involve a demonstration of lack of competence.

The panel considered each of the charges found proved, which it found did not amount to misconduct (as above) in turn.

Charge 5b

The panel considered Witness 2's evidence that to keep a patient's wound review open on the electronic system was good clinical practice, albeit it noted Witness 1's evidence that the wound review should be closed on the electronic system. Notwithstanding this, the panel determined that this was a single incident of you not closing the patient's wound review on the electronic system and not subsequently updating their treatment plan. Accordingly, the panel was not satisfied that this charge, on its own could amount to a lack of competence.

Charge 10

The panel had regard to the timing of this charge, namely that this was nearly two years into the COVID-19 pandemic. However, the panel determined that this was a single instance of you misidentifying a COVID-19 test as negative. Accordingly, it was not satisfied that it was a fair representation of your work, and it found that this, alone, does not amount to a lack of competence.

Charge 11

The panel considered that, following Witness 1's advice on the proper procedures to conduct COVID-19 testing, you proceeded to follow the advice. The panel has no evidence of any further issues in relation to this within your clinical practice. Accordingly, the panel determined that this was a single incident whereby you had the incorrect procedure, which was subsequently corrected by the Home. The panel was not satisfied that this charge, on its own, amounted to a lack of competence.

The panel then considered whether your actions, as a whole, amounted to lack of competence. The panel had regard to the NMC Guidance on lack of competence and considered whether your conduct was a fair sample of your work as a registered nurse, and whether you have demonstrated clinical practice which was at "*an unacceptably low standard*". The panel noted that the charges spanned several areas of nursing practice.

However, the panel considered that these charges spanned a 56-day period of between August 2022 and October 2022, where you worked 27 shifts. The panel reminded itself of its findings on facts, in which it found that 8 of those shifts were induction or training days. The panel therefore found that these charges arose over 19 shifts. The panel further considered this in context of your 16-year nursing career with no previous fitness to practise history before the NMC. The panel took into account that you worked at the Home for a relatively short period of time, and none of the concerns were brought to your attention prior to the probationary meeting on 11 October 2022.

Taking all the above into account, the panel determined that, for the purposes of considering 'Lack of Competence', your performance at the Home was not a fair sample of your clinical practice in light of your long nursing career. Accordingly, it was not satisfied that this amounted to a lack of competence.

Given the panel's decision, the panel has not moved on to consider whether your fitness to practise is currently impaired by way of your lack of competence.

Decision and reasons on impairment

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

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

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

In this regard the panel considered the test approved by Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision at paragraph 76:

> *'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) ….'

Taking the above limbs in turn, the panel was satisfied that patients were put at risk of harm as a result of your misconduct. The panel considered that these charges encompassed failure to adhere to care plans, take necessary readings (both blood sugar and blood pressure), escalate or follow up patients, your poor infection control procedures as well as your poor documentation, both in relation to patient handovers as well as medication management. The panel acknowledged that there is no evidence before it of actual harm coming to any of the patients, but it was satisfied that patients were placed at unwarranted risk of harm as a result of your actions or omissions. Further, the panel determined that your misconduct had breached the fundamental tenets of the nursing profession, namely the provision of safe and effective care to patients as well as communication with your colleagues and therefore brought its reputation into disrepute.

It was satisfied that limb (d) is not engaged in this case.

The panel considered that impairment is a forward-looking exercise, and it next considered whether you are liable, in the future, to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. In reaching its decision, the panel also considered the principles derived from *Cohen,* namely:

- Whether the concern is easily remediable;
- Whether it has in fact been remedied; and

- Whether it is highly unlikely to be repeated.

On whether the concerns are remediable, the panel took into account the NMC Guidance, "*Can the concern be addressed?"* (FTP-15a). The guidance stated:

> *"Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*
>
> - *medication administration errors*
> - *poor record keeping*
> - *failings in a discrete and easily identifiable area of clinical practice*
> - *…"*

The panel considered that, whilst your misconduct spanned several areas of fundamental nursing practice, these areas are clinical in nature. The panel took into account that these occurred within just the Home (in context of your 16 years' nursing experience). The panel was therefore satisfied that the concerns may be remediable through robust training and supervision.

On whether you have remedied the concerns, the panel took into account the NMC Guidance "*Has the concern been addressed?"* (FTP-15b). On assessing insight, the guidance stated:

> *"Decision makers must always consider each case on its own facts and circumstances. However, the following factors will be useful when considering whether the evidence of insight is sufficient to address the concerns in the case.*
>
> - *…*
> - *…*
> - *…*
> - *…*
> - *…*
> - *…*
> - *Does the nurse, midwife or nursing associate acknowledge:*
>   - *any harm or risk of harm, to patients?*

- *any damage to public confidence in the professions?*
- *how far their conduct or practice fell short of professional standards?*
- *their own responsibility for the problem, without seeking to blame others or excuse their actions?"*

The panel considered your reflective piece. The panel took into account that you have considered each of the areas of concern – namely diabetes monitoring, documentation, monitoring blood pressure, feeding tubes, wound management, medicines management and COVID-19 testing – in your reflective piece. The panel considered that the piece comprised of a generic, academic commentary on the clinical importance of each of these identified areas, but it determined that it lacked reflection on your specific conduct. The panel was of the view that the reflective piece did not comment on your recognition of your wrongdoing, the impact of your misconduct on patients, colleagues, families of patients and the wider nursing profession or any apology on your part. The panel found that you have demonstrated limited meaningful insight into your wrongdoing.

The panel also considered whether you have undertaken any training or strengthening of your practice since the incidents. The panel considered the NMC guidance, which stated:

"Key considerations for decision makers in assessing the steps taken by a nurse, midwife or nursing associate to address concerns in their practice will be whether the steps taken are:

- *relevant, in that they are directly linked to the nature of the concerns*
- *measurable (for example, where the nurse, midwife or nursing associate says they have been on a training course, information should be provided to help the decision maker understand the scope of the course, the topics covered and the results of any assessments)*
- *effective, addressing the concerns and clearly demonstrating that past failings have been objectively understood, appreciated and tackled."*

The panel had sight of the training certificates you have provided. The panel

considered that you have undertaken a small amount of relevant training, such as the IT (Digital Training) you undertook in November 2024 and the training in Excel in January 2025. The panel considered that you are attempting to improve your IT competence, and it was of the view that this is relevant training which is directly linked to the charges.

However, the panel also determined that most of the training you have undertaken was not directly linked to the concerns, with the exception of training undertaken in relation to medication management. The panel took into account that the training you have undertaken is more generic (and some form part of the mandatory training for your current role), which may include areas of concern, but are not specifically targeted to the areas of concerns identified. The panel was not satisfied that you have sufficiently retrained in the specific areas of concern.

The panel determined that, in any event, it has no evidence before it of the training being applied in a clinical setting. The panel did not have sight of a sustained period of supervised, safe practice.

The panel also had sight of the testimonials from your colleagues. The panel acknowledged that you are presently working in a healthcare setting, and that some of the testimonials are from your colleagues who work alongside you. The panel also heard, from Ms Flanagan, that all of the authors of these testimonials were aware of the charges against you and that these had been discussed openly at a team meeting. The panel acknowledged that these testimonials were positive and commented on your clinical skills and patient care. However, the panel considered that the testimonials are of limited value to this panel. The panel, in assessing the testimonials, took into account NMC Guidance FtP-15b. The panel considered that the testimonials provided relating to your nursing practice did not follow the guidance in that: they were not on official foundation trust headed paper; some were not dated or signed; they did not appear to directly address all of the charges found proved; and it was not clear how long the individuals had worked with you and in what capacity in terms of your official line management chain. The panel took into account that there is no evidence before it of any independent competency assessment as part of your current role, or any other formal indicator of your clinical proficiency.

Taking all of the above into account, the panel was of the view that, whilst you have taken limited steps to remediate the concerns, you have not sufficiently remediated to alleviate the risk posed to the wider public. The panel determined that, at this stage, you have shown limited meaningful insight, and there is no evidence before it of sustained safe practice in respect of the charges found proved.

The panel next considered whether the conduct is highly unlikely to be repeated. It took into account the NMC Guidance, "*Is it highly unlikely that the conduct will be repeated?"* (FTP-15c). The guidance stated:

> *"Decision makers will consider whether the nurse, midwife or nursing associate is likely to repeat the conduct that caused the concerns. When doing this, they should take into account whether the nurse, midwife or nursing associate has been practising in a similar environment to where the conduct took place. If they have, and have therefore been exposed to occasions when there was a risk of past conduct being repeated, then the absence of repetition will be significant. If they have not been practising in a similar environment (whether because restrictions have been placed on their practice or for any other reason), the absence of repetition will be of little or no relevance.*
>
> *Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:*
>
> - *The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.*
> - *…*
> - *…*
> - *…"*

The panel took into account that your misconduct generally occurred whilst you were working the early-late shifts (circa 14-hour shifts). Whilst the panel acknowledged that you are currently working in a healthcare setting, it was not satisfied that you

have demonstrated how you would respond if you were working in a similar environment to the Home, such as working under pressure or long hours.

Further, the panel determined that you have not fully addressed your shortcomings. The panel considered that you have shown limited meaningful insight in relation to your specific actions and its impact on patients, colleagues and the wider public (as outlined above). The panel also considered that, whilst you have undertaken some training, there is insufficient evidence of any targeted training addressing the specific areas of concern, or any independent or supervised assessment of your competencies in relation to these areas.

Taking all of the above into account, the panel was not satisfied that it is highly unlikely that the conduct would be repeated. The panel was of the view that you have not fully remediated, and there is a high risk of repetition.

Based on the above, the panel determined that you are liable, in the future, to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. Accordingly, the panel determined that a finding of impairment is necessary on the grounds of public protection.

Further, the panel bore in mind that the overarching objectives of the NMC, namely 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 public confidence in the profession would be undermined if a finding of impairment were not made in this case, particularly given that your misconduct was wide-ranging and concerned basic, fundamental areas within nursing practice. The panel was of the view that a reasonable member of the public would be concerned to learn a finding of impairment is not made for a registered nurse who placed highly vulnerable patients within a nursing home at unwarranted

risk of harm as a result of their misconduct. Accordingly, the panel also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired by way of your misconduct on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months with review. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr Kennedy informed the panel that in the Notice of Hearing, dated 5 April 2024, the NMC had advised you that it would seek the imposition of a Conditions of practice order for a period of 12 months with review if it found your fitness to practise currently impaired.

Mr Kennedy submitted that when considering the sanction, the panel must balance the interest of the registrant against the need to protect the public and satisfy the wider public interest. He invited the panel to consider the least restrictive sanction that would satisfy the public protection and the wider public interest.

Mr Kennedy outlined the aggravating features of the case:

- The panel found limited insight.

- The concerns are wide ranging.
- There is a pattern of behaviour which developed over time.
- Whilst there was no actual harm, there was potential for harm
- There has been no remediation or strengthened practice.

Mr Kennedy outlined the mitigating features of the case:

- There is full engagement with the NMC.
- There have been no previous referrals.

Mr Kennedy addressed the sanctions available to the panel. In taking no further action, he referred the panel to the NMC Guidance on *"no further action"* (SAN-3a) and submitted that taking no action would not be appropriate.

Mr Kennedy next referred the panel to the NMC Guidance on *"Caution Order"* (SAN-3b) and submitted that imposing a caution order would not be appropriate as it would not be in the public interest nor mark the seriousness of your behaviour. He submitted that a caution order would be insufficient to maintain the high standards within the profession or the trust that the public placed in the profession. Furthermore, he submitted that the behaviour in this case is not at the lower end of the spectrum and therefore a caution order would not be appropriate.

Mr Kennedy referred the panel to the NMC Guidance on *"Conditions of Practice Order"* (SAN-3c) and informed the panel that according to the guidance, conditions of practice order may be appropriate when some or all of a number of factors are apparent.

- No evidence of harmful deep-seated personality or attitudinal problems
- Identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining
- No evidence of general incompetence
- Potential and willingness to respond positively to retraining
- Patients will not be put in danger either directly or indirectly as a result of the conditions.

- The conditions will protect patients during the period they are in force.
- Conditions can be created that can be monitored and assessed.

Mr Kennedy submitted that, whilst at the local level you blamed the computer system and did not take responsibility, it cannot be said at this stage that you displayed deep-seated attitudinal issues, albeit you showed a lack of insight and remorse. In terms of willingness to adhere to conditions, you were subject to an interim conditions of practice order and have indicated a willingness or potential willingness to comply with conditions of practice order.

Mr Kennedy proposed the following conditions that would address the risk to the public, satisfy the wider public interest and reflect the seriousness of the concerns:

1) You must restrict your employment to a single substantive employer. If an agency, placements should be for a minimum of 3 months.
2) You must not be a nurse in charge of a shift or the sole nurse on duty.
3) You must be directly supervised for medication administration until deemed competent. Evidence of this must be sent to the NMC.
4) You must work with your line manager to create a Professional Development Plan (PDP) to address performance in the following areas:
    a. Clinical observations and assessment
    b. Escalation
    c. Record keeping
    d. PEG feeds
    e. Collaborative working
5) You must have regular meetings to discuss performance in the areas outlined above.
6) Submit a report on performance from your line manager to a future reviewing panel.

Mr Kennedy submitted that, whilst the NMC makes no bid for a suspension order or a striking-off order, this option remains open to the panel if it deems this to be appropriate and proportionate.

In response to panel questions, Mr Kennedy informed the panel that you were initially subject to an interim conditions of practice order but this was replaced with an interim suspension order at some point. Mr Kennedy invited Ms Flanagan to provide her understanding of the history of the interim order against your practice.

Ms Flanagan submitted that you were subject to an interim conditions of practice order, however this was replaced with an interim suspension order in March 2024. She outlined to the panel that you were going through a difficult period due to [PRIVATE] and the [PRIVATE] at the time at the [PRIVATE] NHS Foundation Trust. You were informed about the interim order review around the same time. The RCN provided a letter to you on the day of the actual interim order review hearing, however since your substantive hearing was due to take place imminently, you took no issue with the interim suspension order. Ms Flanagan submitted that the lack of report in respect of interim conditions of practice 5 and 6 may have been due to the [PRIVATE].

Ms Flanagan moved onto her submissions. She submitted that you acknowledged that it is appropriate and proportionate to have some restrictions on your practice for a period of time given the charges found proved. You have taken steps to reflect on the panel's decision and reasons during the course of this hearing. You acknowledged that your nursing skills may not be up-to-date as you have not been working as a nurse for around a year, albeit you have been working at [PRIVATE] as a Healthcare Assistant (HCA).

Ms Flanagan submitted that you are grateful that the panel recognised within its determination that the issues arose during 19 shifts which is set against an unblemished career amounting to 16 years with no disciplinary findings or complaints about your nursing practice.

Ms Flanagan reminded the panel that those shifts came within a period of five weeks, during which point you were fairly new to the Home. She submitted that the panel may feel that, having worked for so many years without issue, it may well be that you lacked appropriate training whilst at the Home, and you needed more support than what you had at the time. Ms Flanagan further submitted that there may

have been an element of mixed messages in terms of what the night staff are allowed to do as opposed to the expectations of the day staff.

Ms Flanagan submitted that the misconduct is that of a clinical nature, and having noted the panel's decision, it is one that is capable of being remedied. Ms Flanagan submitted that you are developing insight, although, not yet developed at the stage the panel may expect, but you have now taken the time to take a step back from these proceedings and look objectively at what went wrong and your role in it. Ms Flanagan submitted that you understand and acknowledge that what you did was wrong and that is why you accepted that you cannot return to nursing without restrictions and to ensure that similar problems do not arise in the future.

Ms Flanagan submitted that you accept that a period of restricted nursing practice is appropriate and within this time, that you are supervised. This will allow you to prove that your practice is safe and competent by working within a personal action plan or development plan, and have that report submitted to ensure confidence that patients are safe, that you are not offending the public interest in any way and that you can practice competently as a nurse as you did for 16 years. Ms Flanagan submitted that there is no suggestion throughout this case that anyone has said that you were anything other than a hard-working nurse.

Ms Flanagan submitted that in terms of steps going forward, you acknowledge that the panel found that the work you have undertaken is insufficient at the moment but you endeavour to take further training including training in IT.

Ms Flanagan informed the panel that you are currently working in a similar field, where you employer is well aware of these regulatory proceedings and have commented positively on your performance at work.

In terms of the previous conditions of practice, Ms Flanagan submitted that the panel has seen references within your bundle which commented on your work whilst at [PRIVATE]. Ms Flanagan submitted that you worked well under the conditions of practice and was supervised. You worked there until the interim conditions of practice order was replaced with an interim suspension order. Ms Flanagan

reiterated that whilst you were employed at the [PRIVATE] , you were going through [PRIVATE] and took some time off work. When you returned to work, [PRIVATE] and did not return until late 2023/early 2024. [PRIVATE] and you were given a new line manager. You were only working for a short period when the interim review hearing took place, and an interim suspension order was imposed. Ms Flanagan submitted that it appeared that the NMC was not informed by the RCN about [PRIVATE].

Ms Flanagan informed the panel that you subsequently took employment at [PRIVATE] as a carer. You have now been offered a permanent position and promotion to senior carer. The manager at [PRIVATE] also indicated that she would be willing to set up supervision should you seek to work as a nurse. The conversation was put on hold as parties are waiting for the outcome of the hearing. You indicated that your manager has dealt with such situations in the past and feels well capable of setting up supervision, therefore conditions of practice would be workable. You have been working at [PRIVATE] for over two months and therefore, you are familiar with the workplace.

In addressing the concerns regarding pressure, Ms Flanagan submitted that [PRIVATE] do not carry out 14-hour shifts, rather, occasional 12-hour shifts, and therefore the working hours are shorter. Ms Flanagan submitted that you are taking your appointment at [PRIVATE] in stages given that you received an offer of a permanent position and then a promotion. She submitted that this shows that you are able to assess what you are capable of doing and therefore, you can cope with pressure moving forward.

Ms Flanagan drew the panel’s attention to the testimonials provided by you. She submitted that this is not a case in which problems are repeating themselves. This was a short period of time at one particular workplace and there is some evidence that you have worked well elsewhere.

Ms Flanagan submitted that conditions of practice order is proportionate, workable, relevant, and measurable by any future reviewing panel to ensure your competence. You are willing to comply with such conditions and are quite capable of responding

to training and remediating the issue that the panel have found against you. She submitted that a conditions of practice order can be monitored and assessed.

Ms Flanagan submitted that you are aware that you are fortunate to have found [PRIVATE], and that they are supportive of you. You could return to work as a nurse and they would feel capable of supporting you in that role at any event.

For all those reasons, Ms Flanagan submitted that you agreed with the submissions of the NMC and therefore a conditions of practice order is appropriate.

The panel asked for clarification as to when the interim order was first imposed. Mr Kennedy informed the panel that the interim conditions of practice order was first imposed on 27 November 2022. This remains unchanged until 13 March 2024 when the interim conditions of practice order was replaced with an interim suspension order. The interim suspension order was confirmed at two subsequent review hearings. Mr Kennedy submitted that the previous panels noted that no report was submitted for the October 2023 and March 2024 interim order review hearings, which was contrary to the formulated conditions 5 and 6. However, Mr Kennedy reminded the panel that there had been no issues regarding your compliance prior to these two dates.

Ms Flanagan informed the panel that this timeline fits with the information that she has provided to the panel. In response to panel questions regarding objective evidence in respect of your supervised practice while under interim conditions of practice order, Ms Flanagan submitted she did not have such evidence before her and it would now be difficult to source.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired (by reason of your misconduct), the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be

appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of remorse and insight into your failings and limited remediation.
- You sought to blame others for your conduct in the charges found proved.
- Your conduct placed people receiving care at risk of suffering harm.
- Your misconduct relates to vulnerable residents, the majority of whom relied entirely on nursing staff to ensure all care and treatment was delivered as specified in their care plans.
- Your misconduct took place across a wide range of areas of fundamental nursing skills.

The panel found no mitigating features.

However, the panel noted that you have engaged with these proceedings and had no previous regulatory findings against you. You had an unblemished career spanning around 16 years. The panel also considered that during your employment, there was a period of transition at the Home, in that they were moving from one nurse on a shift to two nurses on a shift. As such, when there were two nurses on duty, there may have been potential for some confusion as to which registered nurse was responsible for the care and treatment of an individual resident.

The panel first considered whether to take no action and had regard to the NMC Guidance on *"Taking no further action"* (SAN-3a). It concluded that this would be inappropriate given the serious nature of the case and the potential risk of repetition. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered the imposition of a caution order and took into account the NMC Guidance on *"Caution Order"* (SAN-3b) but again determined that, due to

the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG (SAN-3C), in particular:

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel placed weight on Ms Flanagan's submissions that your current employer is supportive of you and have offered you a permanent role as a Senior Carer. The panel accepted Ms Flanagan's submissions that the manager of [PRIVATE] informed you that they had previous experience of managing nurses who were subject to

conditions of practice and would be willing to supervise you in the event that you returned to nursing practice.

The panel had regard to the fact that these incidents happened during the course of your employment at one care home and that, other than these incidents, you had an unblemished career of 16 years as a nurse. The panel considered the numerous patient testimonials that you provided at this hearing and noted that you were described as *"kind", "caring"* and *"supportive".* The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. The panel considered that imposing a suspension-order or a striking-off order would be punitive, particularly as it took the view that you may be able to return to unrestricted practice in the future.

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

The panel determined that the following conditions are appropriate and proportionate in this case; these conditions were devised on the basis that you will be supported in your return to unrestricted practice by [PRIVATE]:

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

1. You must restrict your employment to a single substantive employer. This must not be an agency.

2. You must not work as the registered nurse in charge of any shift nor as the sole registered nurse.

3. You must ensure that you are supervised by a registered nurse at any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, another registered nurse.

4. You must not administer medication until formally assessed as competent to do so by your workplace line manager or supervisor. A report containing the competency assessment must be sent to the NMC within 14 days of successful completion of the assessment.

5. You must meet fortnightly with your workplace line manager or supervisor to discuss your clinical performance, particularly in relation to:
    a) Blood glucose monitoring and recording and taking any remedial action required.
    b) Record keeping, including accurate recording and handover documentation.
    c) Accurate recording of clinical observations including blood pressure and taking remedial action as required. Using effectively a manual blood pressure machine.
    d) Administration and monitoring of Percutaneous Endoscopic Gastrostomy (PEG) feeding.
        i. Ensuring that the patient receives this as prescribed; and
        ii. Taking remedial action as required.

e) Adhering to wound management care plans in line with local policy and taking any remedial action as required.
f) Medicine administration and accurate recording.

6. You must work with your line manager and or supervisor to create a personal development plan (PDP):
   a) Your PDP must address the following:
      i. Blood glucose monitoring and recording and taking any remedial action required.
      ii. Record keeping, including accurate recording and handover documentation.
      iii. Accurate recording of clinical observations including blood pressure and taking remedial action as required. Using effectively a manual blood pressure machine.
      iv. Administration and monitoring of PEG feeding.
         a) Ensuring that the patient receives this as prescribed; and
         b) Taking remedial action as required.
      v. Adhering to wound management care plans in line with local policy and taking any remedial action as required.
      vi. Medicine administration and accurate recording.
   b) You must send your case officer a copy of your PDP one month after gaining employment as a registered nurse.
   c) Send your case officer a report from line manager every three months. This report must show your progress towards achieving the aims set out in your PDP.

7. You must send to the NMC in advance of any review hearing a report from your workplace line manager, or supervisor assessing your clinical performance, particularly in relation to:
   a) Blood glucose monitoring and recording and taking any remedial action required.

b) Record keeping, including accurate recording and handover documentation.
c) Accurate recording of clinical observations including blood pressure and taking remedial action as required. Using effectively a manual blood pressure machine.
d) Administration and monitoring of PEG feeding.
    i. Ensuring that the patient receives this as prescribed; and
    ii. Taking remedial action as required.
e) Adhering to wound management care plans in line with local policy and taking any remedial action as required.
f) Medicine administration and accurate recording.

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

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

10. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).

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

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

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

The period of this order is for 12 months (with review).

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- A reflective piece that focuses on the impact of your conduct, particularly in relation to patients, residents, colleagues and the wider public.
    - This should include your understanding of your failings, why they occurred, what you have learnt and the steps you have taken to address them.
- Recent testimonials from your workplace line manager.

- Up-to-date training certificates, particularly to the areas of the charges found proved.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that the necessity of the order is on the basis of public protection and the wider public interest. He submitted that the sanction decided today would not be taking effect until 28 days after the decision is formally served on you. As such, in the event that you were to make an application to appeal the panel's decision, there may be a period in which you may be allowed to work without restriction. Mr Kennedy therefore invited the panel to impose an interim order for 18 months to cover the period of appeal, as well as to protect the public and the wider public interest in light of the panel's findings.

Ms Flanagan informed the panel that she has no submissions and indicated that she conceded the matter.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the

seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months because it is necessary to protect the public, is otherwise in the wider public interest and to cover the period of appeal.

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

That concludes this determination.