Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 7 – Wednesday, 22 January 2025

Virtual Hearing

Name of Registrant:	Jane Gisbey	
NMC PIN:	89Y0052S	
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 17 April 2002 Registered Nurse – Sub Part 2 General Nursing (Level 2) – 6 May 1991	
Relevant Location:	Renfrewshire	
Type of case:	Lack of competence/Misconduct	
Panel members:	Caroline Rollitt Richard Weydert-Jacquard David Boyd	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Paul Housego	
Hearings Coordinator:	Jumu Ahmed	
Nursing and Midwifery Council:	Represented by Shaun McPhee, Case Presenter	
Miss Gisbey:	Present and represented by Tom Docherty of Anderson Strathern, instructed by Royal College of Nursing (RCN)	
Facts proved by way of your admission:	Charges 1(b), 1(c), 1(d)(ii), 1(d)(iv), 1(e)(ii), 3(b-h)	
Facts proved:	Charges 1(a)(i), 1(a)(ii), 1(d)(i), 1(d)(iii), 1(e)(i), 2	
Facts not proved:	Charges 1(a)(iii), 3(a), 4	

Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (2 years)**
Interim order:	**Interim conditions of practice order (18 months)**

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

At the outset of the hearing, Mr Docherty made an application for this case be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

Mr McPhee supported the application.

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

[PRIVATE], the panel determined to hold the hearing partly in private as and when such issues are raised in order to protect your privacy.

Details of charge

That you, a registered nurse:

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

a. on or around 8/9 April 2020, in relation to Patient B, failed to
   - i. monitor Patient B’s glucose levels before bed, or at all, and/or **[PROVED]**
   - ii. record Patient B’s glucose levels on the insulin and administration form **[PROVED]**

iii. inform the next shift of Patient B's glucose monitoring requirements **[NOT PROVED]**

b. on 26 April 2020 failed to record in Patient C's medication administration chart, that you had administered their medication **[PROVED BY WAY OF ADMISSION]**

c. whilst subject to informal support between June and August 2020 failed to meet the objective of safe and effective administration of medication to patients **[PROVED BY WAY OF ADMISSION]**

d. whilst subject to an informal capability plan between 17 August 2020 and 7 December 2020 failed to meet the following objectives:

   i. development and improvement of leadership skills **[PROVED]**
   ii. safe and effective administration of medication to patients **[PROVED BY WAY OF ADMISSION]**
   iii. safe and effective person-centred care and risk assessment of patients **[PROVED]**
   iv. effective communication with patients and the wider multidisciplinary team **[PROVED BY WAY OF ADMISSION]**

e. whilst subject to a formal capability plan between 8 December 2020 and 8 December 2021 failed to meet objectives 2 and 5, which were:
   i. ability to safely administer medication. **[PROVED]**
   ii. follow safe practice in relation to infection control. **[PROVED BY WAY OF ADMISSION]**

2. On 29 April 2021 whilst undertaking 1:1 observations of Patient A slept whilst on duty. **[PROVED]**

3. [PRIVATE]
    a. 9 January 2020 **[NOT PROVED]**
    b. 7 August 2020 **[PROVED BY WAY OF ADMISSION]**
    c. 26 August 2020 **[PROVED BY WAY OF ADMISSION]**
    d. 27 August 2020 **[PROVED BY WAY OF ADMISSION]**
    e. 3 September 2020 **[PROVED BY WAY OF ADMISSION]**
    f. 4 September 2020 **[PROVED BY WAY OF ADMISSION]**
    g. 6 September 2020 **[PROVED BY WAY OF ADMISSION]**
    h. 7 September 2020 **[PROVED BY WAY OF ADMISSION]**

4. [PRIVATE]. **[NOT PROVED]**

The charge concludes “AND in light of the above, your fitness to practise is impaired by reason of your lack of competency at charge 1 and misconduct at charges 2-4.”

Background

You were referred to the NMC on 2 June 2021 by NHS Greater Glasgow and Clyde (GGC), where you were employed as a band 5 nurse at Queen Elizabeth University Hospital (the Hospital) from 9 December 2019. You were dismissed on 8 December 2021. You were previously employed by the same Trust from 2010 - 2017.

You were also undertaking bank shifts at a second job at Meallmore Health Care at Belleaire House Care Home (the Home).

You were supported by the Clinical Nurse Educator on supervised medication rounds from June 2020. Because there were further errors you were supported by an informal capability process from 17 August 2020. This should have lasted between four and six weeks.

The GGC informed the NMC that you were subject to a formal capability programme from 8 December 2020 as a result of concerns arising during the informal capability process in regard to drug errors, time management and non-compliance with internal policies on infection and control.

The GGC informed the NMC that, despite being managed under their capability process, you continued to make errors. The plan covered:

- development and improvement of leadership skills and time management
- safe and effective administration of medications to patients
- safe and effective person-centred care and risk assessment for patients
- effective communication with patients and the wider multidisciplinary team
- safe infection prevention measures

Further, the GGC informed the NMC that on 9 April 2020, you failed to administer insulin to a patient, who was then not monitored correctly. On 26 April 2020 a second incident was alleged to have occurred. This was that you were said to have administered medication to a patient, but failed to sign the Medication Administration Record ('MAR'). This meant there was a risk that the patient might receive the same medication twice.

The GGC informed the NMC that there was an alleged incident on 29 April 2021, at 16:00, where you were tasked with carrying out enhanced observations on a high risk patient who required constant observations to maintain their safety. The patient frequently attempted to climb out of bed and required constant observation to maintain their safety and to ensure that their oxygen mask remained in situ. It is alleged that on this day, at approximately 16:30, you were found asleep on the chair next to the patient and had to be awoken by a colleague. You were invited to attend an investigatory meeting related to this on 23 June 2021.

[PRIVATE].

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Docherty who informed the panel that you made admissions to charges 1(b), 1(c), 1(d)(ii), 1(d)(iv), 1(e)(ii), 3(a)-(h).

The panel therefore found charges 1(b), 1(c), 1(d)(ii), 1(d)(iv), 1(e)(ii), 3(a)-(h) proved by way of your admissions.

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

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

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

- Witness 1: Head of Financial Governance/ Fraud Liaison Officer at GGC at the time of the incidents;
- Witness 2: Clinical Service Manager at GGC at the time of the incidents;
- Witness 3: Staff Nurse at Queen Elizabeth University Hospital;
- Witness 4: Charge Nurse at GGC at the time of the incidents;

- Witness 5: Staff Nurse at the time of the incidents;

- Witness 6: Senior Charge Nurse at the time of the incidents;

- Witness 7: Interim Lead Nurse at the time of the incidents;

- Witness 8: Clinical Nurse Educator.

The panel heard evidence from you under affirmation.

The panel also heard live evidence from the following witness called on your behalf:

- Witness 9: Your daughter.

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

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

Charge 1(a)(i) and 1(a)(ii)

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

a. on or around 8/9 April 2020, in relation to Patient B, failed to

   i. monitor Patient B’s glucose levels before bed, or at all, and/or
   ii. record Patient B’s glucose levels on the insulin and administration form

These charges are found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 7, which included Patient B’s insulin chart and observation (NEWS) chart, the ‘Datix report for 9 April 2020’, and the ‘Extract from patients notes related to Insulin Datix – 608974’ dated 9 April 2020. It also took into account the oral evidence given by Witness 7 and by you.

In Witness 7’s witness statement dated 7 November 2022, she stated:

> ‘*5.* […] *On 9 April 2020, there was an incident where insulin had not been administered to a patient, and then the patient wasn’t monitored appropriately.’*

In Witness 7’s supplementary witness statement dated 6 December 2024, she stated:

> ‘*3. In paragraph 5 of my first statement I refer to an incident regarding the administration of insulin to a patient (“Patient B”). Patient B is a type 2 diabetic who takes insulin and arrived on ward 7D (“the ward”) at 20.36 on 8 April 2024. The registrant was the nurse who admitted the patient. To clarify, the issues reported were that no blood sugar reading was documented until the morning of 9 April 2020 and that the registrant did not correctly record or hand over concerns regarding Patient B’s blood sugar level and the action taken.*
>
> […]

5. […] *The notes show that the registrant documented when Patient B arrived on the ward. The first concern was that no glucose blood reading was documented at this time on the Insulin Prescription and Administration form* […] *or any other notes. On this form, in the section dated 8 April 2020 'Before Bed', there is no entry for that time in the 'CBG readings' column.*

6. Patient B is a type 2 diabetic who takes insulin. As the Senior Charge Nurse, I set out expectations for the monitoring of blood sugar for patients admitted to the ward with diabetes. For patients prescribed insulin, blood sugar should be checked 4 times a day for at least 48 hours to build a profile and then this can be reviewed thereafter.

7. From the notes […]*, it indicates that Patient B's blood sugar was not checked until 06.50 the following morning. At 06.50 on 9 April 2020, the registrant documented that his blood sugar was 3.0 mmols and she'd given him a hypostop to correct this. The notes say she rechecked his blood sugar and recorded this as 5.7 mmols.*

8. This information was not recorded in Patient B's Insulin and Administration form […]'

In Witness 7's oral evidence, she told the panel that it is standard procedure in Ward 7D to check patient blood glucose four times per day, including before bed, for at least 48 hours after admission. She further told the panel that the readings should be recorded on the insulin prescription and administration form and at the end of a shift, the form should be left on the front desk of the ward, to ensure the nurse on the next shift is aware of diabetic patients and can provide the appropriate care. She told the panel that you ought to have known this.

The panel had sight of Patient B's insulin chart. At around 20:36 on 8 April 2020, you admitted a diabetic patient. You took two blood glucose readings over 12 hours. However,

there was no record entered for an entry of a blood glucose measurement for Patient B before bed in the insulin administration form for 8 and 9 April 2020.

The panel had sight of Patient B's observation (NEWS) chart where you had entered two entries of Patient B's blood glucose measurement.

In your oral evidence, you told the panel that you may have checked Patient B's blood glucose level before bed but that you could not say for sure. You said that you were aware of ward 7D's standard procedure and accepted that you did not record Patient B's glucose levels on the insulin and administration forms.

As some observations were recorded, the panel decided that it was more likely than not that these were the only observations made by you. The recorded observations were not adequate or in accordance with the policy for the ward. Accordingly the panel determined that on the balance of probabilities, it was more likely than not that you failed to monitor Patient B's glucose levels before bed and failed to record Patient B's glucose levels on the insulin and administration form.

Charge 1(a)(iii)

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

a. on or around 8/9 April 2020, in relation to Patient B, failed to

iii. inform the next shift of Patient B's glucose monitoring requirements

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence, including the 'Extract patient B's notes 09.04.20' and oral evidence of Witness 7 and your oral evidence.

Witness 7 stated in her supplementary witness statement dated 6 December 2024:

> *'8. This information was not recorded in Patient B's Insulin and Administration form* [...] *and the registrant did not hand this over to staff on the next shift. The nursing staff on the next shift did not know that the patient might need to be monitored more frequently and were not able to pass the information on to the medical staff. As a result, the medical staff could not take it into account when prescribing the morning dose of insulin. Having known a hypostop had been given by the registrant, it may have affected the amount of insulin prescribed.*
>
> *9. I note the registrant had recorded it in the patient notes* […] *and the result of 3 mmols was documented on the NEWs chart* […]. *However, the procedure is to document this information on the Insulin and Administration form as this is given to the medical staff when prescribing the dose of insulin. This should also have been handed over by the registrant to the next shift so they could monitor the patient accordingly. This form should have been left on the front desk for the staff on the next shift so they are aware of the patients who require insulin and can ensure it is prescribed by medical staff. Patient B's form was not found until after breakfast on 9 April 2020 so the staff on shift did not know until then.'*

In her oral evidence Witness 7 stated that you checked the Patient B's blood glucose at around 06:40 on 9 April 2020 and found that it was low, leading you to administered medication, hypostop. You checked the blood glucose on one occasion later and it had recovered. Witness 7 told the panel that you did not record this patient's insulin administration in prescription form in order to ensure that those providing care to Patient B would be aware of the full background of his blood sugar level. She further told the panel

that you as a result of your failure to properly record the administration of hypostop, it put Patient B at risk because it gave medical staff attending to him an inaccurate picture of his blood sugar level which may have resulted in an incorrect prescription of insulin subsequently.

The panel had sight of the document entitled Extract patient B's notes dated 9 April 2020. An entry was made by you. Thereafter, another entry was made at 8:30am by another nurse on the Insulin Prescription and Administration Form. The panel concluded that glucose monitoring for Patient B was undertaken but was not recorded on the required form.

In your oral evidence, you told the panel in your evidence that you are sure that you would have informed the incoming nurse on the next shift on the morning of 9 April 2020.

The panel was uncertain as to whether you did, or did not, inform the next nurse of Patient B's glucose monitoring requirements. The panel took into account Patient B's Insulin Prescription and Administration Form indicated that monitoring was done at 8:30am after your shift was completed. Taking this into consideration, the panel determined that there not sufficient evidence to find this charge proved on the balance of probabilities.

Charge 1(d)(i)

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

    d. whilst subject to an informal capability plan between 17 August 2020 and 7 December 2020 failed to meet the following objectives:

i. development and improvement of leadership skills

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 7. This included your informal capability plan (support improvement plan) date commencing from 17 August 2020 to 7 December 2020.

The panel noted that development and improvement of leadership skills included leadership, time management, awareness of ward priorities and ability to delegate to ensure standards are met.

In Witness 7's witness statement dated 7 November 2022, she stated:

> *'Informal capability plan*
> *9. I met with the registrant on 12 August 2020. We discussed moving her onto an informal capability plan to provide her with support around medicine proficiency and the nursing care surrounding this. The informal capability process with her started on 17 August 2020, which should have lasted 4 weeks in total, and no longer than 6 weeks. This process support also was provided by* Witness 8 *who supervised her for a total of 27 drug administration rounds on the ward.*
>
> *10. I exhibit a copy of the registrant's informal capability improvement plan dated 17 August 2020* […]*. This plan covered the following objectives:*
>
> *a. Development and improvement of leadership skills* […]
>
> *11.Unfortunately, due to the registrant having significant time off and annual leave, the informal process we had planned to complete with her in 4 weeks had to be elongated.* […]'

Witness 7 in her oral evidence told the panel that although though there were improvements during the informal capability process, your work remained inconsistent, paperwork was not always completed, and the necessary standard was not always met.

The panel had sight of your informal capability plan (support improvement plan) date commencing from 17 August 2020. It stated:

> *'**Specific Areas Requiring Improvement***
> *Skills in relation to leadership and management of staff on individual shift* […]
>
> ***Support required***
> *Mentorship by CN, sourcing input via OD*
>
> ***Success Criteria***
> *Demonstrate ability to lead the team, organise care provided on that shift and provide support and direction to junior staff. Demonstrate that you can provide effective handovers*
>
> ***Evidence***
> *No evidence of Janice leading the team or providing support or direction to junior members. Has provided direction in terms of asking for medications to be reviewed appropriately, but these weren't followed up 20/8/20'*

In your oral evidence, you told the panel that you did not feel part of the team at the GGC. You said that they were not welcoming, and that you felt very much alone while at work. Further, you said that within two months of the start of your employment in the ward, you felt [PRIVATE] out of your comfort zone.

The panel noted that you had made some improvements in your skills. However, it had particular regard to Witness 7's evidence in which she told the panel that in her view your issues with time management, delegation to junior staff and understanding ward priorities

were ongoing and that you were assessed as having not met those objectives in your informal capability process. The panel therefore determined that, on the balance of probabilities, it was more likely than not that whilst you were subject to an informal capability plan between 17 August 2020 and 7 December 2020, you failed to meet the objective of development and improvement of leadership skills. This charge is therefore proved.

Charge 1(d)(iii)

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

    d. whilst subject to an informal capability plan between 17 August 2020 and 7 December 2020 failed to meet the following objectives:

    iii. safe and effective person-centred care and risk assessment of patients

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 7 and Witness 8. The documentary evidence included your informal capability plan (support improvement plan) date commencing from 17 August 2020 to 7 December 2020. The panel also took your oral evidence into account.

The panel noted that this charge is based on two incidents. The first incident occurred when a patient’s medication, delivered through an IV pump had finished. You did not notice, or if you did notice took no action on seeing, that the IV pump was still running. This put the patient at risk of an air bubble developing and going into the patients veins,

which Witness 8 informed the panel could be very serious or indeed life threatening. Furthermore, when later removing the IV line from the patient, you did not according to Witness 8 practice the appropriate 'aseptic cleaning technique' to maintain the expected infection prevention and control standards, which consequently presented a risk of infection to the patient. The second incident related to another patient who had a cannula around their foot. There was redness around the foot, the outline of which had been marked in red. The redness had extended beyond the red outline, possibly indicating a worsening infection but you did not notice this.

The panel took into account Witness 7's witness statement (as above).

The panel also took into account Witness 8's witness statement dated 30 September 2022:

> *'3.* […] *I understand that she started at QEUH in November 2019, she was a Band 5 Staff Nurse and was responsible for running a team, providing patient care, identifying changes within patients and acting upon them, planning for immediate patient care as well as planning ahead to discharge, organising her own workload as well as that of her team, administering medication by various routes and being able to identify a deteriorating patient and taking rapid action. Jane would normally have been expected to take charge of the ward when senior staff were not on duty. However, the senior staff didn't feel this appropriate as she was requiring support and development.*
>
> […]
>
> *7. A lot of the issues Jane had were with her basic skills, like doing safety checks (checking patient names and checking the names of drugs and what they are for before administering), and ensuring prescriptions were signed by the doctor because all of the drugs have to be prescribed. Jane was an experienced nurse and should've been aware of these things but there was a lack of consistency with*

her practice, she was doing these things correctly at times and then not doing them at other times. I had to go back to basics with her in terms of her nursing practice and had to treat her as though she was totally inexperienced which meant going back to nursing policy and taking her through this.
[…]

13. […], *I asked Jane if the IV drip for antibiotics had been turned off and wasn't going into the patient any longer. In this case the IV antibiotic fluid had finished but it continued running. I asked Jane more than once whether this has been turned off. The risk here was that air could've gone into the tube and then the patient and this could've been fatal for the patient, Jane was focused on the medications only and wasn't alert to the other issues. She should be able to identify any issued that could cause a patient harm such as this and take action.*

14. In addition to that when turning the IV drip off Jane disconnected the IV without following aseptic technique. She had gloves on at the time but had been using them, touching other things. Jane should've washed her hands, put on clean gloves and cleaned the connection before disconnecting the IV to avoid a blood infection to the patient which can be very serious.

15. There was a cannula in the patient's foot and she didn't comment on the fact that there was a large red area on the foot around the cannula that had been identified as an issue. When there is a red area like this, we put a mark around it to see if it is spreading. The red mark had spread beyond the drawn mark for this patient and she hadn't acknowledged this or taken any action. I had to prompt Jane to go an alert the medical staff to this. The red mark could indicate that there is infection in the tissue, which means that the cannula has to come out and the patient may become unwell. Jane failed to recognise this.'

The panel had sight of your informal capability plan (support improvement plan) date commencing from 17 August 2020. It stated:

*‘**Specific Areas Requiring Improvement***

Evidence ability to risk assess patients & show decision making skills which reflects needs of the individual

Support required

Mentorship by CN, support from CNE nurse to identify and address any learning needs

Success Criteria

Demonstrate ability to make sound clinical decisions which reduce risk of harm to patients

Evidence

Good evidence noted by CN on the 09/10/20 for updates risk assessments and care rounding however this isn’t consistent. On instigation we found that on the 09/10/20 that signification omissions were made in documentation leading to an avoidable pressure ulcer.’

[…]

‘Objective 3: To demonstrate effective, safe, person centred care planning and risk assessment for patients in your care

Specific Areas Requiring Improvement

Understanding and delivery of Care rounding to meet the needs of individual patients

Evidence

Learnpro module not completed as off 27/10/20. Janice involved in red dot day for 7D due to not completed care rounding effectively 09/10/20.

Specific Areas Requiring Improvement

Person centred care

Evidence

Documented in both CN and CNE notes regarding care of an unwell patient. NEWS taken but not rechecked when appropriate to the patients' needs 01/10/20

Specific Areas Requiring Improvement

Risk Assessment

Evidence

Evidence of good risk assessment updates 12/09/2020 and 09/10/20. However risk assessments in relation to a acquired red dot day provided evidence of Janice not completing this consistently 09/10/20'

During your oral evidence, you accepted that you did not use proper aseptic technique when disconnecting the patient's IV line. You said that you had put on gloves but did not have an alcohol wipe to hand. You further accepted that this is basic safe care, and that you failed to provide it on that occasion. You fully accepted that you failed to meet the objective of safe and effective care and risk assessment.

The panel heard evidence from Witness 8 that you were a caring nurse towards your patients. However, in light of the above, the panel therefore determined that you had failed to safely and effectively risk assess your patients. Consequently, the panel was of the view that you could also not deliver safe and effective patient centred care. Therefore, on the balance of probabilities it was more likely than not that failed to meet the whole objective on safe and effective risk assessment of patients. This charge is found proved.

Charge 1(e)(i)

That you, a registered nurse:

1. That you, between 9 December 2019 and 8 December 2021 whilst employed as a Band 5 nurse at NHS Greater Glasgow and Clyde, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in medication administration and infection control, in that you:

e. whilst subject to a formal capability plan between 8 December 2020 and 8 December 2021 failed to meet objectives 2 and 5, which were:

    i. ability to safely administer medication

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 7 and Witness 8. The documentary evidence included a Formal stage 1 Capabilities Document, a Formal Stage 1 Supported Improvement Plan dated 8 December 2020 to 8 December 2021 and a record provided by Witness 8 of supervised drug rounds undertaken during this period. The panel also took into account your oral evidence.

In Witness 7's witness statement dated 7 November 2022, she stated:

> *'Formal stage 1 capability plan*
>
> *14.It was decided that the informal capability process having now exceeded 4 weeks would proceed to formal capability, to allow her a fresh start with a new plan. Both capability plans were very similar in terms of content and the objectives. This was because the registrant had not been able to successfully improve her practice to be signed off at the informal stage. The formal stage 1 process was due to and agreed to commence on 8 December 2020.*

[…]

24. […] *but we were unable to sign her off for any of those objectives in their entirety because she wasn't meeting the required standard and there were ongoing errors.*

25. The registrant's administration of medications vastly improved but there were still drug errors being made. She had been taken off controlled drugs administration after the time when she was supposed to administer Oxynorm liquid, but instead she had given Oramorph. This prompted her to be moved onto the formal process I discussed above. We stopped her from administering controlled drugs at this stge. She didn't have a consistent approach to administering medications, which had the potential to put patients at great risk.

[…]

29.There was a lack of consistency and attention to detail with her practice. Once, she discharged a patient with no oxygen and the medication and IDL wasn't complete. I cannot confirm the exact date when the incident happened. The patient had to be brought back to the ward because the oxygen wasn't provided for them. These errors were numerous and created great risks to the patients.

30.We did reach a point where we thought of signing off her drug competency, when for all of three drug rounds, she hadn't made any mistakes, but at the last hurdle she made another drug error. As such she was unable to be signed off. There were two breaches in terms of her PPE as well, and cumulatively all this required referral to stage 2 process.'

The panel took into account the Formal stage 1 Capabilities Document which included the meeting minutes with you and Witness 7. It also noted that the formal stage 1 process was never completed.

The panel also took into account your Supported Improvement Plan, Formal Stage 1, dated 8 December 2020:

> ‘***Specific Areas of Requiring Improvement***
> *Administration of Medicines.*
>
> ***Support Required***
> *Mentorship, teaching and competency review by CN with support from CNE.*
>
> ***Success Criteria***
> *Demonstration of safe administration of medicines in line with NHSGGC Safe and Secure administration of medicines policy.*
>
> ***Timescale***
> *6 weeks initially then moved to 4 weeks post absence.*
>
> ***Achieved Yes/ No***
> *No*
>
> ***Evidence***
> *Overall has made improvement with administration of medications and drug knowledge. This is noted throughout both CN and CNE notes. However made a drug error noted on CNE notes dated – 14/04/21’*

In Witness 8’s witness statement dated 30 September 2022, she stated:

> *‘18.* […] *The clinical errors continued into 2021 when she was on formal capability.*
>
> […]

20. To some extent there was progress at times from Jane but it was inconsistent. In general she did improve but she never ever achieved consistency. There was no harm to the patients in any of these instances because I was there to stop her as soon as we identified that there were concerns she couldn't practice unsupervised.'

The panel noted that Witness 8 supervised you on 27 drug rounds. The panel took into account Witness 8's documentation on '14/04/2021 Drug Competency 26':

'A patient was prescribed Ursodeoxycholic Acid 150mg followed by a prescription for Ursodeoxycholic Acid 500mg. This was to make a total dose of 650mg. There was a box of 250mg tablets in the patient's drug pod. Janice said that she would issue the 500mg prescription but that she was unable to issue the 150mg prescription. She said that she would finish putting out all the drugs before going to the central drug cupboard to see if there was a box of Ursodeoxycholic Acid 150mg.

Having issued another couple of drugs, Janice came across a prescription for Symkevi. She started to look it up in the BNF and said that she knew it was for cystic fibrosis but wasn't sure of exactly what it did. She noted that it was a combination of tezacaftor and ivacaftor and she checked the strengths of these on the box of Symkevi before putting it in the cup.

After issuing another couple of tablets, Janice noticed a box which had Tezacaftor 150mg in fairly large letters on it. She lifted the box and made a comment that indicated she thought it was the drug she had been missing, the Ursodeoxycholic Acid. I asked her to clarify what she was giving and she told me it was the one she couldn't find earlier. I asked her again what she was giving and she told me it was the drug that had been missing at the start of this patient's drug administration. I asked her if she thought she should check it again and she said that it was the 150mg dose of the drug that had been missing. I stopped her as she went to put the tablet in the cup and made her read the prescription again. At this point she

realised her mistake. She carried on issuing the drugs correctly and fetched the missing drug at the end.'

In her oral evidence Witness 8 told the panel that you did not meet this objective. She said that you had continued to make progress but that you then regressed and made further errors. Witness 8 said that this showed that you were unable to demonstrate consistent safe practice in the administration of medication.

During your oral evidence, you accepted that you made drug errors during your formal capability plan. You told the panel that you are competent to administer medical safely and [PRIVATE].

Because of the number of drug rounds that were uneventful the panel was of the view that you inconsistently demonstrated you had the knowledge to administer medication safely. The panel therefore determined that it was more likely than not that you failed to meet the objective set in your formal capability plan of demonstrating the ability to safely administer medication.

Charge 2

2. On 29 April 2021 whilst undertaking 1:1 observations of Patient A slept whilst on duty

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence from Witness 3, Witness 4 and Witness 5. The documentary evidence included Witness 5's undated local statement, Witness 6's investigatory meeting notes with Witness 5 dated 8 July 2021, Witness 5's local statement dated 29 April 2021 and Witness 6's investigatory meeting notes dated 3 June 2021. In addition, the panel had regard to Witness 6's local

investigation report dated 20 August 2021. The panel also took into account your oral evidence.

Witness 3 in her witness statement dated 25 October 2022 stated:

> *'Incident 29 April 2021*
>
> […]
>
> *6. It was a busy day, and we were having breaks later than normal. I had finished my break and was checking on all my patients as I would normally do. It was about 16:30, and I remember seeing Patient A who was safely in her bed when I walked by. The registrant was doing the one-to-one observations and was sat in the chair in the patient's room. She was doing her e-learning.*
>
> *7. About half an hour later, I walked by again, and saw the registrant slouched over in the chair. Her eyes were closed, and she looked unresponsive. The patient was safely in her bed at this point, but the registrant appeared to be asleep. I therefore went and got the Charge Nurse,* [Witness 4], *and went back to the room with her and another staff nurse,* [Witness 5]. *They both went into the room ahead of myself and saw the registrant asleep.'*

In Witness 5's undated local statement, it stated:

> *'Around 1700 I walked past the room again on my way to check the observations of the new patient I'd received into my care. I looked into the room to check on my patient and to check if Janice needed anything. I found Janice slouched over in her chair sleeping. The patient was safely in her bed but now awake.*

I went and got the Nurse in Charge, who came with me to the patient's room. Janice was woken up by a fellow colleague who shouted her name at least twice and another staff member took over the care of the patient enhanced observations.'

The panel had regard to the investigatory meeting notes made by Witness 6 dated 8 July 2021:

*'**Question 6: Can you describe to us the incident?***
Response: I returned from my break and was checking my patients and a half hour later I was walking past the room going to do observations and I noticed Janice was slumped over and appeared to be sleeping. I then got [Witness 4] *to come and see and we made sure the patient was safe.*

[…]

Question 15: How long did it take to wake SN Gisbey?
Response: [Witness 5] *and* [Witness 4] *went into the room first, I was at the back and they tried to wake her which they did, so not too long.*

[…]

Question 26: Was SN Gisbey in a deep sleep?
Response: Janice was not aware when we went into the room but she was roused quite quickly.'

Witness 4 in her witness statement dated 20 October 2022 stated:

'6. At around 17:00, one of my colleagues, [Witness 3], *came to me and said that she had seen the registrant sleeping in the patient's room. The Registrant has been in the room observing for approximately one hour after family had left. I followed her*

to the room and saw her sleeping. She was slumped to one side of the patient's armchair and her eyes were closed.

7. The registrant had been using one of the computers to do some extra learning as part of her competencies. Another colleague, [Witness 5], *who was passing and giving out drug medication, also saw her asleep and shouted to her three times in an attempt to wake her. The first and second time she shouted the registrant's name. She did not respond but on the third time calling the registrant she roused. I have no doubt that she was sleeping because she did not respond on the first two occasions.*

8. When she woke up, she was startled but did not say anything at all. She just followed me out of the room. I asked her to leave the room, to go and get a drink and to take some time to make herself feel more awake before […]

[…]

10. Once we had given out the meals, I took the registrant aside and asked her what had happened, […]. *She asked to not be put into a situation where she was on one-to-one observations because she would fall asleep.*

The panel also took into account Witness 5's witness statement dated 9 November 2022. It stated:

'Incident 29 April 2021

2. On 29 April 2021 between 16:00 and 17:00, the registrant was found to be asleep while on one-to-one observations for a vulnerable patient. I went into the room with other colleagues and saw that she was asleep. I shouted twice or three times to try to wake her up. She only reacted on the third attempt. It looked as though she was waking up when I shouted for the third time.'

The panel had regard to Witness 5's local statement dated 29 April 2021:

> *'As I was passing room 36 I witnessed that S/N Janice Gisbey appeared to be sleeping. Her head was leaned over to the side and her eyes were shut. I shouted her name x3 to try and get her attention as the patient she was specialing* [sic] *was attempting to climb out the other side of the bed* […] *On the 3rd attempt she sat and responded and it was decided that I would observe the patient.'*

The panel had regard to Witness 6's Investigation meeting notes Witness 5 dated 3 June 2021:

> ***'Question 5: Can you describe to us the incident?***
> *Response: I was walking past room 36 with* [Witness 4] *and* [Witness 3] *and I shouted Janice's name 3 times as looked like she was sleeping. Janice was sitting in a chair at the bottom of the bed with her hand on the bed.*
>
> […]
>
> ***Question 9: What was SN Gisbey's response?***
> *Response: She mumbled it was too hot.'*

The panel had regard to your oral evidence. You told the panel that the room was warm, that it was getting dark outside [PRIVATE]. [PRIVATE]. Furthermore, the panel had regard to your oral evidence in which you stated that shortly after this incident on the same shift, you asked Witness 4 not to allocate you to 1:1 observations as there was a risk due to the heat of the room that you would fall asleep. The panel determined that this was consistent with what Witness 4 had stated in her Local Statement dated 29 April 2021:

'After the dinners were served I spoke to Janice privately and asked if she was alright. Janice replied that yes she was ok but was very hot in the room and said not to ask her to special a patient in the room as she could fall asleep.'

[PRIVATE].

In relation to this incident, you said that you closed your eyes '*for what felt like a second*'. You said that you do not think you fell asleep but that you could not say for certain.

[PRIVATE].

The panel noted that the evidence of the three witnesses to this incident contained inconsistencies. However, you accepted that your eyes were closed, and it was clear that Witness 5 had called you three times, increasingly loudly, and that you had not reacted until the third occasion, when you reacted in a startled way. This indicated that you were asleep. From the evidence before it, the panel concluded that you did not intend to fall asleep, but inadvertently nodded off as you were tired, you were in a hot room, had been supervising the patient for longer than was usual, and [PRIVATE]. These factors [PRIVATE] resulted in you inadvertently nodding off. Furthermore, the panel noted that you had asked Witness 4 to not have you observe this patient as you said you could fall asleep, showing that you thought there might be a risk of you doing so.

In light of the above, the panel determined that on the balance of probabilities, it was more likely than not that you slept whilst undertaking 1:1 observations of Patient A.

Charge 3

3. [PRIVATE]

    a. 9 January 2020

This charge is found NOT proved.

[PRIVATE].

Accordingly, the panel did not accept your admission to this sub charge.

Charge 4

4. [PRIVATE]

This charge is found NOT proved.

[PRIVATE].

In considering whether your actions were dishonest, the panel had regard to the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- *What was the person's actual state of knowledge or belief as to the facts; and*
- *Was that conduct dishonest by the standards of ordinary decent people?*

The panel also took into account the NMC Guidance document 'Making decisions on dishonesty charges and the professional duty of candour' (Reference: DMA-8) (Last Updated 27/02/2024).

[PRIVATE].

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to lack of competence and misconduct

and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on lack of competence and misconduct

Mr McPhee provided the panel with written submissions on misconduct as well as oral submissions.

Mr McPhee invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision.

Mr McPhee identified specific standards which he submitted were relevant and which indicated that your actions amounted to misconduct. He submitted that you fell short of the standards expected in relation to standards: 10, 10.1, 18, 18.3, 18.4, 19 and 19.1.

Mr McPhee submitted:

‘7. The charges found proved by the panel involve a plain risk of harm to patients. The panel will recall in full the evidence of [Witness 7] *and* [Witness 8]*. Some incidents bear emphasis but do not detract from the whole of their evidence.* [Witness 7] *spoke of two incidents of concern. First, where the registrant administered Oxynorm to a patient who was in fact prescribed Oramorph. Second, where the registrant failed to undertake a skin integrity assessment on admitting a patient, which led to a preventable pressure ulcer. Ms Telfer spoke of two further incidents. First, where the registrant removed a cannula without using proper aseptic technique. Second, where the registrant failed to identify that a cannula in a patient’s foot was surrounded by a growing area of redness. Both* [Witness 7] *and* [Witness 8] *spoke to the risks of this and other conduct identified.*

8. The panel will recall the evidence of [Witness 7]*,* [Witness 3]*, and* [Witness 5] *in relation to charge 2. The registrant was entrusted to care for a vulnerable patient, at risk of removing her oxygen mask, when she fell asleep on duty. All witnesses spoke to the potential harm to the patient - that her oxygen levels may have dropped, with very serious consequences for her health.*

9. All of the foregoing amounts to serious misconduct. It is closely linked to the registrant’s clinical practice. It involves serious risk of harm to patients - and in the case of infection control failures, colleagues and the wider public. It falls short of the standards the public properly expect of a registered nurse.’

Mr McPhee, in his oral submissions, told the panel that in relation to remediation, you have provided some certificates and a reference from [PRIVATE] (your current employer), which can fairly be characterised as supportive. He submitted that you have not practised as a registered nurse and therefore have not had the opportunity to demonstrate remediation of the concerns. [PRIVATE]. Therefore, the panel should find your practice impaired on the ground of misconduct.

Mr McPhee also submitted that the competency concerns were such that the panel should find your practice impaired.

Mr Docherty also provided the panel with written and oral submissions.

Mr Docherty submitted:

> *'In my submission, whilst Janice may have breached the standards set out in the code, this does not automatically mean these actions are misconduct. The misconduct must be serious.*
>
> *In my submission, it is key to this determination that the panel have found the charge relating to dishonesty, not proved. Once again we bear in mind that overall impact of the evidence of* [Witness 7] *and* [Witness 8] *to the effect that but for the sleeping allegation Janice was nearly there in terms of the improvement plan. We also bear in mind the positive comments which confirmed that you are dealing with a nurse of over 30 years experience who was pleasant and always professional and for* [Witness 7]*, Janice tried her best and she tried hard. You may take the view that in context and taking into account the overall position and not just focussing upon the "fails" that the matters proved would amount to a lack of competence as opposed to misconduct as such. We heard that there were other nurses on the level of supervision which* [Witness 8] *mentioned and I am asking you to take the view that but for the incident on 29th April 2021 it is more likely than not that the plans would have been completed where Janice, as we heard, was nearly there until that point.*
>
> *It is a matter for the panel to determine whether these charges amount to misconduct.'*

Mr Docherty told the panel that there has been an interim suspension order on your practice since June 2021 which meant that you were not in a position to demonstrate your skills as a nurse but that you have kept your skills up to date as much as you could.

Mr Docherty submitted that, notwithstanding that the matters found proved are serious, the panel should take into account the evidence it heard on the progress you had made subsequently.

Submissions on impairment

Mr McPhee 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. He submitted:

> *'10. If satisfied that the registrant's admitted and proved conduct amounts to misconduct, the panel will ask itself: can the registrant practise kindly, safely and professionally? The panel will have regard to the need to protect the public and the wider public interest, including the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The NMC submits that with those considerations in mind, the question must be answered in the negative.*
>
> *11. Reference is made to those sections of the Code which the NMC says are engaged. The Code codifies basic tenets of the nursing profession. The registrant here breached several provisions in serious ways. Protection of the public requires that nurses, in positions of exceptional trust in caring for the most vulnerable members of society, keep to those tenets, to protect the public and maintain their confidence. The registrant breached those tenets in that she failed to:*
>
> *a. follow safe procedures for the administration of medication;*

b. provide basic care effectively, including following safe practice in relation to infection control especially in the context of the Covid-19 pandemic;

c. maintain accurate records of care provided and not, preventing others involved in care from having a full, accurate, and up-to-date picture of the patient's health and circumstances.

12. Those concerns are largely amenable to remediation. It is for the panel to determine, having regard to the evidence provided, whether they have been remediated. The NMC reminds the panel that the registrant has not worked as a nurse since she left her employment with NHS Greater Glasgow and Clyde, and has had no opportunity to demonstrate that she has fully remediated the concerns in a work environment. The concerns persisted for a considerable period, despite intensive support.

13. The concerns placed patients at risk of harm. Reference is made to paragraphs 7 and 8 above. The registrant's conduct persisted for a considerable time - from June 2020 to December 2021 in charge 1. It involved numerous, serious incidents which entailed risk of harm to patients. The NMC respectfully submits that though the concerns are amenable to remediation, the registrant has not yet remediated the concerns.

14. Public confidence in the nursing profession, and the NMC as its regulator, would be very seriously undermined if the registrant were permitted to return to unrestricted practice, against findings that she administered incorrect medications; failed to follow safe practice for administration of medication, infection control, and risk assessment; and fell asleep whilst on one-to-one observations of a vulnerable patient.

15. The registrant's fitness to practice is currently impaired. There is no robust evidence to the contrary. Given the seriousness of the misconduct,

real risk of repetition, and lack of opportunity to demonstrate full remediation in a clinical setting, the panel should find the registrant is currently impaired.

Conclusion

16. The panel should find the registrant's conduct amounts to misconduct and her fitness to practise is currently impaired as a result.'

Mr Docherty submitted:

'Janice has been subject to a suspension form [sic] *practice since 21st June 2021. Members will have heard submissions in other cases before today where the point in effect is that an order of suspension, that most draconian of interim measure, will mean that the nurse is limited in terms of putting herself in a position to demonstrate good and safe practice where she is of course not able to work in her normal role as a nurse or at all. In circumstances such as those all the nurse can do, if she is able to obtain work, is to try to keep her skills up to date with training, This is precisely what Janice has done and you will see the 17 certificates which have been lodged. In my submission Janice has done what she could in the circumstances and her work here in my submission is highly significant in terms of your forthcoming disposal.*

The admissions made by Janice at the outset of the case are evidence of both a sensible approach to the issues facing her but also redolent of insight into the overall mater of drugs administration errors. Janice can be regarded as a sensible professional who does not shirk from her responsibilities while she was able to practice freely now a substantial number of years ago.

[PRIVATE]*. As she puts it to me, she is fighting for her much cherished career. In my submission that she is making progress and still committed to seeing it through the chances of repetition are vanishingly small.*

> *It is submitted that the Registrant has shown remorse and insight, through her submissions and evidence both in chief and in cross.* [PRIVATE].
>
> *You may take the view that Janice is entitled to the view that the whole matter of these protracted proceedings have been an educational experience for her. In my submission that is further comfort for you that the risk of repetition is very low indeed.'*

Mr Docherty submitted that there is no real risk of repetition and that your fitness to practice is not impaired by reason of misconduct or lack of competence.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin), *Nursing and Midwifery Council v Persand* [2023] EWHC 3356 (Admin), *Spencer and General Osteopathic Council* [2012] EWHC 3147 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Decision and reasons on lack of competence and misconduct

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.'*

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

When determining whether the facts found proved amount to lack of competence and misconduct, the panel had regard to the terms of the Code.

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

> '***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***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*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> *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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

To achieve this, you must:

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

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

18.4 take all steps to keep medicines stored securely

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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 and when considering a finding on lack of competence, it bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

Lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code as set out above.

The panel was of the view that taken all the charges found proved altogether demonstrated that your practise did not meet the standards of competence expected of a

qualified band 5 nurse of 30 years post qualification experience. [PRIVATE]. However, it noted that there were multiple incidents over a period of over 18 months, from April 2020 to December 2021, and the errors continued even whilst you were given full support by the Hospital.

The panel identified the following areas of concern in respect of its findings:

- You failed in monitoring blood glucose levels;
- recording that blood glucose level on the prescription and administration chart;
- recording safe and effective medication administration;
- leadership skills and effective communication;
- infection control; and
- patient risk assessment.

The panel was of the view that all these failures relate to fundamental skills expected of a registered nurse. The panel concluded that your practice failed to meet the minimum standards applicable to the post to which you were appointed, namely a band 5 nurse.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Misconduct

The panel decided that your actions, set out in charge 2, was serious and amounted to misconduct.

In relation to charge 2, the panel considered its finding of fact that you had fallen asleep whilst undertaking your 1:1 observations of Patient A. It was of the view that this was a single incident, and that you had accidentally fallen asleep. However, the panel also bore in mind the context when determining whether this lapse amounted to misconduct. It considered Witness 3’s evidence that Patient A, was highly vulnerable, as an elderly respiratory patient living with dementia, confused at the time, and presently receiving

oxygen therapy, as her oxygen levels were low. The panel took into account the evidence of Witness 4 who informed the panel that:

> *'She (Patient A) was at risk of taking her oxygen mask off and needed to be observed at all times. Someone was always required to sit in the room with the patient. The patient was able to get out of the bed, and therefore she had bed rails placed on either side. However, there still was a risk of her taking off her oxygen mask, which is why someone had to be in the room to monitor the situation.'*

Additionally:

> *'…there was still a risk that she could have managed to get to the edge of the bed. There is a gap on either side of the bed where the rails are up. If she had managed to get there, it could have been a risk of her falling because she was not able to mobilise without assistance. Also, her oxygen mask was off. She was on 4 litres of oxygen, which means the incident could have been very serious.'*

The panel also bore in mind that Witness 7 had informed the panel under questioning that the risk of Patient A not receiving oxygen therapy (had she removed her mask) could have been life threatening.

The panel furthermore considered the context of you having fallen asleep. [PRIVATE].

In light of the above, the panel determined that your falling asleep had placed Patient A at a high risk of harm. [PRIVATE], the effect of which resulted in risk to your vulnerable patient. The panel determined that, as a nurse of more than 30 years of experience, you should have considered that [PRIVATE] at risk of falling asleep to accept the allocation of 1:1 observations, or that, you should have as a minimum exercised your right to request a break or to be relieved by another member of staff, [PRIVATE].

The panel, therefore found that your actions in charge 2 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to charge 3b – h, given the findings of facts on the context of [PRIVATE] the panel did not find this charge amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) ...'

The panel determined that limbs a – c of the *Grant* test were engaged.

The panel determined that your competency issues and your misconduct at charge 2 had in the past placed patients at an unwarranted risk of harm. Further, that your misconduct at charge 2 had brought the profession into disrepute. Additionally, that your long term

competency issues and misconduct at charge 2 had breached fundamental tenets of the profession. Consequently, limbs b – c were engaged in the past.

However, the misconduct was not such that the panel considered that a finding of current impairment was required by reason of that past misconduct.

The panel then considered whether the *Grant* test was satisfied in respect of future risk to the public. In doing so, it considered the guidance in the case of *Cohen.*

The panel was satisfied that the misconduct and the lack of competence in this case is capable of being addressed through thorough retraining, clinical supervision/support/assessment and by showing fully developed insight demonstrated through reflections upon the impact of your failings on your patients, your colleagues and the wider impact upon public confidence in the nursing profession. [PRIVATE]. It noted that you have made admissions to some of the charges. However, it was of the view that your insight was insufficient as it was self-centred. It focused on the impact it had on you and did not acknowledge the impact your actions had on the patients that were affected, your colleagues and the wider public confidence in the profession.

The panel carefully considered the evidence before it in determining whether or not you have sufficiently strengthened your practice. It took into account the training certificates you have provided demonstrating training you had undertaken in 2022. It noted that you have not been able to practise as a registered nurse since June 2021. However, it was of the view that you could have taken steps to strengthen your practice other than completing e-learning courses. The panel noted that there was nothing before it relating to competence in the administration of medication.

The panel determined that, taking all your evidence into account, the level of insight you have demonstrated is currently insufficient for the panel to be satisfied that it is highly unlikely for your misconduct to recur. However, the panel was of the view that your insight

has the potential to develop in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel also took into account the testimonial provided by your current employer [PRIVATE]. The panel also noted that your employer stated *‘Janice is a kind and caring individual, and I am sure given the right support, retraining and guidance she would be able to return to the post of Nurse.’* This indicated that the person perhaps closest to your current work in a caring capacity considered that currently you are not able to practice without support.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. Your practice was marred by a recurrent and intermittent general lack of competence. In addition, misconduct was found proved. The panel considered that the public as well as the wider profession would expect that the combination of lack of competence and misconduct would be marked by a finding of current impairment of fitness to practise. The panel is satisfied that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore finds your fitness to practise also impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 2 years. 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

In the Notice of Hearing, dated 4 December 2024, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that conditions of practice order for a period of 12 months with a review is more appropriate in light of the panel's findings.

Mr McPhee submitted:

> *'13. The panel should impose a conditions of practice order for a period of 12 months. No lesser sanction is adequate to protect the public. No greater sanction is appropriate and proportionate. The registrant's fitness to practise is impaired as a result of remediable concerns, relating to clinical practice. There is significant public interest in the registrant returning to practice, with appropriate conditions formulated to safeguard the public. The panel, experts in assessment and management of risk, can identify and formulate appropriate conditions.'*

Mr Docherty submitted:

> '[…] [PRIVATE]. *Janice has been subject to a suspension from June 2021. We're nearly 4 years down the line now and as you will know the matter of delay in terms*

of how long it has taken to get to this stage is not insignificant in terms of what the proportionate sanction may be.

[…] *a conditions of practice order to entail focused training to address the issues you have identified would be appropriate together with some element of supervision. Such would allow Janice an opportunity to fully remediate the misconduct by addressing gaps in her insight, strengthen her practice and demonstrate that she, over time, no longer presents a risk to the public or patients. For completeness I would simply submit that in this case any sanction more severe than a conditions of practice order would be wholly disproportionate in light of the findings you have made.*'

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A protracted period of 18 months of unsafe clinical practice whilst in receipt of high levels of support.
- Conduct that put vulnerable patients at risk of suffering harm.
- Limited insight into the impact of your failings on your patients, your colleagues and the wider public's confidence in the profession.

The panel also took into account the following mitigating features:

- Early admissions to some of the charges.
- [PRIVATE].
- [PRIVATE].
- [PRIVATE].
- You have continued to work in a healthcare related field demonstrating commitment to continuing to support others and maintain skills within this field.

Lack of competence

The panel was concerned that there was a repeating pattern of you making progress in your clinical skills but then relapsing, which meant that there was an inconsistency in your progress. [PRIVATE]. The panel also noted that the incidents took place during the Covid-19 pandemic, which could be a mitigating feature. However, there was no evidence before the panel that the Covid-19 pandemic had affected your clinical abilities and noted that you were supervised and supported by the Hospital.

The panel first considered whether to take no action but concluded that this would be inappropriate because this would not address the issue of competence. As these concerns were wide ranging and over a prolonged period this would leave the public protection issues unaddressed. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, for the same reasons 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 lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the risk to the public from practising unrestricted. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 noted that during the time of the incidents, you were supported by the Hospital by having supervision during drug rounds and by undertaking informal and formal capability plans. [PRIVATE]. The panel was concerned that the competency issues found proved might indicate a general incompetence. [PRIVATE]. The panel was impressed that you continued to practise in the caring sector and took into account [PRIVATE]'s testimony, which stated:

> '*Janice is a kind and caring individual, and I am sure given the right support, retraining and guidance she would be able to return to the post of Nurse*.'

In light of the above, 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 noted that there was no evidence of any harmful, deep-seated personality or attitudinal issues that would suggest a fundamental risk to patient safety. Instead, the panel identified specific areas of your practice that would benefit from targeted assessment and supervision. The panel was concerned that you lack insight into your clinical practice as well as the impact of your errors on your patients, colleagues, and the wider public. This was because your reflective piece focussed on your own issues, and while insightful to an extent it lacked insight into the effect of your competency issues on patients and colleagues, and on the reputation of the profession.

The panel accepted that you are willing to comply with conditions of practice. The panel concluded that it could formulate conditions that allows for ongoing monitoring and assessment, so as to protect the public and assist you to strengthen your practice. 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, particularly given your extended commitment to a caring role.

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

The panel decided that to impose a suspension order would be disproportionate and would not enable you to address the fundamental issue of competence. The panel noted that in relation to the competency charges a striking off order was not available to it, and in any event would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that the competency charges found proved were best addressed through a conditions of practice order. This will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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

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

1. You must limit your nursing practice to one substantive post within an acute care setting (hospital or equivalent). This must not be through an agency and not in a care/nursing home (this does not prevent you from working as a healthcare assistant).

2. You must not be the nurse in charge.

3. You must ensure that you are supervised whenever you are administering medication. The supervision requirements are as follows:

   a) For a minimum term of 4 weeks, you must be directly supervised by another registered nurse.
   b) After the initial 4-week period, and upon assessment of your medication administration practice, if assessed by a registered nurse safe to do so may transition to indirect supervision.

   You must provide to the NMC a report from the assessing nurse summarising the assessment and decision to transition to indirect supervision which must be submitted to your case officer one week before you commence indirect supervision.

4. You must work with a band 6 or above nurse to create a personal development plan (PDP). It must contain provisions for monthly review meetings. It must address concerns about:
   a) monitoring blood glucose levels;
   b) recording blood glucose levels on the prescription and administration chart (or where required by local policy);
   c) recording safe and effective medication administration;
   d) leadership skills and effective communication within the multidisciplinary team;
   e) infection control; and
   f) patient risk assessment.

   You must:
   - send your NMC case officer a copy of your PDP within two months of commencing employment;
   - send your NMC case officer a report from a band 6 or above nurse before the next review hearing. This report must show your progress towards achieving the aims set out in your PDP.

5. You must keep a reflective practice profile every 6 months which details examples of when:
   a) you were monitoring blood glucose levels;
   b) recording blood glucose levels on the prescription and administration chart (or where required by local policy);
   c) recording safe and effective medication administration;
   d) leadership skills and effective communication within the multidisciplinary team;
   e) infection control; and
   f) patient risk assessment.

This should be:

- reviewed and signed by your supervisor; and
- sent to your NMC case officer before the next review hearing.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 2 years. The panel concluded that this period of time would allow you sufficient time to secure employment and support your return to nursing practice. This order will be reviewed at six-monthly intervals so that if your progress is rapid you can ask a reviewing panel to shorten the period of the order.

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.

<u>Misconduct</u>

The panel next considered the misconduct charge found proved. The panel noted that you have been subject to an interim suspension order for a period of almost four years. The panel considered that it was unlikely that you would repeat such misconduct, which was a one off incident in a long career. For these reasons the panel did not consider any further sanction was required in respect of the misconduct charge., However the panel was concerned that your reflective statement was self-focused, and did not indicate awareness and insight into the consequences or possible consequences for the patient and the reputation of the profession. While in all the circumstances this did not lead the panel to consider a sanction for the misconduct, it considered that a future panel, which would be

considering your level of insight overall, would be assisted by a further reflection from you about this misconduct.

Accordingly, the panel was satisfied that the conditions of practice order was sufficient to address all the issues in this case.

Any future panel reviewing this case would be assisted by:

- Your attendance at any future hearing;
- A reflective statement demonstrating your insight on the impact of your misconduct and lack of competence on the patients, colleagues and on the public's confidence in the nursing profession
- Evidence of competent practice in:
    - medication administration;
    - recording safe and effective medication administration;
    - monitoring blood glucose levels;
    - recording blood glucose levels on the prescription and administration chart (or where required by local policy);
    - leadership skills and effective communication within the multidisciplinary team;
    - infection control; and
    - patient risk assessment.
- Testimonials from managers, colleagues and (if provided spontaneously) from patients.

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.

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

Submissions on interim order

The panel took account of the submissions made by Mr McPhee. He invited the panel to make an interim conditions of practice order that mirrors the substantive conditions of practice order for a period of 18 months to cover any appeal period until the substantive conditions of practice order takes effect. He submitted that such an order is necessary for the protection of the public and is otherwise in the public interest.

Mr Docherty supported the application.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that you cannot practise unrestricted before the substantive conditions of practice order takes effect. This will cover the 28 days during

which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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.