Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

12 August 2019 – 16 August 2019 and 19 August 2019

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Tracey King
NMC PIN:	08I1404E
Parts of the register:	Registered Nurse – Sub part 1 – Adult Nursing (22 September 2008)
Area of registered address:	England
Type of case:	Misconduct
Panel members:	Mary Monnington (Chair, Registrant member) Sue O'Sullivan (Registrant member) John Haines (Lay member)
Legal Assessor:	Nicholas Wilcox
Panel Secretary:	Deepan Jaddoo
Miss King:	Not present and not represented
Nursing and Midwifery Council:	David Claydon, Case Presenter
No evidence offered:	2(b)(i), 2b(ii), 2(b)(iv) and 2(b)(v)
Facts proved:	1 (in its entirety), 2(a)(i), 2(a)(ii), 3(a)(i), 3(a)(ii), 3(b)(ii)(a), 3(b)(ii)(c), 3(b)(ii)(d), 3(b)(ii)(e), 3(c)(i), 3(c)(iv), 3(d)(i), 3(d)(ii)
Facts not proved:	2(b)(iii), 2(c)(i), 3(b)(i), 3(b)(ii)(b), 3(c)(ii), 3(c)(iii)
Fitness to practise:	Impaired
Sanction:	Striking Off Order
Interim order:	Interim Suspension Order – 18 Months

Decision on service of Notice of Hearing

Miss King was not in attendance or represented at the hearing. The panel examined the proof of posting and was satisfied that written notice of this hearing had been sent to Miss King's registered address by recorded delivery and by first class post on 12 July 2019. Royal Mail Track and Trace confirmed that the notice was delivered to Miss King's registered address on 13 July 2019 and signed for in the printed name of 'KING'.

The panel took into account that the notice of hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Miss King's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. Mr Claydon submitted that the NMC had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended ("the Rules").

In the light of all of the information available and the advice of the legal assessor which the panel accepted, the panel was satisfied that Miss King has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34(1), 34(4) and 34(5).

Decision on proceeding in the absence of Miss King

Mr Claydon invited the panel to proceed in the absence of Miss King on the basis that she had voluntarily absented herself. In support of his application, Mr Claydon referred the panel to the NMC's Proceeding in Absence Bundle which comprised:

- A page of Miss King's case management form regarding her hearing attendance;
- Telephone communication notes dated 22 February 2019, 13 May 2019 and 30 July 2019 between the NMC and Miss King;
- E-mail correspondence between the NMC and Miss King dated 30 July 2019.

Mr Claydon drew the panel's attention to the e-mail from Miss King dated 30 July 2019 in which she states:

"Thanks for your email. I will not be attending the hearing."

Mr Claydon submitted that it was clear from the information outlined above, that Miss King was aware of these proceedings but had decided not to attend and had not made any application for an adjournment. Mr Claydon submitted that there was no good reason to believe that an adjournment would secure Miss King's attendance on some future occasion and that indeed, Miss King has provided a bundle of documentation for the panel to consider. As such, Mr Claydon invited the panel to consider that whilst Miss King was engaging with the NMC, she had voluntarily absented herself from the hearing. Mr Claydon noted that there were six witnesses scheduled to give oral evidence. He therefore invited the panel to proceed in the absence of Miss King.

Rule 21 states:

> "Where the registrant fails to attend and is not represented at the hearing, the Committee…
>
> (b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant...
>
> (c) may adjourn the hearing and issue directions."

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is one that should be exercised “with the utmost care and caution”.

In reaching its decision, the panel considered the submissions of the case presenter and accepted the advice of the legal assessor. It had regard to the overall interests of justice and fairness to all parties. The panel carefully considered the correspondence and communication between Miss King and the NMC.

Taking into account all of the above, the panel concluded that Miss King has been afforded adequate opportunity to attend the hearing and had made a conscious decision not to do so.

The panel also noted:

- Six witnesses were scheduled to attend, in person, to give evidence.
- Not proceeding may inconvenience these witnesses;
- Further delay may have an adverse effect on the ability of these witnesses to accurately recall events and their willingness to attend a future hearing;
- The allegations are serious and there is clear public interest in the expeditious disposal of the case;
- Miss King is clearly aware of the proceedings today and it is clear that she is content for the proceedings to go ahead;
- Miss King had not requested an adjournment;
- Miss King has provided a bundle of documentation setting out her position in relation to the charges set against her;
- There was no information before this panel to satisfy it that Miss King would attend proceedings at a later date.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss King.

Details of charge

That you, a registered nurse:

1. *Whilst employed at Forde Park Nursing Home between 18 August 2016 and 10 September 2016:*
   (a) On one or more occasions between 23 August 2016 and 7 September 2016, made inappropriate comments about residents, in that you said words to the effect of:
      i. "She shouldn't be wandering around, she needs medication to make her sleep"
      ii. "What's the point; these people are old and ill";
   (b) On an unknown date between 24 August 2016 and 10 September 2016, left medication unattended in Resident A's room;
   (c) On an unknown date between 24 August 2016 and 10 September 2016, inappropriately handled Resident B;
   (d) On or around 8 September 2016, forcibly administered medication to Resident C;
   (e) On 10 September 2016, left Resident D on a commode and did not return to assist them;
   (f) On an unknown date, did not clean Resident D when changing their pad, before putting them to bed;

2. *Whilst employed at Pinewood Nursing Home between 14 March 2017 and 3 April 2017:*
   (a) *On 23 March:*
      i. *Dispensed medication incorrectly by pre-potting it for more than one resident at a time;*
      ii. *Administered medication incorrectly by handling it;*

   (b) *On 25 March 2017:*

i. *Did not administer paracetamol to Resident E during the lunchtime medication round;*

ii. *Recorded in a MAR chart that paracetamol had been administered to Resident E, when this was not the case;*

iii. *Did not administer or record that you had administered a Hydroxocobalamin Injection to Resident F;*

iv. *Did not administer a pain patch to Resident G;*

v. *Did not administer Tramadol to Resident H;*

(c) *On 29 March 2017:*

i. *Did not monitor and/or record the blood glucose level of Resident J;*

3. *Whilst employed by Your World Recruitment Group between 18 March 2017 and 25 May 2017:*

(a) *Between 12 and 13 April 2017, while working on Braunton Ward at Derriford Hospital:*

i. *Did not administer pre-surgery medications (Temezepam, Rantidine, Oxygen and Levetiracetam) to Patient A;*

ii. *Did not attend to an infusion pump alarm, despite this being brought to your attention;*

(b) *Between 16 and 17 April 2017 whilst working on Okement Ward at The Royal Devon and Exeter Hospital:*

i. *Miscalculated an Early Warning Score ('EWS') in respect of Patient B;*

ii. *Did not demonstrate safe practice whilst attempting to administer Flucloxacillin to an unknown patient by:*

a. *attempting to give a 2 gram dose via a push;*

b. *handling equipment without gloves;*

c. *not gathering a flush;*

d. *not cleaning the cannula; and/or*

e. *allowing the open tube to trail along the floor;*

(c) *Between 17 and 18 April 2017 whilst working at Monkswell Ward at Derriford Hospital:*

i. *Did not administer and/or record that you had administered insulin to Patient C;*

ii. *Did not record the time that Oxycodone was administered to Patient C;*

iii. *Did not connect Patient D's nasogastric line correctly;*

iv. *Did not administer Oxycodone to Patient E;*

(d) *Between 24 and 25 May 2017 whilst working at Tavistock Hospital:*

i. *Did not administer insulin to Patient F until prompted by a colleague;*

ii. *Dispensed medication incorrectly by administering it to more than one patient at a time without using a drugs chart to identify patients;*

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

Background

Miss King qualified as a registered nurse in September 2008. The NMC received three separate referrals concerning Miss King. The referrals relate to concerns surrounding Miss King's alleged conduct towards patients and staff, and her clinical practice.

First set of allegations – Forde Park Nursing Home ("Forde") - Referral received on 13 September 2016

The first set of allegations relate to concerns arising from Forde, where Miss King worked form 18 August 2016 until her dismissal on 10 September 2016. Miss King is alleged to have:

- Force-fed a resident their medication (9 September 2016);
- Left a resident on a commode without means to contact assistance (10 September 2016);
- Failed to provide personal care to a resident who had been doubly incontinent instead putting them to bed without washing or cleaning them (date unknown);
- Made inappropriate comments about residents (23 August 2016 and 7 September 2016);
- Rough handled a resident to bed (one occasion between 24 August 2016 and 10 September 2016); and
- Left medication unattended in a resident's room (unknown date between 24 August 2016 and 10 September 2016).

Second set of allegations – Elmwood Nursing Home Limited t/a Pinewood Nursing Home ("Pinewood") - Referral received on 27 April 2017

The second set of allegations relate to concerns arising from Pinewood, where Miss King worked from 14 March 2017 until her resignation on 3 April 2017. Miss King is alleged to have:

- Administered and dispensed medication incorrectly on 25 and 29 March 2017; and
- Failed to monitor a resident's blood glucose levels on 29 March 2017.

Third set of allegations – Your World Recruitment Group ("Your World") - Referral received on 1 June 2017

The third set of allegations relate to concerns arising from Your World, where Miss King worked from 18 March 2017 until the termination of her contract on 25 May 2017. Your World received five separate complaints between 28 March 2017 and 25 May 2017 from various wards that Miss King had worked on.

On 12 April 2017 whilst working on the Braunton Ward ("Braunton") at Derriford Hospital, Miss King is alleged to have:

- Failed to administer the following pre-surgery medications: Temezepam, Rantidine, Oxygen and Levetiracetam to a patient; and
- Failed to attend to an infusion pump alarm, despite being asked to do so.

On 16 April 2017 whilst working on the Okement Ward ("Okement") at Royal Devon & Exeter Hospital, Miss King is alleged to have:

- Failed to demonstrate safe practice whilst attempting to administer Flucloxacillin to a patient; and
- Miscalculated a patient's Early Warning Score ('EWS').

On 17-18 April 2017 whilst working at Monkswell Ward ("Monkswell") at Derriford Hospital, Miss King is alleged to have:

- Failed to administer a prescribed dose of insulin to a patient;
- Failed to connect a patient's nasogastric line correctly; and

- Failed to administer medication to a patient.

On 24-25 May 2017 whilst working at Tavistock Hospital, Miss King is alleged to have:

- Failed to administer insulin to a patient; and
- Failed to follow the correct procedure for administering medication to patients.

Application to offer no evidence under Rule 24(7) in respect of charges 2(b)(i), 2b(ii), 2b(iv) and 2(b)(v)

The panel heard an application from Mr Claydon, on behalf of the NMC, to offer no evidence in respect of charges 2(b)(i), 2b(ii), 2b(iv) and 2(b)(v).

Mr Claydon noted that the charges outlined above relied solely on the evidence of Colleague G. Mr Claydon told the panel that during the course of its investigation, and despite efforts made by the NMC to obtain a signed copy of Colleague G's statement and secure her live attendance at this hearing, engagement with Colleague G had unfortunately broken down.

Mr Claydon noted that on 21 September 2018, Colleague G had submitted a written complaint to the NMC, in which she stated *"I did not work with this nurse and only met a couple of times during handover. On reflection and over time I considered some of the points I had made on the statement and felt that rather than being bad practice could actually just of (sic) been down to the nurse having a judgement of error (sic) on the day and I felt I wasn't the best person to pass judgement on her actions as I had only met her for such a short time."*

Mr Claydon therefore told the panel that Colleague G's lack of engagement may potentially be due to her not being in agreement with the contents of her statement and not satisfied with the NMC process. Mr Claydon submitted that as a consequence of this lack of engagement, the NMC had not obtained a signed statement from Colleague G,

nor was it able to secure her attendance. Mr Claydon informed the panel that it was the NMC's position that it would not be appropriate to compel Colleague G to attend. Mr Claydon acknowledged that the evidence in support of these charges stemmed solely from the evidence of Colleague G. Given the difficulties outlined above in securing Colleague G's attendance, Mr Claydon invited the panel to find that there was no evidence in respect of these charges.

This application was made under Rule 24 (7) of the Rules. This Rule states:

(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and—

(i) either upon the application of the registrant, or
(ii) of its own volition,

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

The panel was solely considering whether sufficient evidence was available, such that it could find the facts proved and whether Miss King has a case to answer in respect of charges 2(b)(i), 2b(ii), 2b(iv) and 2(b)(v).

The panel took into account the above circumstances and was of the view that there was no longer any direct evidence in relation to these charges. The panel also noted that these allegations were highly contested and disputed by Miss King. Given that there was no longer any reliable evidence to support these charges, the panel determined that there was no longer a case to answer in respect of these charges.

Accordingly, the panel accepted the NMC's application to offer no evidence for charges 2(b)(i), 2b(ii), 2b(iv) and 2(b)(v).

Details of charge following Rule 24(7) application

That you, a registered nurse:

1. *Whilst employed at Forde Park Nursing Home between 18 August 2016 and 10 September 2016:*
   (a) On one or more occasions between 23 August 2016 and 7 September 2016, made inappropriate comments about residents, in that you said words to the effect of:
      i. "She shouldn't be wandering around, she needs medication to make her sleep"
      ii. "What's the point; these people are old and ill";
   (b) On an unknown date between 24 August 2016 and 10 September 2016, left medication unattended in Resident A's room;
   (c) On an unknown date between 24 August 2016 and 10 September 2016, inappropriately handled Resident B;
   (d) On or around 8 September 2016, forcibly administered medication to Resident C;
   (e) On 10 September 2016, left Resident D on a commode and did not return to assist them;
   (f) On an unknown date, did not clean Resident D when changing their pad, before putting them to bed;

2. *Whilst employed at Pinewood Nursing Home between 14 March 2017 and 3 April 2017:*
   (a) *On 23 March:*
      i. *Dispensed medication incorrectly by pre-potting it for more than one resident at a time;*
      ii. *Administered medication incorrectly by handling it;*

   (b) *On 25 March 2017:*

i. …

ii. …

iii. Did not administer or record that you had administered a Hydroxocobalamin Injection to Resident F;

iv. …

v. …

(c) *On 29 March 2017:*

i. *Did not monitor and/or record the blood glucose level of Resident J;*

3. *Whilst employed by Your World Recruitment Group between 18 March 2017 and 25 May 2017:*

(a) *Between 12 and 13 April 2017, while working on Braunton Ward at Derriford Hospital:*

i. Did not administer pre-surgery medications (Temezepam, Rantidine, Oxygen and Levetiracetam) to Patient A;

ii. Did not attend to an infusion pump alarm, despite this being brought to your attention;

(b) *Between 16 and 17 April 2017 whilst working on Okement Ward at The Royal Devon and Exeter Hospital:*

i. Miscalculated an Early Warning Score ('EWS') in respect of Patient B;

ii. Did not demonstrate safe practice whilst attempting to administer Flucloxacillin to an unknown patient by:

a. attempting to give a 2 gram dose via a push;

b. handling equipment without gloves;

c. not gathering a flush;

d. not cleaning the cannula; and/or

e. allowing the open tube to trail along the floor;

(c) *Between 17 and 18 April 2017 whilst working at Monkswell Ward at Derriford Hospital:*

i. Did not administer and/or record that you had administered insulin to Patient C;

ii. *Did not record the time that Oxycodone was administered to Patient C;*

iii. *Did not connect Patient D's nasogastric line correctly;*

iv. *Did not administer Oxycodone to Patient E;*

(d) *Between 24 and 25 May 2017 whilst working at Tavistock Hospital:*

i. *Did not administer insulin to Patient F until prompted by a colleague;*

ii. *Dispensed medication incorrectly by administering it to more than one patient at a time without using a drugs chart to identify patients;*

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

Decision and reasons on application pursuant to Rule 31 in relation to Colleague D's evidence via video-link

The panel heard an application made by Mr Claydon under Rule 31 to allow Colleague D to provide evidence to the panel via video-link. Mr Claydon submitted that this application was being made due to substantial difficulties faced by Colleague D with regard to her travel arrangements which prevented her from physically attending the hearing. Mr Claydon noted that in addition to the practical difficulties, this hearing had been listed on dates which Colleague D had already booked annual leave. Mr Claydon therefore submitted that given the above, it would be fair and appropriate for Colleague D to give her evidence via video-link.

The panel accepted the advice of the legal assessor.

The panel gave consideration to the application and noted that Colleague D's statement had been prepared in anticipation of being used in these proceedings and was signed by her. The panel was of the view that her evidence is clearly relevant. The panel also noted that it will be in a position to question Colleague D and assess her demeanour and credibility. There was also the public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be right for Colleague D to give evidence to the panel by video-link.

Decision on the findings on facts and reasons

In reaching its decision on the charges, the panel took account of all of the evidence, oral and documentary, adduced in this case, including the accounts given by Miss King, together with the submissions made by Mr Claydon on behalf of the NMC.

The panel accepted the advice of the legal assessor.

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 the facts will be proved if the panel is satisfied that it was more likely than not that the incidents occurred as alleged.

The NMC's live witness evidence came from:

- Colleague A, Manager at Forde at the time;
- Colleague B, Support Worker at Forde at the time;
- Colleague C, Registered Manager at Pinewood at the time;
- Colleague D (via video-link), Band 5 Staff Nurse on the Okement Ward, at The Royal Devon and Exeter Hospital at the time;
- Colleague E, Band 5 Staff Nurse, on the Monkswell Ward, at Derriford Hospital at the time;
- Colleague F, Nurse Manager on the Medical Ward at Tavistock Hospital.

The panel also considered all the documentary evidence covering accounts of events given by Colleague G, Colleague H, Colleague I, Colleague J, Colleague K, Colleague L, Colleague M, Colleague N, Colleague O and Miss King.

The panel considered Colleague A's evidence. Colleague A was clear, logical and professional. She was able to address areas of confusion within the NMC's evidence and was convincing in her explanations to the panel. Colleague A tried her best to assist the panel despite having some issues of recall which she accepted.

The panel considered Colleague B's evidence. The panel found her to be an open and honest witness who tried to assist the panel. The panel found that Colleague B was clear when she could remember details and clear when she could not. She was candid about her inexperience at the time and the panel found her to be a caring individual.

The panel considered Colleague C's evidence. The panel found that she was of limited assistance as she was not a first-hand witness to events. Colleague C was a professional witness who tried to be helpful to the panel.

The panel considered Colleague D's evidence. The panel found Colleague D to be an honest, straight forward witness and that her oral evidence remained consistent with her witness statement. However, the panel noted that, by her own admission, she had limitations to her memory due to the passage of time. Colleague D had a good grasp of the clinical issues involved in the case and the panel found that she was able to comment on Miss King's clinical performance in detail. The panel found her to be a credible witness.

The panel considered Colleague E's evidence. The panel found her evidence unclear at times, and therefore placed limited weight on her evidence. The panel also found that she appeared to be unclear as to her own professional responsibilities in relation to some of the issues highlighted in the case. She was also unable to provide any clarity as to the related procedures and policies at the Hospital. Nonetheless, the panel found that she tried her best to assist where she was able.

The panel considered the evidence of Colleague F. The panel found Colleague F to be a clear, open and honest witness. The panel found that she was professional and provided thoughtful answers to questions. Colleague F had a very good recollection of events and provided the panel with a high level of detail and clarity in her evidence. The panel found that Colleague F was able to provide it with a contextual background in relation to the working environment of the Ward.

The panel considered the following charges.

Charge 1(a)

That you, a registered nurse:

1. *Whilst employed at Forde Park Nursing Home between 18 August 2016 and 10 September 2016:*
   (a) On one or more occasions between 23 August 2016 and 7 September 2016, made inappropriate comments about residents, in that you said words to the effect of:
      i. "She shouldn't be wandering around, she needs medication to make her sleep"
      ii. "What's the point; these people are old and ill";

These charges are found PROVED

The panel noted that the evidence in support of this charge came solely from Colleague I.

Colleague I, in her witness statement stated:

"The registrant said "She shouldn't be wondering (sic) around, she needs medication to make her sleep". This made me quite angry to think a qualified nurse would have such an opinion…"

The panel noted that this evidence was consistent with her local statement produced at the time of the investigation of the incident, in which Colleague I stated:

"On Tracey's second day of employment, Tuesday 23rd August she stopped me as a I was leaving my shift to say "that woman needs a mental health assessment" pointing to Resident B to which I replied "why, she only had one last week", Tracey then said to me "she shouldn't be wondering (sic) around, she needs medication to make her sleep", I admittedly replied firmly "No chance, we do not do that here, Resident B is always unsettled early evening."

With respect to charge 1(a)(ii), Colleague I in her contemporaneous statement to her manager stated that on 7 September 2016 she turned the TV on to stimulate residents in the Home. Tracey said *"what's the point, these people are old and ill".* Colleague I explained why she had switched the TV on.

The panel also noted that Colleague I went on to say *"On Saturday Tracey did say to me she took it all on board and would now look to put something on for the residents."*

The panel found Colleague I's contemporaneous statement written for her manager at the time to be clear and compelling, and determined that it was more likely than not that Miss King had made inappropriate comments about residents, as alleged.

Accordingly, these charges are found proved.

Charge 1(b)

(b) On an unknown date between 24 August 2016 and 10 September 2016, left medication unattended in Resident A's room;

This charge is found PROVED

The panel noted that the evidence in support of this charge came from Colleague H.

The panel noted that whilst Colleague H records the date of this incident as 12 August 2017 in her local statement, she clarifies in her NMC statement that this was in fact 12 September 2017. The panel noted that this date corresponded with her signature on the document.

Colleague H, in her NMC statement, stated:

"On one occasion, I cannot recall the date, I went into Resident A's room to attend to her personal care. I noticed that there were 2 medication pots on Resident A's bedside table with the medication in them. I went and asked the registrant (who was the Nurse in Charge during the shift) about the two medication pots. The registrant told me that "Resident A wouldn't open her mouth, so I left them there". I thought that she should have kept trying to administer the medication or tried to get assistance.

Resident A was unable to take her medication independently."

The panel noted that this was consistent with her local statement, in which she described the incident in detail and confirmed that Ms King was the nurse in charge.

In the panel's view, it was more likely than not that this incident occurred as alleged. The panel considered that Miss King's response, as quoted by Colleague H, appears to support the view that two medication pots were left in the room without the medication being administered.

Accordingly, this charge is found proved.

Charge 1(c)

(c) On an unknown date between 24 August 2016 and 10 September 2016, inappropriately handled Resident B;

This charge is found PROVED.

The panel considered the evidence of Colleague I.

In her local statement, Colleague I stated: *"On another occasion a few days later I seen (sic) Tracey roughly handling (pulling her, leading her to her bed)…"*

Colleague I provides further detail into this incident in her NMC statement, in which she stated:

"A few days later, I witnessed the registrant roughly handling Resident B. The registrant was trying to lead Resident B to her bedroom from the lobby area but she was pulling her quite roughly. The registrant was telling Resident B to go and lie down on her bed…

This behaviour from TK alarmed me as her manual handling was wrong, her whole attitude to Resident B was awful, she simply wanted her in bed out of the way."

The panel noted that whilst Miss King refutes this allegation, it had no helpful information from her as to what occurred. In the panel's view, Colleague I's contemporaneous version of events as supported by her NMC statement was compelling evidence of her observation of Miss King's unnecessarily rough handling a vulnerable resident. The panel was also of the view that Colleague I was clearly aware of and understood basic principles of manual handling.

The panel noted that it had no evidence before it which suggested that Colleague I bore any prejudice or ill feeling toward Miss King.

Accordingly, this charge is found proved.

Charge 1(d)

(d) On or around 8 September 2016, forcibly administered medication to Resident C;

This charge is found PROVED.

The panel noted that the evidence in support of this charge came from Colleague B, who gave live evidence and was a direct eye witness to this incident and from Colleague A, albeit to a lesser extent.

Colleague B, in her NMC statement stated:

"I put Resident C's dinner down so that the registrant could finish administering the medication. The registrant put the whole pot deep into Resident C's mouth. Resident C's eyes were wide open; she looked really worried and shocked by what was being done. The medicine was dribbling out the side of Resident's C's mouth and running down onto her chin and chest. I didn't know how to react. I got a napkin and wiped up the spill. The registrant then left the room and came back with a syringe. During this time, she didn't talk to me or Resident C at all. The registrant drew up the remaining liquid in the pot and shoved the syringe into the back of Resident C's mouth. She then squirted the medication into her mouth very quickly…

… The registrant then drew up the liquid and again shoved the syringe into Resident C's mouth and squirted the medication in very quickly… I was shocked and stunned by

what the registrant had done; Resident C looked very shocked and upset with having the syringe and liquid shoved in her mouth….

… The following day… I told my manager about what had happened. I was so shocked and upset by the registrant's treatment of Resident C. I was in tears trying to explain what had occurred. I have nothing against the registrant as a person but to see that kind of treatment of a vulnerable resident was shocking".

The panel noted that Colleague B, despite being a junior member of staff at the time, in terms of her experience, was clearly very distressed at the time of reporting this incident. The panel found Colleague B's oral evidence in relation to this allegation to be consistent with her written statement. Further, when asked a series of detailed questions about the medication pot and syringe, Colleague B was clear and adamant about her version of events and was able to provide highly detailed and descriptive answers.

Colleague B was a compelling witness and was able to explain the manner in which Resident C communicated by using her eyes. Colleague B told the panel that she was familiar with Resident C and her method of communication and that Resident C looked frightened and shocked at the time.

Colleague A told the panel that in her opinion, Miss King's actions as detailed by Colleague B was unacceptable and the use of syringes for administering oral medication was a "no-no".

In the panel's view, it was more likely than not, that both the medication pot and syringe were used to forcibly administer medication to Resident C by Miss King.

Accordingly, this charge is found proved.

Charge 1(e)

(e) On 10 September 2016, left Resident D on a commode and did not return to assist them;

This charge is found PROVED.

The panel noted that the evidence in support of this charge came from Colleague A, Colleague H and Resident D. The panel noted that Colleague H was an eye witness to this incident.

The panel took into account that Resident D's statement had been dictated to Colleague A at the time. Colleague A, in her oral evidence, explained to the panel that at the time of taking this statement on Resident D's behalf, Resident D was very upset and anxious. Colleague A's main focus was to simply take the statement as quickly as possible from Resident D without causing her any further distress. This resulted in her not obtaining a signature for the statement, and accounted for it not being dated.

Colleague H, in her NMC statement stated:

"On 10 September 2016, I answered Resident D's call bell. When I got to Resident D's room, I saw that she had pulled herself towards the door of her bedroom to call for help. Resident D was very upset and told me that the registrant had put her on the commode and left her there. Resident D told me that she knew the registrant was not going to come back to her."

This evidence was corroborated by Resident D's statement, in which it is recorded:

"This morning, Tracey King put me on the commode, she did not come back to help me to get off the commode. Support worker [Colleague H] came to help me. My heart sinks

when I see her come in as I know that something is going to happen."

The panel had no information from Miss King which provided any explanation regarding this incident. The panel considered the corroborative evidence of Colleague A, Colleague I and Resident D, which it found compelling. The panel therefore determined that it was more likely than not that Miss King had acted in the manner alleged.

Accordingly, this charge is found proved.

Charge 1(f)

(f) On an unknown date, did not clean Resident D when changing their pad, before putting them to bed;

This charge is found PROVED.

The panel considered the statement of Resident D, who dictated to Colleague A:

"Unfortunately I had an accident when wearing my pad. When she took the pad off me Tracey King put a pad back on my bottom without cleaning me, I was upset all night, as I felt dirty. I did not sleep all night."

Colleague A, in her NMC statement stated:

"Resident D informed that on one occasion whilst being put to bed by the registrant. The registrant placed a new pad on Resident D without washing her."

In the panel's view, Resident D's account of events was compelling.

The panel found that it was more likely than not that Miss King did not clean Resident D when changing her pad before putting her to bed.

Accordingly, the panel found this charge proved.

Charge 2 (a)

2. *Whilst employed at Pinewood Nursing Home between 14 March 2017 and 3 April 2017:*
   (a) *On 23 March:*
      i. *Dispensed medication incorrectly by pre-potting it for more than one resident at a time;*
      ii. *Administered medication incorrectly by handling it;*

This charge is found PROVED in both aspects.

The panel noted that the evidence in support of these charges came from Colleague J who was an eye witness to these incidents, and Colleague C.

Colleague J, in her contemporaneous local statement, stated:

"I was on shift with Tracey King at approx. 9:30pm I was in Room 8 with a client and Tracey came in she put 4 medicine pots on the clients table she took the top one and said she had some medication to take (to the client) She took them out with her fingers and put them into the clients mouth, No spoon was used. She left the room picking up the 3 remaining pots that had room numbers on bits of paper. I didn't say anything as she had been abrupt with me earlier, because I asked her to kindly Turn off the bells with sensors as she left the clients Rooms. She said not my problem and walked away."

The panel noted that whilst Colleague J's statement had been signed and dated 29 March 2017 at the bottom of the page, the date '23 March 2019' had been recorded at the top of the page (the date that these incidents are said to have occurred). The panel

therefore disregarded an incorrect date of 29 March 2017 contained in the NMC statement of Colleague J, which was otherwise consistent with her account above.

The panel considered that Colleague J's evidence was clear and descriptive. The panel noted that Colleague C, in her oral evidence, told the panel that all nursing staff would have had training in infection control in their pre-registration programme and would therefore be aware of the requirement not to touch medication by hand.

In the panel's view, Colleague J was clear about what she had observed, and had provided great detail in her evidence.

The panel accepted the evidence of Colleague J and found it more likely than not, that Miss King had dispensed medication incorrectly and had also incorrectly handled the medication as alleged on 23 March 2017.

Accordingly, these charges are found proved.

Charge 2(b)(iii)

(b) *On 25 March 2017:*

iii. *Did not administer or record that you had administered a Hydroxocobalamin Injection to Resident F;*

This charge is found NOT PROVED.

The panel considered the documentary evidence before it, namely the MAR Chart for resident F, and the evidence provided by Colleague C.

Colleague C, in her NMC statement said *"the registrant did not sign for a vitamin B12 [Hydroxocobalamin] injection which was due".*

The panel took into account that whilst it was clear, from viewing the MAR chart, that there was no signature recorded to indicate that Hydroxocobalamin had been administered to Resident F, it had no evidence before it to suggest that it was Miss King's responsibility to administer this medication.

In all the circumstances, the panel determined that the NMC had failed to discharge its burden in proof in relation to this charge.

Accordingly, this charge is found not proved.

Charge 2(c)

(c) *On 29 March 2017:*

i. *Did not monitor and/or record the blood glucose level of Resident J;*

This charge is found NOT PROVED.

The panel noted that the evidence in support of this charge came from Colleague C. The panel noted that when Colleague C was specifically asked whether she had looked at the blood glucose monitoring chart for Resident J at the time, Colleague C informed the panel "*yes, it was not there"*. Further, when asked whether she had seen the MAR Chart for Resident J at the time, Colleague C informed the panel *"yes, I didn't see any insulin recorded for 29 March 2017".*

The panel took into account that by her acceptance, there was no single place where such a recording should be entered, but rather a variety of places where this could have been recorded.

In the panel's view, given that it did not have before it the blood glucose chart or a clearly identified MAR Chart for Resident J, and that it was relying solely on Colleague

C's memory, it was not satisfied that, on balance, it was more likely than not that this incident had occurred.

Accordingly, this charge is found not proved.

Charge 3

3. *Whilst employed by Your World Recruitment Group between 18 March 2017 and 25 May 2017:*
   (a) *Between 12 and 13 April 2017, while working on Braunton Ward at Derriford Hospital:*
      i. *Did not administer pre-surgery medications (Temezepam, Rantidine, Oxygen and Levetiracetam) to Patient A;*

This charge is found PROVED.

The panel took into account Miss King's response to this charge and found that she appears to make an admission to this, although she has not provided an explanation as to why this occurred.

The panel also noted that the MAR chart for the pre surgery medications for Patient A was not signed.

Accordingly, this charge is found proved.

Charge 3(a)(ii)

ii. *Did not attend to an infusion pump alarm, despite this being brought to your attention;*

This charge is found PROVED.

The panel noted that the evidence in support of this charge came from Colleague L and Colleague K. The panel noted that Colleague L was an eye witness to this incident.

Colleague L, in her NMC statement, stated:

"I cannot remember the time, but it was during the night, after all the initial nursing duties had been completed, I heard one of the registrants' patients' infusion alarms bleeping... About 10 minutes later the registrant had still not addressed this so I went over and changed it myself."

Colleague K, in her NMC statement, stated:

"When I questioned the registrant regarding these two errors, I got the impression that she didn't appear to think it was her problem. I got this impression because she just gave an excuse to explain the mistake; that she didn't hear the alarm, but I didn't think that was justified… She didn't apologise or make any attempts to rectify the situation"

The panel considered that Colleague K's evidence corroborated Colleague L's version of events. The panel had no explanation from Miss King in relation to this.

The panel therefore found it more likely than not that this incident occurred as alleged.

Accordingly, this charge is found proved.

Charge 3(b)(i)

(b) *Between 16 and 17 April 2017 whilst working on Okement Ward at The Royal Devon and Exeter Hospital:*

i. Miscalculated an Early Warning Score ('EWS') in respect of Patient B;

This charge is found NOT PROVED.

The panel carefully examined the Patient Observation Chart for Patient B and the corresponding EWS obtained by the NMC. In the panel's view, based on the assessment made at the time by Miss King, a score of '6' could have been correct.

Accordingly, this charge is found proved.

Charge 3(b)(ii)

ii. Did not demonstrate safe practice whilst attempting to administer Flucloxacillin to an unknown patient by:

a. attempting to give a 2 gram dose via a push;

b. handling equipment without gloves;

c. not gathering a flush;

d. not cleaning the cannula; and/or

e. allowing the open tube to trail along the floor;

This charge is found PROVED in its entirety, apart from charge 3(b)(ii)(b)

The panel considered Colleague D's local statement, in which she provided a detailed summary of the concerns regarding Miss King in relation to her night shift on 16/17 April 2017.

In this statement, she outlines very clearly how Miss King is alleged to have provided unsafe care. This evidence is supported by her NMC statement in which she stated:

"In this case, the registrant was drawing up a commonly used antibiotic, Flucloxacillin. Her patient required a 2g dose, yet she was attempting to give this via a 'push'… Two grams of any antibiotic should never be given as a push. I don't actually know the reason for this and so I cannot comment on what the risk of patient of harm is. It is only

when the dose is up to 1 gram that it can be directly administered into the vein. When I saw the registrant preparing the antibiotic in this way, I interrupted her and explained that this is strictly against trust policy. I described how 2 grams of Flucloxacillin has to be mixed with saline and water and administered slowly through an infusion over 30 minutes….

The IV pumps at the trust were new… Normal practice would be to take a tray, and clean it and then gather all the necessary equipment on the sterilised tray. The registrant did not do this, instead she took the equipment over by hand.
The registrant did not gather a 'flush' … She also didn't take over an antiseptic wipe, which is used to clean the end of the cannula to remove any bacteria before the infusion is connected up…

When we arrived at the patient's bed, the patient was still connected up to a previous infusion, which meant the registrant could not have 'flushed' the cannula. I told the registrant that this was unacceptable and went away to get a flush and an antiseptic wipe as it was clear that she was not intending to clean it….I came back and decided to take over the connection of the infusion, as it was becoming apparent to me that the registrant was incapable of doing so safely.

The registrant had also carried over the IV 'giving set'… and had been dragging it along the corridor floor. This tube has a cap on the end of it to keep it sterile, which should not be removed, until a split second before it is connected. The registrant had removed the cap in the treatment room and then trailed the open tube along the corridor…"

Colleague D confirmed her account of this in her oral evidence. The panel noted that Colleague D was an eye witness to this incident and provided detailed evidence in relation to this. However the only evidence which the panel found was lacking was in support of charge 3(b)(ii)(b), as there is no direct evidence to suggest that Miss King was not wearing gloves at the time of this incident, although this had been alluded to by Colleague D.

The panel found that it was more likely than not, in respect of the remaining charges, the incident occurred as alleged.

Accordingly, charges 3(b)(ii)(a), 3(b)(ii)(c), 3(b)(ii)(d), 3(b)(ii)(e) were found proved, and charge 3(b)(ii)(b) were found not proved.

Charge 3(c)(i)

(c) *Between 17 and 18 April 2017 whilst working at Monkswell Ward at Derriford Hospital:*

i. Did not administer and/or record that you had administered insulin to Patient C;

This charge is found PROVED.

The panel noted that the evidence in support of this charge came from Colleague E.

Colleague E, in her local statement, stated:

"One day in April, I handed over to the agency nurse that I had missed the evening insulin and if she could give it later. The nurse did not administer the insulin despite the reminder from the patient that she was not given in the evening because she was not confused."

In her NMC statement, she stated:

"I cannot comment on the events that night concerning Patient C because I was not there, however, I was informed by a colleague that following day that the insulin had not been administered. "

The panel considered this evidence alongside Patient C's drug chart, which confirmed that this medication had not been recorded as being administered to Patient C at 20:00.

The panel found on the balance of probabilities that such medication had not been administered to Patient C, although it noted that there was no direct evidence to say that it was Miss King's responsibility to do so.

Accordingly, this charge is found proved.

Charge 3(c)(ii)

ii. Did not record the time that Oxycodone was administered to Patient C;

This charge is found NOT PROVED.

The panel noted that the time of the administration was recorded in the controlled drug book, which indicates that this was signed by two nurses, one of whom was Miss King.

The panel considered that whilst it may have been best practice to record on the MAR Chart when the medication had been administered, there was no evidence which suggested that this was mandatory in terms of policy.

In all the circumstances, the panel determined that the NMC had failed to discharge its burden in proof in relation to this charge.

Accordingly, this charge is found not proved.

Charge 3(c)(iii)

iii. Did not connect Patient D's nasogastric line correctly;

This charge is found NOT PROVED.

Colleague E, in her NMC statement, stated:

“When I arrived at the patient’s bedside I noticed that the cardigan was soaking, this meant that all the bedding was also soaked. I realised that the feed had been leaking.

This would have been just after 08:00 so the resident would have been in wet bedding for 2 hours.”

The panel considered the daily fluid chart for Patient D, which contained signed entries made by Miss King, which appeared to evidence her continuous monitoring of the nasogastric line until the end of her shift.

In the panel’s view, whilst it accepted that there had clearly been a leak in the line, as evidenced by Patient D’s bed being wet, Colleague E’s oral evidence appears to suggest that there was still fluid left in the fluid bag when she arrived. This was crucial, as it suggests that the nasogastric line could not have been completely disconnected. If the nasogastric line was completely disconnected, there would not have been any fluid left in the bag. This therefore allows for the possibility of there being a hole somewhere, where fluid was leaking out of the feed administration bag. In the panel’s view, it was not satisfied that this leak had occurred as a result of Miss King’s actions when preparing the equipment.

The panel therefore determined that the NMC had failed to discharge its burden in proof in relation to this charge.

Accorgingly, the panel found this charge not proved.

Charge 3(c)(iv)

iv. Did not administer Oxycodone to Patient E;

This charge is found PROVED.

The panel took into account that Miss King's entry in the MAR chart of Patient E indicates that the patient had refused the medication. The medication was therefore not administered.

Accordingly, this charge is found proved.

Charge 3(d)(i)

(d) *Between 24 and 25 May 2017 whilst working at Tavistock Hospital:*

i. Did not administer insulin to Patient F until prompted by a colleague;

This charge is found PROVED.

The evidence in support of this charge came from Colleague F, and from Colleague O.

Colleague O, an eye witness to this incident, in her NMC statement stated:

"I was in the middle of dealing with a patient when the registrant approached me, so I said once I had finished administering the medication to my patient, I would help. I did mention at this point that the patient, who the registrant was referring to, had a blood sugar level of 6.8mmol, which I knew from the pre-breakfast report, which I received during the handover. When I did remind her of the CBG level the registrant responded to this by saying something along the lines of 'well I won't give the insulin then because the result is in the normal range'. I found this to be a strange response, but I did not

address it at the time as I will still in the process of administering medication to my patient.

Once I had finished attending to my patient, I approached the registrant and questioned what she had meant exactly by not giving insulin when the blood sugar was in the 'normal range'. The insulin that the patient required was Levemere (sic), a long-acting insulin, which is given at 24-hour intervals. As a trained nurse, I am aware that all patients prescribed this require this as they are not producing insulin themselves. [Patient F's] CBG level was within the normal range, so I was confused by TK's rationale for not giving the insulin. The patient was prescribed her insulin to be administered with her breakfast and she had been routinely given insulin daily as prescribed per the medication chart.

The registrant said that is what she had been taught about insulin (I was still unclear as to what she meant by this and could not understand why she felt Insulin could not have been given to [Patient F] when her CBG level was normal). I didn't ask the registrant for any further information, but she then added that she had heard about two nurses who had been convicted of manslaughter after being involved in a patient's hypo-glycaemia.

In my opinion this patient should have had been given insulin, her blood sugar was within normal limits and she would need the insulin to maintain the CBG levels throughout the day. I informed the registrant of this, and she said she would recheck the patients' levels. By this time approx. one hour had passed since her blood sugar had been checked (as the night staff routinely check all patients with diabetes on Insulin before their breakfast). I informed the registrant that if she did not want to check the blood sugar levels herself, I would do this with her, but the important thing that needed to be done, was to administer the insulin."

The panel found Colleague O's version of events highly detailed and compelling. Colleague F told the panel that said *"even if [Miss King] wasn't sure about long lasting insulin, she should have looked it up"*.

In the panel's view, it accepted the evidence of Colleague O, and determined that Miss King had failed to comprehend fundamental aspects pertaining to such medication administration. Colleague O stated: *"She showed a poor understanding of diabetes and long acting insulin by not giving the insulin…I would have expected the nurse to discuss the incident rather than withhold the insulin."*

Accordingly, this charge is found proved.

Charge 3(d)(ii)

> *ii. Dispensed medication incorrectly by administering it to more than one patient at a time without using a drugs chart to identify patients;*

This charge is found PROVED.

The panel considered the evidence of Colleague F, who in her NMC witness statement, stated:

"Also on this day at around 12pm I went onto the ward and I saw the registrant with three pots of tablets in her hand and no drug charts with which to identify the patient with the prescription and ensure the patient received the correct medications. The registrant walked into the 4 bedded room and handed the drugs out to three of the four patients without identifying them. I heard her say, "Right, one for you, one for you and one for you." She could have given the tablets to the wrong patient and this could have harmed the patients. The patients could have been on medication which could have reacted with what the registrant was administering, the patient could have had an allergy to the drug or the patient might overdose if a dose was given too soon. The procedure is to check drugs with an individual's prescription, go to the bed side with a drug chart, check the patient's details against the name band and drugs chart, administer the drugs and watch the patient taking them, bearing in mind a lot of patients

have dementia and swallowing difficulties or difficulty with fine motor skills and require assistance and supervision. I would also expect her to document this on the MAR chart."

Colleague F when questioned by the panel indicated that Miss King made no attempt to identify the patients by name or identification band.

The panel considered that the evidence provided by Colleague F was clear, detailed and compelling and had nothing to refute this. Colleague F was able to expand on Miss King's poor clinical practice during her oral evidence to the panel, and the panel was satisfied that Miss King made a range of errors on the date in question.

Accordingly, this charge is found proved.

Determination on misconduct and impairment:

Having announced its finding on all the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Miss King's fitness to practise is currently impaired. The NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

Mr Claydon referred the panel to the case of *Roylance v General Medical Council (no. 2)* [2000] 1 AC 311 in which Lord Clyde 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 a practitioner in the [relevant field]. Such falling short as is established should be serious."*

Mr Claydon submitted that this case engages both public protection and public interest considerations. He reminded the panel that there is no burden of proof at this stage and the decision on misconduct is for the panel's independent judgement.

Mr Claydon invited the panel to take the view that Miss King's actions amount to a breach of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)', (the Code). He then invited the panel's attention to specific paragraphs and identified where, in the NMC's view, Miss King's actions amounted to misconduct.

He then 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. Mr Claydon referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

Mr Claydon submitted that the following limbs are engaged:

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;
d. […]

Mr Claydon submitted that Miss King's clinical errors were of a basic and fundamental nature which placed patients under her care at unwarranted risk of harm. Mr Claydon invited the panel to consider whether some of Miss King's actions in this regard could be attributed to an underlying attitudinal issue. He further submitted that by her actions, Miss King had brought the reputation of the nursing profession into disrepute and breached fundamental tenets of the nursing profession.

Mr Claydon reminded the panel that in order to assess whether Miss King would put patients at risk of harm in the future, it should determine to what extent she has remedied any misconduct.

Mr Claydon submitted that in light of Miss King having brought the profession into disrepute and placed patients at unwarranted risk of harm, a finding of impairment is necessary on both public protection and public interest grounds in order to uphold proper professional standards and uphold public confidence in the NMC as a regulator.

The panel accepted the advice of the legal assessor.

Decision on misconduct

The panel first considered whether the facts found proved amounted to misconduct. This is a matter for the panel's judgement. In considering whether the conduct, as found proved, amounted to misconduct, the panel reminded itself that not every act falling short of what would be proper in the circumstances, and not every breach of the Code, would be sufficiently serious that it could properly be described as misconduct.

The panel has reminded itself that registrants are personally accountable under the NMC Code for acts and omissions in their practice. The panel had regard to the relevant version of the NMC Code (2015). The Code contains the underlying principles that guide the nursing profession and is in place to protect the public and to ensure that proper standards of the profession are upheld.

Charge 1

1. *Whilst employed at Forde Park Nursing Home between 18 August 2016 and 10 September 2016:*
   (a) On one or more occasions between 23 August 2016 and 7 September 2016, made inappropriate comments about residents, in that you said words to the effect of:
      iii. "She shouldn't be wandering around, she needs medication to make her sleep"
      iv. "What's the point; these people are old and ill";
   (b) On an unknown date between 24 August 2016 and 10 September 2016, left medication unattended in Resident A's room;
   (c) On an unknown date between 24 August 2016 and 10 September 2016, inappropriately handled Resident B;
   (d) On or around 8 September 2016, forcibly administered medication to Resident C;

(e) On 10 September 2016, left Resident D on a commode and did not return to assist them;

(f) On an unknown date, did not clean Resident D when changing their pad, before putting them to bed;

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

In the panel's view, Miss King's comments were wholly inappropriate and considered that she took no account of her residents' needs or how they presented. In particular, Miss King's comment "what's the point; these people are old and ill" showed a complete lack of respect for vulnerable residents in her care. In the panel's view, such dismissive comments made about residents were completely unacceptable. Although the panel noted that Miss King had taken action shortly after the time of the events to address the issue, the panel determined that Miss King's conduct in making these remarks fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 1(b)

The panel determined that leaving medication unattended, in such an environment, put residents at significant unwarranted risk of harm, given that anyone could have taken the medication. This was unacceptable conduct which could have presented a serious resident safety issue. As such, Miss King's conduct in this regard fell far below the standards expected of a registered nurse and amounted to misconduct.

Charge 1(c)

The panel determined that Miss King's conduct, in rough handling a resident in the manner found proved, was unkind and cruel. Her actions were inappropriate and represented an adult safeguarding concern. The panel determined that Miss King's

conduct with regard to charge 1(c) fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 1(d)

In the panel's view, Miss King's actions, in relation to Resident C, were deplorable. Miss King's actions were completely unsafe (particularly given Resident C's vulnerability due to her assessed swallowing difficulty), dangerous and wholly disrespectful. There was no question that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 1 (e)

The panel determined that the action of Miss King, by leaving a resident on a commode, who as a consequence had to pull herself towards the door in order to call for help, was appalling conduct which no doubt caused Resident D major personal upset. The panel determined that Miss King's conduct with regard to charge 1(e) fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 1(f)

In the panel's view, Miss King's actions represented deplorable practice and were disgraceful. There was no conceivable rationale for treating Resident D in the manner found proved. The panel considered that Miss King's actions failed to treat Resident D with dignity. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 2

2. Whilst employed at Pinewood Nursing Home between 14 March 2017 and 3 April 2017:

(a) *On 23 March:*

i. *Dispensed medication incorrectly by pre-potting it for more than one resident at a time;*

ii. *Administered medication incorrectly by handling it;*

Charge 2(a)(i)

The panel was of the view that through her actions Ms King failed to adhere to the Home's policies and procedures and presented a serious resident safety risk. The potential for significant harm presented to patients was unwarranted. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 2(a)(ii)

The panel determined that Miss King's actions were carried out contrary to proper clinical practice and significantly increased the risk of cross infection. In the panel's view, directly handling the oral medication and placing it into a resident's mouth was completely unnecessary and unsafe. It determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 3

3. *Whilst employed by Your World Recruitment Group between 18 March 2017 and 25 May 2017:*
   (a) *Between 12 and 13 April 2017, while working on Braunton Ward at Derriford Hospital:*
      i. *Did not administer pre-surgery medications (Temezepam, Rantidine, Oxygen and Levetiracetam) to Patient A;*
      ii. *Did not attend to an infusion pump alarm, despite this being brought to your attention;*
   (b) *Between 16 and 17 April 2017 whilst working on Okement Ward at The Royal Devon and Exeter Hospital:*
      i. *…*
      ii. *Did not demonstrate safe practice whilst attempting to administer Flucloxacillin to an unknown patient by:*
         a. *attempting to give a 2 gram dose via a push;*
         b. *…*
         c. *not gathering a flush;*
         d. *not cleaning the cannula; and/or*
         e. *allowing the open tube to trail along the floor;*
   (c) *Between 17 and 18 April 2017 whilst working at Monkswell Ward at Derriford Hospital:*
      i. *Did not administer and/or record that you had administered insulin to Patient C;*
      ii. *...*
      iii. *…*
      iv. *Did not administer Oxycodone to Patient E;*
   (d) *Between 24 and 25 May 2017 whilst working at Tavistock Hospital:*
      i. *Did not administer insulin to Patient F until prompted by a colleague;*
      ii. *Dispensed medication incorrectly by administering it to more than one patient at a time without using a drugs chart to identify patients;*

Charge 3(a)(i)

The panel took account of Miss King's explanation in relation to the conduct found proved. However, as Miss King was responsible for the administration of medication to Patient A and given the fact that she clearly was aware that Patient A was for theatre, and there was a written instruction to give the medication at 06:30, the panel determined that Miss King did not provide safe care by failing to administer essential pre-surgery medication, one of which should have been administered via a nasal cannula. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 3(a)(ii)

In the panel's view, irrespective of whether Miss King was busy at the time, this conduct was another clear example of her failure to practise safely and effectively. The panel considered that Miss King's actions gave rise for the potential to place a patient at risk of harm, having been told the pump was alarming by a colleague but taking no action. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 3(b)(ii)(a)

The panel noted that the witness in relation to this charge was able to clearly and articulately provide the panel as to what constituted appropriate practice. In the panel's view, Miss King's actions contravened the procedures of the hospital and could have caused harm to the patient. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 3(b)(ii)(c), 3(b)(ii)(d) and 3(b)(ii)(e)

The panel heard clear evidence as to the dangers of not gathering a flush, not cleaning the cannula and dragging the unprotected feed line across the floor. In the panel's view, there was no excuse for Miss King, as a relatively experienced nurse, to fail to follow basic and safe medication administration practice. The panel noted that the type of medication specified is one of the most commonly administered antibiotics, one that, the panel heard, even newly qualified nurses would be able to administer safely. The panel determined that her actions in this regard demonstrated further examples of poor clinical practice, in relation to basic infection control. It determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 3(c)(i)

The panel considered its earlier findings in respect of this particular charge found proved and was not of the view that Miss King's actions in this regard were so serious as to amount to misconduct. There was no prescribed instruction to administer the drug at 20:00 and therefore although not administered, this was not considered misconduct.

Charge 3(c)(iv)

The panel took account of Miss King's response to this charge and noted that the rationale for not providing this medication was due to the patient refusing the medication which Miss King has documented in the medication chart. The panel found this to be a legitimate reason for not administering this to Patient E and on that basis, did not consider Miss King's actions to amount to misconduct.

Charge 3(d)(i)

The panel noted that whilst Miss King's actions in this regard exposed her lack of knowledge of the use and administration of Levemir (long acting insulin), Miss King did in fact go and seek advice at the time. The panel therefore found that Miss King did take appropriate care and caution and did not consider Miss King's actions to be so serious as to amount to misconduct.

Charge 3(d)(ii)

The panel noted that Colleague F, an eye witness to this incident, provided clear oral evidence to the panel in relation to what she observed. In the panel's view, there was no question that Miss King's actions placed patients at significant and unwarranted risk of harm. The panel noted that there would have been no way of Miss King knowing which patient she was administering medication to, as she failed to properly identify them and further, there was a risk that a patient may have been administered another patient's medication. Miss King did not follow safe medication administration procedure and policy and acted in a reckless manner. The panel determined that Miss King's conduct fell significantly below the standards expected of a registered nurse and amounted to misconduct.

The panel therefore determined that Miss King's actions, in relation to the following charges amounted to misconduct: 1 (in its entirety), 2(a)(i), 2(a)(ii), 3(a)(i), 3(a)(ii), 3(b)(ii)(a), 3(b)(ii)(c), 3(b)(ii)(d), 3(b)(ii)(e), 3(d)(ii).

It was of the view that Miss King's conduct breached the following standards in the Code:

Prioritise people (pre-amble)

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.5 respect and uphold people's human rights

6 Always practise in line with the best available evidence

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

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures…

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

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

Decision on impairment:

The panel next went on to decide whether as a result of the misconduct found, Miss King's fitness to practise is currently impaired. In reaching its decision the panel took into account all of the circumstances together with its overarching objective.

The panel considered that Miss King's conduct had engaged the first three criteria of the guidance in *Grant*.

The panel concluded as a consequence of Miss King's poor clinical practice and the lack of respect and care provided, she placed vulnerable patients under her care at significant and unwarranted risk of harm. The panel noted that Miss King's conduct in relation to Residents B, C and D showed a complete disregard for their safety and dignity. Nurses are expected to treat residents and patients in a caring and compassionate manner, Miss King failed to do to this and has provided no explanation for her actions.

The panel determined that Miss King failed to act in her patients' best interests, failed to protect their dignity, and breached the fundamental professional principle that one should cause no harm. The panel also determined that Miss King failed to meet the standards which the public and the profession would expect. The panel therefore found Miss King's conduct brought the nursing profession into disrepute and breached fundamental tenets of the profession.

The panel bore in mind that it had to look to the future and consider whether Miss King was liable to act in such a way again.

The panel noted that Miss King has not provided the NMC with any information which demonstrated insight or remediation since these incidents. Although the panel noted that there is one example to suggest that Miss King showed insight shortly after the incident, the panel noted that in general it has no recent evidence of reflection, insight,

remorse or remediation from Miss King to indicate that she appreciates the seriousness of her misconduct, and the potential harm that could have been caused to patients in her care, or indicating what she would do differently in the future if placed in a similar situation.

The panel determined that whilst Miss King's clinical conduct is in principle capable of remediation, it has not been remedied. The panel also determined that Miss King's conduct and behaviour demonstrated attitudinal concerns, which by their nature are hard to remedy. Miss King has not provided the panel with any demonstrable evidence of insight to suggest that she acknowledges her wrong doing, despite having made clinical errors and demonstrating poor conduct at several places of employment over a sustained period of time.

The panel therefore concluded that the risk of repetition remained high in that if she were placed in a similar situation Miss King could in the future act so as to put patients at unwarranted risk of harm, breach the fundamental tenets of the profession and bring the profession into disrepute. Accordingly, a finding of impairment on the grounds of public protection is necessary.

The panel bore in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards and behaviour. In the judgement of the panel, irrespective of the risk of repetition, public confidence in the profession and the regulator would be undermined if a finding of impairment were not made in light of the seriousness of the matters found proved in this case.

The panel determined that Miss King's fitness to practise is currently impaired on both public protection and public interest grounds.

Determination on sanction:

The panel has considered this case carefully and has decided to make a striking off order. In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case together with the submissions of Mr Claydon, on behalf of the NMC.

Mr Claydon outlined what he submitted were the aggravating and mitigating factors in this case and referred the panel to the Sanctions Guidance ("SG"). He invited the panel to consider imposing a striking off order, given its earlier findings, which indicated attitudinal concerns in addition to Miss King's clinical failings but submitted that, ultimately, this is a matter for the panel.

The panel heard and accepted the advice of the legal assessor, who also referred the panel to the SG.

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. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgment.

The panel first considered whether there were any aggravating and/or mitigating factors in this case.

The panel identified the following aggravating factors:

- Miss King's clinical failings are numerous, wide ranging across nursing practice and occurred in six different clinical environments over a sustained period of time;
- Miss King's conduct allowed highly vulnerable residents and patients under her care to be placed at significant unwarranted risk of harm;

- Miss King's actions with regard to her conduct demonstrate a pattern of inappropriate and unacceptable behaviour;
- Miss King's behaviour and her response to the regulator demonstrate serious attitudinal issues;
- Miss King has not shown any meaningful evidence of insight, remediation, or remorse for any of her actions, nor has she apologised for her behaviour;
- Miss King has failed to take responsibility for her misconduct.

The panel identified the following mitigating factors:

- There is evidence that Miss King may have difficulties hearing, which may have contributed to concerns relating to her communication;
- A reference from 2014 identified previous good clinical practice, specifically between 2009-2010;
- There is evidence of early engagement with the NMC.

The panel then turned to the question of which sanction, if any, to impose. It considered each available sanction in turn, starting with the least restrictive sanction and moving upwards.

The panel first considered whether to take no action. The panel bore in mind that it had identified at the impairment stage that Miss King's failings were serious and that there is a risk of repetition. To take no action would not protect the public. In addition, the panel considered that to take no further action would be inadequate to mark the seriousness of the misconduct and would not satisfy the wider public interest.

Next, the panel considered whether a caution order would be appropriate. The panel took into account the SG, which 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 Fitness to Practise Committee wishes to mark that the behaviour was unacceptable and must not happen again'.* The panel considered that Miss King's conduct was far from

the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case, Miss King's lack of insight and the risk of repetition identified. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing a conditions of practice order would be a sufficient and appropriate sanction. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel considered that it has no information before it to suggest that Miss King would be willing or able to comply with conditions. The panel also determined that it would be difficult to formulate any conditions which would address Miss King's attitudinal and behavioural issues, which by their nature would be hard to remediate. Taking account of all the above, the panel concluded that placing conditions on Miss King's registration would not adequately protect the public or address the seriousness of Miss King's failings.

The panel then went on to consider whether a suspension order would be an appropriate and proportionate sanction. Whilst the panel has identified that a suspension order would be sufficient to protect the public, and that some of the conduct was capable of remediation, there was no evidence whatsoever of any reflection or remediation such as to suggest that the failings which have been identified could be addressed over time.

Miss King has not demonstrated any meaningful insight or remorse for her actions despite having been referred by three different employers. The panel took into account the seriousness of the misconduct, which allowed highly vulnerable residents and patients under her care to be placed at unwarranted risk of harm, and its overarching duty to uphold proper standards and uphold the public confidence in the profession. The panel carefully considered the SG in relation to suspension orders, however it concluded that none of the relevant factors in support of a suspension order applied in this case.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction as it would fail to meet the wider public interest in maintaining public confidence in the nursing profession.

Finally, in relation to a striking-off order, the panel carefully considered the following questions as set out in the SG:

Is striking-off the only sanction which will be sufficient to protect the public interest? Is the seriousness of the case incompatible with ongoing registration?

Can public confidence in the professions and the NMC be sustained if the nurse or midwife is not removed from the register?

It noted the following points:

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following:

> *Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity.*
> *Persistent lack of insight into seriousness of actions or consequences.*

The panel had particular regard to the seriousness of the misconduct which allowed highly vulnerable residents and patients to be placed at unwarranted risk of harm. There was no evidence that Miss King has taken any steps to remedy the deficiencies in her clinical practice or developed any insight into why or how these incidents occurred. As a result, there remained the potential that other residents and patients could be placed at unwarranted risk of harm.

The panel noted that Miss King disregarded correct procedure and made repeated errors of a similar nature over a sustained period of time. As a consequence, Miss King continually placed vulnerable residents and patients under her care at risk of harm. The panel has no evidence of remorse whatsoever from Miss King for her actions, which it found concerning.

To the contrary, Miss King has sought to minimise her actions by attempting to deflect criticisms of her shortcomings by criticising other members of staff and her clinical working environment. The panel noted that Miss King has failed to provide reasonable explanations for her misconduct. The panel determined that this pattern of behaviour demonstrated serious underlying attitudinal issues.

Given the risk identified, coupled with Miss King's lack of insight, remorse, and her failure to take responsibility and be accountable for her actions, the panel formed the view that her conduct is fundamentally incompatible with her remaining on the register. To allow Miss King to remain on the register would significantly undermine public confidence in the profession and in the NMC as a regulatory body. Having considered the SG, the panel concluded that nothing short of a striking off order would be sufficient in this case.

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

The panel therefore directs the registrar to strike Miss King's name off the register. The effect of this order is that the NMC register will show that she has been struck off the register.

Determination on interim order

The panel has considered the submissions made by Mr Claydon that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after Miss King is sent the decision of this hearing in writing.

That concludes this determination.