Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

13 – 21 May 2019

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

Name of registrant:	Tania White
NMC PIN:	00I2940E
Part(s) of the register:	Registered Adult Nurse – Sub Part 1 1 September 2003
Area of Registered Address:	England
Type of Case:	Misconduct and Lack of Competence
Panel Members:	Edward Lucas (Chair, lay member) Carole Panteli (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Nicholas Wilcox
Panel Secretary:	Sophie Cubillo-Barsi
Registrant:	Not present and not represented
Nursing and Midwifery Council:	Represented by Neil Jeffs
Facts proved:	All charges
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim Order:	Interim suspension order – 18 months

Details of charge:

That you, while employed by Oxford University Hospitals NHS Foundation Trust as a Band 5 Staff Nurse between 20 June 2016 and 22 December 2016, failed to demonstrate the standards of knowledge, skill and judgment required to practise as a Band 5 Staff Nurse in that:

1. While working within the Renal Day Case Unit between 20 June 2016 and 24 July 2016, you: ***Charge found proved in its entirety***
   (a) On 7 July 2016, prepared 1g of Methylprednisolone for administration to Patient A when 100mg had been prescribed;
   (b) On 7 July 2016, did not administer 500mg of Rituximab to Patient A as prescribed;
   (c) On 8 July 2016, provided incorrect advice to patients about bed rest following renal biopsies;
   (d) On 8 July 2016, suggested administering insulin to Patient C which had not been prescribed;
   (e) Between 11 and 12 July 2016, were responsible for the care of Patient D when you did not have proof of competency in Patient Controlled Analgesia;
   (f) Between 11 and 12 July 2016, did not ensure that patient observations were carried out on Patient D between 00:30 and 05:48;
   (g) Between 11 and 12 July 2016, incorrectly recorded details of the safety checks for Patient D;

2. While subject to an informal Performance Improvement Plan between 25 July 2016 and 14 December 2016, you failed to demonstrate that you were capable of working safely without supervision, in particular: ***Charge found proved in its entirety***

   (a) On 25 July 2016, after cannulating a patient, flushed the cannula without first cleaning the bung with a sanicloth;

   (b) On 25 July 2016, while preparing Ferinject for Patient E:

(i) Walked away from the drugs cupboard while leaving the door open and keys in it, without consulting with another member of staff;
(ii) Were unable to identify how to prime the Intravenous Medication (IV) giving set, without assistance;
(iii) Made a number of attempts to programme the Alaris infusion pump to 1080ml/hr when it could not be programmed above 999ml/hour;

(c) Having completed the venepuncture and cannulation study day on 26 July 2016:
(i) Did not complete the venepuncture or cannulation workbooks following the training;

(d) On 27 July 2016:
(i) While cannulating Patient F, did not obtain informed consent regarding inserting a cannula and taking blood samples at the same time;
(ii) Attempted to use blood left on a needle to measure Patient F's glucose levels, without obtaining their consent;
(iii) Did not complete or delegate the taking of observations for a patient following a kidney biopsy, which were required every 15 minutes;
(iv) Did not escalate Patient F's systolic blood pressure of 191mmHg and/or early warning score (EWS) of 3 to a doctor;
(v) Did not save Patient F's observations onto the SEND system until prompted;

(e) On 28 July 2016, while undertaking the medication Objective Structured Clinical Examination (OSCE) (attempt 1):
(i) Did not identify the patient using the correct procedure;
(ii) Did not check for allergies;
(iii) Did not verbalise the side effects and cautions/contra-indications;

(f) On 29 July 2016:

(i) Did not check how to administer Chlorphenamine IV before preparing it for administration, despite being unsure;

(ii) Prepared 1g of Methylprednisolone for administration to Patient G when 100mg had been prescribed;

(iii) While undertaking the medication OSCE (attempt 2), were unable to give full information about Paracetamol and/or Lactulose, including side effects;

(g) On 1 August 2016, while being assessed in venepuncture:

(i) Did not anchor the needle on one or more occasion;

(ii) Under filled several of the bottles containing blood;

(iii) Used your finger to stop blood having removed a needle, as you did not have cotton wool ready;

(iv) Taped the puncture sites without applying pressure or waiting to see if the bleeding had stopped on one or more occasion;

(v) Did not complete any documentation for one patient, until prompted;

(h) On 1 August 2016, while undertaking a medication OSCE assessment (attempt 3) for Lactulose and Amlodipine:

(i) Did not carry out the necessary safety checks, in that you gave Amlodipine without checking the patient's blood pressure;

(ii) Inappropriately tried to advise a renal patient about alternative remedies when discussing Lactulose;

(i) On 2 August 2016:

(i) Did not obtain informed consent from a patient by explaining why they needed a cannula and what blood tests were being taken and why;

(ii) Inadequately delegated a task of taking patient observations to a colleague;

(iii) Did not pass a maths assessment in respect of drugs calculations;

(j) On 3 August 2016:

(i) Did not close the curtains and window blind before Patient H got undressed;

(ii) Indicated that you would return a controlled drug (Oxycodone) to a patient after administration rather than store it securely;

(iii) While undertaking a medication OSCE assessment (attempt 4) for Doxazosin and Amoxicillin:

a. did not check the patient's wristband before dispensing medications;

b. gave Doxazosin without checking the patient's blood pressure;

c. were unclear when explaining how many times a day Amoxicillin should be taken;

d. incorrectly stated that Amoxicillin was contraindicated for renal patients;

e. did not explain adequately the cautions for Amoxicillin;

(iv) While undertaking a further medication OSCE assessment for Paracetamol and Furosemide:

a. Did not check whether a patient had already taken Paracetamol before administering Furosemide;

b. Did not explain what Paracetamol was for or whether the patient required it;

c. Did not verbalise the contraindications of Paracetamol and/or Furosemide;

(k) Between 15 and 18 November 2016:

(i) Dispensed 280mg of Frusemide for Patient I, when 240mg was prescribed;

(ii) On one or more occasion, took an excessive amount of time to complete a drugs round;

(iii) Required prompting to check blood pressure readings before giving antihypertensive medications;

(l) On 22 November 2016:

(i) On one or more occasion, had to be prompted to check the correct time/date on the drug chart when administering medication;

(ii) When administering insulin to Patient J:

a. did not prime the insulin pen until prompted;

b. prepared the wrong dose for administration;

c. did not wait 10 seconds before removing the needle;

(m) On 25 November 2016:

(i) Misread the hospital number of Patient K and interpreted it as correct;

(ii) Having dropped a 500mg Calcium Carbonate tablet while dispensing it, did not recognise without prompting that a further tablet was required for a 1000mg prescription;

(iii) While administering insulin:

a. incorrectly primed a needle for insulin administration;

b. released the insulin before waiting for the safety needle to click;

c. did not wait 10 seconds before removing the needle;

(iv) Did not ask questions or for further information following an inadequate handover from a colleague about a patient;

(n) On 13 December 2016:

(i) Demonstrated poor communication when dealing with one or more patients;

(o) On 14 December 2016:

(i) Did not prepare a care plan or refer a patient to a dietician, who had scored 4 on a Malnutrition Universal Screening Tool (MUST) risk assessment;

(ii) Did not check Patient N's blood pressure before dispensing Ramipril;

(iii) Signed to say that a Becotide inhaler had been administered to Patient N, when this was a Salbutamol inhaler;

(iv) Administered Morphine to Patient N but did not observe that it had been taken;

(v) Dispensed Furosemide without checking a patient's blood pressure first;

(p) On one or more occasion, did not dispose of sharps correctly;

3. While subject to a formal Performance Improvement Plan between 15 December 2016 and 22 December 2016, you failed to demonstrate that you were capable of working safely with supervision, in particular: ***Charge found proved in its entirety***

(a) On 20 December 2016:

(i) On one or more occasion, did not verbally confirm a patient's identity before dispensing medications;

(ii) Did not clean your hands before dispensing medications;

(iii) Signed for medication which had not yet been administered;

(iv) Did not check for allergies when speaking to Patient P;

(v) While undertaking a medication OSCE assessment for Paracetamol 1g, Amlodipine 5mg, Senna 7.5mg and Gliclazide 80mg:

a. Did not check the patient's hospital number at the time of administration;

b. Did not identify the requirements for the drugs;

c. Repeated the patient's blood glucose level incorrectly on one or more occasions;

d. Did not sign for the administration of Senna;

e. Said that Paracetamol had expired in 2001 and then dispensed it;

(vi) When preparing IV medications, did not complete a Visual Infusion Phlebitis (VIP) score for the patient's cannula;

(vii) Indicated that you would leave a second flush for a cannula unattended for approximately 20 minutes until after the infusion;

(viii) Did not scan Patient Q's wristband and/or check for allergies when preparing IV medications;

(ix) Were unable to calculate the correct rate for an infusion pump;

(x) Administered medication to Patient Q without obtaining informed consent;

(b) On 22 December 2016:

(i) Offered Patient R a nutritional supplement which had been discontinued on the drugs chart;
(ii) Marked that you had dispensed Bumetanide for Patient R when you had not;
(iii) Dispensed Lactulose from an open bottle with no date indicating when it was opened;
(iv) Did not administer Ensure to Patient R as prescribed;
(v) Did not identify without prompting that it was too early to administer Meropenem to a patient;
(vi) Did not check a patient's wristband details against the drug chart when identifying them before administering IV Metronidazole;

4. Did not keep your mandatory training up-to-date in the following areas: ***Charge found proved***
   (i) IV medication;
   (ii) Anaphylaxis;
   (iii) Cannulation;
   (iv) Venepuncture;
   (v) Patient Controlled Analgesia;

5. Failed to cooperate with an NMC investigation into your fitness to practise, in that you did not respond to requests for medical consent between 3 July 2018 and 28 January 2019. ***Charge found proved***

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in relation to charges 1-3 and misconduct in relation to charges 4-5.

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Ms White was not in attendance and that written notice of this hearing had been sent to Ms White registered address by recorded delivery and by first class post on 12 April 2019. Notice of this hearing was unable to be delivered on 16 April 2019 and was returned to the sender.

The panel took into account that the notice letter provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Ms White's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Jeffs submitted 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").

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms White has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Ms White.

The panel had regard to Rule 21 (2) states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(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; or

(c) may adjourn the hearing and issue directions.

Mr Jeffs provided the panel with a chronology of communication with Ms White, including:

- A telephone note, dated 20 June 2018, detailing a conversation between Ms White and an NMC Investigator, within which Ms White states that she 'has no intention of returning to nursing and doesn't think she would be able to put a response in writing to due dredging up bad memories.' [sic].
- A letter sent to Ms White, dated 18 April 2019, asking her to confirm her attendance and informing her of other ways in which she can attend the hearing, including video link or telephone.
- An email to Ms White, dated 25 April 2019, asking her to confirm her attendance and informing her of other ways in which she can attend the hearing, including video link or telephone.
- Evidence of an alternative address for Ms White, provided by a tracing agency.
- A letter to Ms White, sent to the suggested alternative address, dated 8 May 2019, asking her to confirm her current contact details.
- A telephone note, dated 8 May 2019, confirming that a voicemail was left for Ms White due to the call been unanswered.
- Evidence of two SMS messages sent to Ms White on 8 May 2019.

Mr Jeffs informed the panel that no response has been received from Ms White, despite the considerable efforts made by the NMC. He invited the panel to proceed in the

absence of Ms White. Mr Jeffs submitted that Ms White has voluntarily absented herself and that there is no suggestion that an adjournment would secure her attendance on a future occasion. He referred the panel to the case of *GMC v. Adeogba [2016] EWCA Civ 162* in this regard.

The panel accepted the advice of the legal assessor. He referred the panel to the case of *Sanusi v. GMC [2018] EWHC 1388 (Admin).*

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised "*with the utmost care and caution*" as referred to in the case of *R.* v *Jones (Anthony William), (No.2) [2002] UKHL 5* . The panel further noted the case of *R (on the application of Raheem) v Nursing and Midwifery Council [2010] EWHC 2549 (Admin)* and the ruling of Mr Justice Holman that:

> *"...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion "with the utmost care and caution", it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution."*

The panel has decided to proceed in the absence of Ms White. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- no application for an adjournment has been made by Ms White;
- Ms White has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Ms White has not provided the NMC with details of how she may be contacted other than her registered address;

- there is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence, another is due to attend;
- not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms White in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgment, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms White's decisions to absent herself from the hearing, waive her rights to attend and/or be represented and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Ms White. The panel will draw no adverse inference from Ms White's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Jeffs, to amend the wording of charge 2.

The proposed amendment was to replace the word 'with' with the word 'without', specifically:

"2. While subject to an informal Performance Improvement Plan between 25 July 2016 and 14 December 2016, you failed to demonstrate that you were capable of working safely ~~with~~ ***without*** supervision, in particular:"

It was submitted by Mr Jeffs that the proposed amendment would provide clarity and more accurately reflect the evidence.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> 28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—
>
> (a) the charge set out in the notice of hearing; or
>
> (b) the facts set out in the charge, on which the allegation is based,
>
> unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.
>
> (2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Ms White and no injustice would be caused to either party by the proposed amendment being allowed. It

was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application pursuant to Rule 31

The panel heard an application made by Mr Jeffs under Rule 31 of the Rules to allow the written statement of Ms 2 into evidence. Mr Jeffs told the panel that Ms White had been informed that a Rule 31 application was going to be made at the hearing, by way of a letter dated 3 April 2019. Ms 2 is an NMC Case Officer. Mr Jeffs submitted that her evidence relates solely to procedural matters, specifically Ms 2's attempted to obtain a completed medical consent form from Ms White. Mr Jeffs submitted that Ms 2's evidence is relevant to the charge and that it would be fair to admit the evidence under Rule 31.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 of the Rules provides that, so far as it is '*fair and relevant,'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Ms 2 serious consideration. The panel noted that Ms 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph 'This statement consisting of two pages is true to the best of my information, knowledge and belief' and was signed by her.

The panel considered whether Ms White would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 2 to that of a written statement. The panel considered that as Ms White had been provided with a copy of Ms 2's statement and, as the panel had already determined that Ms White had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross examine this witness in any case. 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 came to the view that it would be fair and relevant to accept into evidence the written statement of Ms 2 but would give what it

deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The NMC received a referral from Oxford University Hospitals NHS Foundation Trust ("the Trust") on 13 June 2017. At the material time, Ms White was employed as a Band 5 Staff Nurse and worked on the Renal Day Case Unit ("the Unit") and the Renal Inpatient Ward ("the Ward") at Churchill Hospital ('the Hospital'), part of the Trust.

Ms White had been employed as a registered nurse since 2008. Following a re-organisation by the Trust in 2013, Ms White started working in the Surgery and Oncology Division. The material events occurred whilst Ms White worked as a Band 5 Staff Nurse in the Urology Department from October 2014. Ms White was transferred from the Urology Outpatients Department to the Renal Day Case Unit on 20 June 2016, [PRIVATE] before moving to the Renal Inpatient Ward in September 2016.

The referral raised numerous concerns about the Ms White's ability to practise safely in the areas of:

(a) medicines management;
(b) patient care;
(c) escalation of deteriorating patients;
(d) record keeping; and
(e) communication.

Despite extensive support, which included performance improvement plans (both informal and formal), support from the professional development nurse and other nursing staff on a daily basis and training, Ms White not able to reach the required standards for safe and effective practice.

The various regulatory concerns, are grouped into defined periods of Ms White's employment with the Trust, namely:

a) Between 7 July 2016 and 12 July 2016, during which various clinical concerns regardin Ms White ‘s performance were raised;

b) Between 25 July 2016 to 14 December 2016, Ms White was unable to demonstrate that she was capable of working safely without supervision whilst subject to an informal Performance Improvement Plan and;

c) Between 15 December 2016 and 22 December 2016, Ms White was unable to demonstrate that she was able to work safely without supervision whilst subject to a formal Performance Improvement Plan (“PIP”).

Additionally, it is alleged that Ms White failed to keep her mandatory training up to date in relation to various clinical competencies.

On 22 December 2016 an informal meeting was held to review Ms White’s performance under the formal PIP. Concerns were ongoing, particular relating to drug errors and the potential for harm to patients. Ms White was informed that the Trust were looking to move matters to the second formal stage of the PIP. Whilst waiting for the second formal stage, Ms White could not undertake nursing duties and was required to act as a nursing assistant.

Ms White was invited to second a formal stage meeting on 18 January 2017. The meeting did not take place [PRIVATE]. As a result of the ongoing concerns, Ms White was redeployed by the Trust into a non-clinical role in the vascular department in May 2017.

It is further alleged that between 3 July 2018 and 28 January 2019, Ms White failed to co-operate with an NMC investigation in relation into her fitness to practise, by failing to respond to requests for consent to investigate health matters.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Jeffs.

The panel heard and 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 was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel has drawn no adverse inference from the non-attendance of Ms White.

The panel heard oral evidence from two witnesses tendered on behalf of the NMC. In addition, the panel heard oral evidence from you.

Witnesses called on behalf of the NMC were:

- Ms 1 – Renal Ward Sister; and
- Mr 1 – Band 5 Staff Nurse.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from.

The panel found Ms 1 to be a compelling, objective, credible and reliable witness. The panel were helpfully assisted by her measured and detailed witness statement, which was completed with care, effort and considerable detail.

The panel found Mr 1 to be a reliable, objective, and credible witness, whom was able to assist the panel to the best of his ability.

Before considering the following charges, the panel carefully considered the telephone note dated 20 June 2018, detailing a conversation between an NMC Investigation Officer and Ms White. [PRIVATE]
The panel next considered each charge individually, considering all of the evidence before it and made the following findings:

Charge 1 (a)

1. While working within the Renal Day Case Unit between 20 June 2016 and 24 July 2016, you:
   (a) On 7 July 2016, prepared 1g of Methylprednisolone for administration to Patient A when 100mg had been prescribed;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, within which she states:

“On 7 July 2016, I happened to be sat at the computer next to the drugs preparation area and saw that Tania had a 1 gram via of methylprednisolone to give to a patient called [Patient A]. The unit is very small (only 6 patients maximum at a time) and I was very familiar with what all of the patients were in for and also very familiar with all the drug regimes. I immediately knew this was a wrong dose as Patient A was prescribed 100mg of methylprednisolone.”

The panel noted that this error was identified before the medication was administered and was subsequently reported onto a DATIX incident form. The panel further noted Ms 1’s evidence that when challenged, Ms White maintained that the dose of methylprednisolone, which she had prepared, was correct before eventually accepting that the dose was incorrect.

It is the evidence of Ms 1 that Ms White was asked to complete a written reflection in relation to this incident but failed to do so.

The panel accepted the evidence of Ms 1. It acknowledged that the administration of the said dose of methylprednisolone could have caused side effects such as anaphylaxis, cardiac arrest, shortness of breathe, constriction of airways and low blood pressure. Based on the evidence before it, the panel concluded that, on the balance of probabilities, Ms White did prepare 1g of Methylprednisolone for administration to Patient A when 100mg had been prescribed.

Charge 1 (b)

(b) On 7 July 2016, did not administer 500mg of Rituximab to Patient A as prescribed;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, within which she states:

"On 11 July 2016 while Tania was away, I discovered a 500mg vial of Rituximab in the drugs fridge clearly labelled for Patient A who Tania had looked after on 7 July 2016. Rituximab is a form of monoclonal chemotherapy. It is used to treat auto-immune disease such as vasculitis or lupus…

…I therefore concluded that another drug error had been made as Patient A had only been infused 1 x 500mg vial of Rituximab because pharmacy confirmed that 2 x 500mg vials were sent to us and one 500mg vial was still in our drugs fridge."

The panel noted the screenshot provided to it which evidences that Ms White had signed that she had administered the full dose. Further, when referring to the Rituximab Care Plan, the panel noted that Ms White's initials are against the boxes relating to pre-medication administration.

As a result of the alleged error, a DATIX incident form was completed and an apology was made to the patient.

The panel found that Ms White's actions in signing Patient A's action list, indicating that she had administered the drug and the signing completed on the Rituximab Care Plan, supported Ms 1's assertion that it was Ms White who was responsible for administering the medication.

Whilst no patient harm was caused, the panel accepted that by not receiving the full dose of Rituximab, Patient A's underlying health condition would not be treated but Patient A would still be exposed to the side effects of the drug without the benefits of the treatment. The panel accepted the written statement of Ms 1. The panel concluded, that on the balance of probabilities, Ms White did not administer 500mg of Rituximab to Patient A as prescribed.

Charge 1 (c)

(c) On 8 July 2016, provided incorrect advice to patients about bed rest following renal biopsies;

This charge is found PROVED

When determining this charge, the panel took into account Ms 1's written statement, within which she states:

"On 8 July 2016, 2 patients who had presented for renal biopsies told me that they had been informed by Tania that they only needed 2 hours of bed rest after their procedure. The checklist clearly states that patients need 4 hours of bed rest and so this was highlighted to Tania, and again raised concerns about her ability to follow procedures. There were 3 patients having kidney biopsies on 8 July 2016."

The panel noted that both the Kidney Biopsy Post Procedure checklist and the Trust's Kidney Biopsy Leaflet confirms that four hours bed rest is required post procedure.

The panel had no evidence before it of Ms White recording her advice to the patients.

The panel accepted the evidence of Ms 1. It reminded itself that not one, but two patients confirmed the incorrect advice provided by Ms White. The panel noted that documentary evidence before it corroborates Ms 1's oral and written evidence. In light of this, the panel found that on the balance of probabilities, Ms White did provide incorrect advice to patients about bed rest following renal biopsies.

Charge 1 (d)

(d) On 8 July 2016, suggested administering insulin to Patient C which had not been prescribed;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she states:

"On 8 July 2016, Tania asked me if it was okay to give a patient called [Patient C] insulin which hadn't been prescribed. Insulin is a hormone made by the pancreas which helps the body convert glucose (from carbohydrates) into energy. After Tania asked me if she could give the insulin even though it wasn't prescribed, I asked her to speak with the Doctors to get it prescribed. All medications given by staff must be prescribed and the Trust's procedure for administering medication should be followed."

The panel had before it the Trust's procedure for administering medication. At paragraph 25, the Policy states:

"25. Medicines that have not been prescribed by an authorised prescriber must not be administered to patients…"

Further, it states that one should 'ensure the prescription is correct' and that all sections of the prescription 'should be checked before administering a medicine'.

The panel accepted the evidence of Ms 1 and found that the documentary evidence before it corroborated her witness statement. It concluded that, on the balance of

probabilities, it is more likely than not that Ms White did suggest administering insulin to Patient C which had not been prescribed.

Charge 1 (e)

(e) Between 11 and 12 July 2016, were responsible for the care of Patient D when you did not have proof of competency in Patient Controlled Analgesia;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the written statement of Ms 1, in which she explains:

"On 11 July 2016, Tania worked a bank night shift in Jane Ashley/Lower Gastroenterology Ward. During this shift, Tania had been responsible for the care of a patient called [Patient D] for which Tania did not have proof of competency in PCA."

She further states:

"Tania was not able to produce any evidence of competency regarding the usage of these devices. The certificate she presented afterwards was dated 14 April 2010 and was simply showing attendance at the session…The certificate clearly states at the bottom that it is "not a recognition of competency"."

The panel had sight of the said certificate. The panel also had sight of the Trust's Policy for Patient Controlled Analgesia, which states that "all adult inpatients with PCA must only be cared for by nurses/ODPs who have completed the OUHFT approved training."

The panel accepted the evidence of Ms 1 and found that the documentary evidence corroborated her witness statement. In the absence of any documentation from Ms White evidencing that she was competent in PCA, the panel was satisfied, on the balance of probabilities that this charge is found proved.

Charge 1 (f)

(f) Between 11 and 12 July 2016, did not ensure that patient observations were carried out on Patient D between 00:30 and 05:48;

The panel found this charge PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she states:

“In Patient D’s case, checks should have been done every 4 hours. Tania has documented the safety checks at irregular times, but never more than 4 hours apart, but there is a period between 00:30 and 05:48 where Patient D’s observations were not carried out.”

The panel had sight of Patient D’s Adult Patient Pain Chart and Adult Track and Trigger Chart, which evidences that Ms White carried out observations at 00:30 and 05:48. The panel again noted the Trust’s policy for PCAs which provides information as to the frequency of safety checks and patient observations, specifically that checks should be completed every four hours.

The panel determined that, in light of the evidence before it, observations should have been carried out every four hours. The panel accepted the evidence of Ms 1 and determined that it was Ms White’s responsibility to have completed an observation of Patient D at 04:30. The panel was therefore satisfied, on the balance of probabilities, that Ms White failed to so and determined that she did not ensure that patient observations were carried out on Patient D between 00:30 and 05:48.

Charge 1 (g)

(g) Between 11 and 12 July 2016, incorrectly recorded details of the safety checks for Patient D;

The panel found this charge PROVED

In reaching this decision, the panel had regard to Ms 1's witness statement, within which she explains:

"In the section for 'bolus dose' (which is the dose delivered each time the patient presses the button) of Patient D's adult inpatient pain chart, Tania had written 7 at 21:00, 10 at 23:00, 12 at 02:00 and 12 at 06:00. This would appear to suggest the patient received doses of 7mg, 10 mg or 12mg. I believe this to be an error as she has also written 7, 10, and 12 against the section for 'number of attempts' and 'successful attempts'.

The panel had sight of Patient D's Adult Patient Pain Chart.

Having found Ms 1 to be a credible and reliable witness, the panel accepted her evidence. It found that the documentary evidence before it corroborated Ms 1's witness statement. In light of this, the panel was satisfied on a balance of probabilities that Ms White did incorrectly record details of the safety checks for Patient D.

Charge 2 (a)

2. While subject to an informal Performance Improvement Plan between 25 July 2016 and 14 December 2016, you failed to demonstrate that you were capable of working safely without supervision, in particular:

   (a) On 25 July 2016, after cannulating a patient, flushed the cannula without first cleaning the bung with a sanicloth;

The panel found this charge PROVED

When considering this charge, the panel referred to the minutes from an Informal Meeting held on 25 July 2016, with Ms White and Ms 1. [PRIVATE]

The panel noted that after the meeting, an information Performance Improvement Plan (PIP) was issued to Ms White. The PIP was for six months, with weekly reviews

involving Ms 1 and others. Deadlines were set for Ms White to achieve the competencies set out for her.

Ms White was not to administer medication unsupervised until she was able to demonstrate competence in line with the Trust's Medicines Management Objective Structured Clinical examination ('OSCE). Ms White agreed and signed the PIP.

It is the evidence of Ms 1 that, after meeting with Ms White on 25 July 2016, she directly observed her on the Unit. The panel had sight of Ms 1's Daily Review of Ms White. In her witness statement, Ms 1 explains:

"After cannulating the patient, I witnessed Tania flush the cannula without first cleaning the bung with a sanicloth. After inserting the cannula you inject a small amount (normally 10mls) of normal saline intravenously. This is known as flushing…

If the bung is not cleaned before you connect the syringe there is the danger of micro-organisms entering the patient's blood stream as you administer the medication and/or fluid and therefore the risk of infection is increased."

The panel considered Ms 1's evidence that Ms White's actions were a failure of part 6 of the 'Peripherally inserted venous Cannulation: Supervised Practice Framework'. The panel noted that this failure was also covered by the Trust's Infection Control Policy.

The panel was satisfied that Ms White would have and/or should have known the correct procedure when flushing a cannula. The panel accepted the evidence of Ms 1 and found that the documentary evidence before it, corroborated her witness statement and oral evidence. The panel was therefore satisfied on the balance of probabilities, that Ms White did flush the cannula without first cleaning the bung with a sanicloth.

Charge 2 (b) (i)

(b) On 25 July 2016, while preparing Ferinject for Patient E:

(i) Walked away from the drugs cupboard while leaving the door open and keys in it, without consulting with another member of staff;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

"Whilst preparing medication Ferinject to a patient called Patient E (who was the only person booked in for Ferinject that day), I witnessed Tania walk away from the drugs cupboard whilst leaving the doors open and keys in it…

…Giving her the benefit of the doubt, it may have been that because I was standing there she thought it would be okay, but I advised her that she should not do this without checking with whoever is there. I remained standing by the cupboard but reminded Tania to check in future before walking away."

The panel considered both Patient E's electronic medication record which evidences the prescription for Ferinject and Patient E's action list which demonstrates that Ms White had administered and signed for the Ferinject.

The panel has found Ms 1 to be a credible and reliable witness and accepted her evidence as a direct witness to this incident. The panel was satisfied that Ms White did leave the medication cupboard unlocked and unattended. It determined that Ms White would have and/or should have known that leaving the medication cupboard open could have potentially allowed unauthorised personnel to access the medication. In light of this, the panel was satisfied on the balance of probabilities that Ms White did walk away from the drugs cupboard while leaving the door open and keys in it, without consulting with another member of staff.

Charge 2 (b) (ii)

(ii) Were unable to identify how to prime the Intravenous Medication (IV) giving set, without assistance;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“Tania had some issues with priming the giving set, the giving set is the tube which allows medication to travel from the medicine bag or bottle through to a patient’s cannula. Priming the giving set is the action of filling the tube with the liquid medication, ensuring that all air bubbles are dispelled. This is important as air bubbles delivered intravenously can cause an embolism which can lead to a heart attack or stroke.

Turning the giving set means that any air in the line is pushed to the end of the giving set first and therefore out of the line first. This means that your tube will only contain liquid when you have finished. I advised her to turn the filter upside down and to slow her priming rate as this helps to eliminate issues of air in the line. Tania advised me that she had never been told this. I was very surprised by this, especially as she had apparently been practising as a registered nurse for many years and will have given many IV medicines in this time.”

It is the evidence of Ms 1 that this procedure is taught at both Injectable Medicines study days and Infusion Devices training days. The panel accepted Ms 1’s evidence that being able to successfully prime an IV giving set forms part of the infusion device assessment, which has to be passed before the Trust allows a nurse to use the infusion devices independently. This assessment is repeated every three years.

The panel determined that Ms White should have undertaken this assessment several times in the course of her career. It was of the view that if Ms White could not successfully prime an IV giving set, she should have raised this with her superiors prior to this incident. The panel acknowledged the evidence that failing to properly prime an IV giving set can put patients at risk of an air embolism, which could prove fatal.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It was therefore satisfied, on the balance of probabilities, that Ms White was unable to identify how to prime the Intravenous Medication (IV) giving set, without assistance.

Charge 2 (b) (iii)

(iii) Made a number of attempts to programme the Alaris infusion pump to 1080ml/hr when it could not be programmed above 999ml/hour;

This charge is found PROVED

In reaching this decision, the panel had regard to Ms 1's witness statement, which states:

"The drug (Ferinject) was 1g which was 270mls to be given over 15 minutes. A 1 gram vial of Ferinject is available as a 20ml liquid medication. Before infusion the nurse needs to mix it with 250mls of normal saline. Therefore the final volume of liquid to be infused is 270mls (20mls Ferinject plus 250mls normal saline). This was equal to 1080mls per hour. Tania attempted several times to programme 1080mls per hour but the pump rejected this as invalid. After approximately 4 attempts, Tania turned to me and said "Okay, I give up. What is it?" I pointed out that you can only enter 3 digits and therefore the fastest rate you can programme is 999ml/hr."

The panel noted that Ms 1's witness statement is corroborated by the contemporaneous notes she completed in her Daily Review of Ms White, dated 25 July 2016.

It is the evidence of Ms 1 that the Trust requires that Infusion Device training and assessment is carried out before a nurse is allowed to use an Alaris infusion pump and that competency is reassessed every three years.

Having found Ms 1 to be a credible and reliable witness, the panel accepted her evidence as a direct witness to the incident. It was therefore satisfied, on the balance of probabilities, that Ms White did make a number of attempts to programme the Alaris infusion pump to 1080ml/hr when it could not be programmed above 999ml/hour.

Charge 2 (c) (i)

(c) Having completed the venepuncture and cannulation study day on 26 July 2016:

(i) Did not complete the venepuncture or cannulation workbooks following the training;

This charge is found PROVED

When considering this charge the panel referred to the witness statement of Ms 1, in which she states:

"On 26 July 2016, Tania attended the venepuncture and cannulation study day from 09:00 – 12:30. She attended the study day and I believe she completed the relevant e-learnings. However, she did not complete the venepuncture or cannulation workbooks following the training i.e. the 10 successfully observed attempts and therefore was never able to carry out these skills independently."

The panel had no evidence before it from Ms White of any completed work books in relation to the study day. Ms White has not provided any explanation for this. Having found Ms 1 to be a credible and reliable witness, the panel accepted her evidence. It was therefore satisfied, on the balance of probabilities that Ms White did not complete the venepuncture or cannulation workbooks following the training on 26 July 2016.

Charge 2 (d) (i)

(d) On 27 July 2016:

(i) While cannulating Patient F, did not obtain informed consent regarding inserting a cannula and taking blood samples at the same time;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the written statement of Ms 1, in which she explains:

“This was an observed assessment which is part of the cannula supervised practice framework. Tania needed to pass observed attempts before being signed off to work independently. Unfortunately, she did not pass this observation and was not signed off as she did not explain what she was doing to Patient F. Tania was inserting a cannula into Patient F and taking blood samples at the same time, which is fine, but she should have fully explained this to him so that he could give informed consent.”

It is the evidence of Ms 1 that, when questioned about the incident, Ms White stated that ‘Patient F knew he had to have his bloods taken.’

The panel had sight of the Cannula Supervised Practice Framework, within which it is evidenced that Ms White did not ensure that the patient received an explanation of the procedure and gained verbal consent. Further, the panel noted Ms White’s Daily Review for the 27 July 2016, within which Ms 1 provides a contemporaneous account of the incident.

The panel accepted the evidence of Ms 1. It found that her Daily Review notes corroborated her witness statement. The panel accepted that Ms White would and/or should have known that she was to explain to Patient F what the blood samples were for, and why. The panel has determined that Ms White did not fulfil this requirement. It was therefore satisfied, on the balance of probabilities, that while cannulating Patient F, Ms White did not obtain informed consent regarding inserting a cannula and taking blood samples at the same time.

Charge 2 (d) (ii)

(ii) Attempted to use blood left on a needle to measure Patient F’s glucose levels, without obtaining their consent;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she states:

“She was using a drop of blood left from a needle to measure Patient F’s blood glucose levels. I asked what she was doing and she replied ‘Ahh!’ and then nothing. So I asked her again what she was doing. She replied ‘Haven’t you ever seen this before?’ I said ‘No, and again, what are you doing?’. She then told me that she was going to use some of the blood which was left on one of the items to check Patient F’s blood glucose levels. I asked if she thought this was acceptable. She said ‘It’s what I was told by the blood people’. I do not know who Tania meant by ‘the blood people’ as I didn’t ask her. It was wrong for Tania to have dome this because not only is there a risk of a needle stick injury, but I feel she shouldn’t have carried out the test without gaining consent from Patient F.’

The panel had sight of Ms White’s Daily Review, completed by Ms 1 on 27 July 2016.

The panel accepted the evidence of Ms 1. It had already found her to be a credible and reliable witness and her contemporaneous notes within the Daily Review, corroborated her witness statement. In light of this, and when considering it’s findings at charge 2 (d) (i), the panel was satisfied on the balance of probabilities that Ms White did attempt to use blood left on a needle to measure Patient F’s glucose levels, without obtaining their consent.

Charge 2 (d) (iii)

(iii) Did not complete or delegate the taking of observations for a patient following a kidney biopsy, which were required every 15 minutes;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“Tania had an issue that day whereby she was trying to check a patient’s blood glucose level, which was high and so was then also trying to check ketones…As a result, another patient who should have been having observations checked every 15 minutes didn’t get them. The kidney biopsy checklist shows that patients should have

observations every 15 minutes for the first hour, every 30 minutes for the next hour and then hourly to assess for signs of bleeding, complications or distress. Tania had been allocated this patient."

The panel further noted Ms 1's evidence that, when questioned as to why she had not been carrying out the observations, Ms White explained that she was 'busy checking blood sugars.'

The panel had before it the Post Biopsy Checklist, which confirms Ms 1's evidence that observations should be completed every 15 minutes for one hour.

The panel accepted the evidence of Ms 1 and noted that her contemporaneous notes made within the Daily Review for Ms White, corroborated her witness statement. In light of this, and Ms White's apparent admission to Ms 1 when questioned on the day, the panel was satisfied on the balance of probabilities that Ms White did not complete or delegate the taking of observations for a patient following a kidney biopsy, which were required every 15 minutes.

Charge 2 (d) (iv)

(i) Did not escalate Patient F's systolic blood pressure of 191mmHg and/or early warning score (EWS) of 3 to a doctor;

This charge is found PROVED

When considering this charge, the panel noted Ms 1's evidence that observations for a patient are recorded on a 'System for Electronic Notifications and Documentation' ('SEND') and that, based on the observations, an early warning score is calculated ('EWS'). The score gives information regarding the need to escalate concerns and/or the frequency of observations. Ms 1's evidence was that when she saw the screen, the systolic blood pressure was 191mmHg. Ms White did not save this.

The panel only had before it a screenshot of Patient F's SEND monitor and the Action Logs recording the observations performed and saved by Ms White. The panel noted

that the SEND screenshot does not evidence that Patient F had a systolic blood pressure of 191mmHg but did evidence a EWS of 3. In Ms 1's witness statement, she explains the consequences of what she saw on the screen regarding the blood pressure:

"This is a high reading. Normal systolic blood pressure is anything between 100mmHg and 140mmHg. There are often no symptoms associated with a high blood pressure, but over time can lead to damage to blood vessels, heart attack or stroke."

Further, she states:

"An EWS of 3 suggests that the patient could be showing signs of deterioration and needs close monitoring and possibly medical intervention…It was important that the EWS of 3 was escalated as Patient F may have needed medication to bring their blood pressure down. The doctor is the only one that can make that assessment and prescribe any medication."

Ms 1 confirmed that when she spoke to Ms White about this incident, Ms White stated that she had told Mr 1 about Patient F's condition when handing over but confirmed that she had not escalated the concerns to a doctor herself.

The panel accepted the evidence of Ms 1. It determined that Ms White should and/or would have known that a EWS of 3 requires escalation. The panel acknowledged the evidence before it that on the Ward it is usual for three Senior House Officers and a Registrar to be on duty. It determined that it was the responsibility of Ms White to escalate Patient F's condition. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not escalate Patient F's systolic blood pressure of 191mmHg and/or early warning score (EWS) of 3 to a doctor as required.

Charge 2 (d) (v)

(ii) Did not save Patient F's observations onto the SEND system until prompted;

This charge is found PROVED

When making a decision in relation to this charge, the panel referred to the witness statement of Ms 1, in which she states:

"Tania soon returned and told me that she had spoken to the doctor. I checked to see if the observations had been saved on SEND but they hadn't so I asked Tania to do it. However the screen had been logged off. Tania then told me that she had already saved them, but I pointed out that she hadn't as there no record of them. Tania then said she thought they were saved automatically."

Ms White was asked by Ms 1 to take the observations again.

The panel had before it the Daily Review notes completed by Ms 1, dated 27 July 2016, detailing this incident.

The panel accepted the evidence of Ms 1. It has already found her to be a credible and reliable witness and her recordings made within the Daily Review, corroborated her witness statement. The panel was therefore satisfied, on the balance of probabilities that Ms White did not save Patient F's observations onto the SEND system until prompted.

Charge 2 (e)

(e) On 28 July 2016, while undertaking the medication Objective Structured Clinical Examination (OSCE) (attempt 1):

(i) Did not identify the patient using the correct procedure;

(ii) Did not check for allergies;

(iii) Did not verbalise the side effects and cautions/contra-indications;

This charge is found PROVED in its entirety

In reaching this decision, the panel had regard to the witness statement of Ms 1, within which she explains that on 28 July 2016, Ms White practised for the medication OSCE with Ms 4.

The panel had before it the OCSE checklist which confirms that Ms White did not pass the exam. The OCSE confirms Ms 1's statement that Ms White did not verbally check with the patient his or her identity, failed to check for any allergies and did not verbalise any side effects to the patient. Whilst the panel did not have any information before it as to what drug Ms White was been tested on, in light of the evidence before it, the panel was satisfied on the balance of probabilities that on 28 July 2016, while undertaking the medication Objective Structured Clinical Examination, Ms White failed the three areas as stated within the charge.

Charge 2 (f) (i)

(f) On 29 July 2016:

(i) Did not check how to administer Chlorphenamine IV before preparing it for administration, despite being unsure;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she states:

"the next medication that was due was 10mg of Chlorphenamine IV. Tania prepared the drug using an ATT and her technique was good. Once Tania had drawn up the medication and disposed of her needle correctly, I asked Tania if she was sure the medication had been drawn up correctly. Tania replied 'I thought it was supposed to be diluted but I don't know. It doesn't say anything on EPR.'… Although technically speaking the way she had prepared the drug was correct, she didn't actually know if it was or not and even admitted that she wasn't sure."

It is the evidence of Ms 1 that Ms White's failure to check how to administer the medication was a breach of both the Injectable Medicine Supervised Framework and the NMC code.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White should have checked how to administer the medication before drawing it up. It found that her failure to do demonstrated a lack of awareness of her limitations and knowledge. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not check how to administer Chlorphenamine IV before preparing it for administration, despite being unsure.

Charge 2 (f) (ii)

(ii) Prepared 1g of Methylprednisolone for administration to Patient G when 100mg had been prescribed;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

"The final pre-med was 100mg of IV Methylprednisolone. I watched Tania prepare this medication. Bearing in mind this was the exact same drug and dose which Tania had made the 'near miss' error on 7 July 2016, Tania made the exact same mistake again ie Tania read out loud from the EPR prescription 100mg, yet selected a 1 gram vial from the drug cupboard." [sic]

It is the evidence of Ms 1 that when this mistake was explained to Ms White, she appeared 'surprised' and 'could not believe she had done it wrong again'.

The panel accepted the evidence of Ms 1, a direct witness to the incident. The panel noted the potential consequences of the error had Ms 1 not been present when the error was made. The evidence before it states that a patient receiving ten times the amount of Methylprednisolone could have suffered anaphylactic reactions, cardiac

arrhythmias and cardiac arrest. In light of the evidence before it, and it's previous determination in relation to a similar event on 7 July 2016 (charge 1(a)), the panel was satisfied on the balance of probabilities that Ms White did prepare 1g of Methylprednisolone for administration to Patient G when 100mg had been prescribed.

Charge 2 (f) (iii)

(i) While undertaking the medication OSCE (attempt 2), were unable to give full information about Paracetamol and/or Lactulose, including side effects;

This charge is found PROVED

When determining this charge, the panel took into account the evidence of Ms 1 who explained that on 29 July 2016, Ms 1 and Ms White and another nurse completed further medication administration practice in the form of OSCE. Ms White had two attempts at administering paracetamol and lactulose but neither attempts were successful.

The panel had before it the OCSE checklist which confirms that Ms White did not pass the exam on 29 July 2016. The OCSE confirms Ms 1's statement. In light of the evidence before it, the panel was satisfied on the balance of probabilities that on 29 July 2016, while undertaking the medication Objective Structured Clinical Examination, Ms White failed to give full information about Paracetamol and/or Lactulose, including side effects.

Charge 2 (g) (i)

(g) On 1 August 2016, while being assessed in venepuncture:

(i) Did not anchor the needle on one or more occasion;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she explains:

“On 1 August 2016, I directly observed Tania’s practice…I had the opportunity to observe Tania’s venepuncture skills, with a view to signing some competencies. I observed Tania at 7 different attempts. Unfortunately, I was unable to sign any of them off as a ‘pass’, for different reasons… Tania often did not anchor the needle, meaning the needle moved and as a result the vein was sometimes missed. I reminded Tania about the importance of this on more than one occasion.”

It is the evidence of Ms 1 that Ms White’s failings breached the Venepuncture Practice Framework in that Ms White did not ‘anchor the vein using the non-dominant hand’.

The panel had before it Ms 1’s Daily Review notes of Ms White’s practice on 1 August 2016. The panel accepted the evidence of Ms 1. It has already found her to be a credible and reliable witness and her contemporaneous recordings made within the Daily Review, corroborated her witness statement. The panel was therefore satisfied, on the balance of probabilities that Ms White failed to anchor the needle on one or more occasion.

Charge 2 (g) (ii)

(ii) Under filled several of the bottles containing blood;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she states:

“Tania under filled several of the bottles. I reminded her often and as a consequence she was then showing me the bottles to check there was sufficient blood. This was not acceptable as I may not always be there and Tania should have been able to do this herself. Tania did not know where the full line was on each bottle which I showed her, explaining that the leeway is 10%, except for the blue (clotting screen) bottles which should be filled exactly. There is a risk that if the bottles are under filled there would not be enough blood available in order to perform the required tests.”

It is the evidence of Ms 1 that Ms White's failure to fill the bottles correctly amounted to a failure of the Venepuncture Supervised Practice Framework. The panel had the framework before it and noted that part 12 states 'bottles to fill according to manufacturing guidelines'.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White should have been aware of the correct amount of blood which should be collected and that her failure to do so breached part 12 of Venepuncture Supervised Practice Framework. In light of this, the panel was satisfied on the balance of probabilities that Ms White did under fill several bottles containing blood.

Charge 2 (g) (iii)

(iii) Used your finger to stop blood having removed a needle, as you did not have cotton wool ready;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

"On one occasion, Tania removed a needle from a patient without having any cotton wool ready. I do not recall the patient's name. She quickly put her finger over the puncture site until she located cotton wool, but I could see from the patient's face he was not happy and he told her so. Sometimes when the needle is removed some blood can ooze from the puncture site. As well as being an infection risk for others, it is not nice if it spills onto the patient's clothes. Cotton wool is used to press on the puncture site to help stem bleeding and prevent bruising."

It is the evidence of Ms 1 that Ms White's failure to have cotton wool ready in order to stem the bleeding amounted to a failure of the Venepuncture Supervised Practice Framework. The panel had sight of the framework and noted that part 14 states 'apply

gauze over the puncture site without applying pressure and quickly remove the needle from the vein'.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White's in using her finger to stop the blood was incorrect and breached part 14 of Venepuncture Supervised Practice Framework. In light of this, the panel was satisfied on the balance of probabilities that Ms White did use her finger to top blood having removed a needle, as she did not have cotton wool ready.

Charge 2 (g) (iv)

(iv) Taped the puncture sites without applying pressure or waiting to see if the bleeding had stopped on one or more occasion;

This charge is found PROVED

When determining this charge, the panel took into account Ms 1's witness statement, in which she states:

"For the first two venepunctures, Tania taped the puncture sites without applying pressure or waiting to see if the bleeding had stopped. There is a risk that the vein could continue to bleed, causing oozing from the puncture site or bruising."

It is the evidence of Ms 1 that Ms White's failure to apply pressure to the puncture site amounted to a breach of the Venepuncture Supervised Practice Framework. The panel had sight of the framework and noted that part 15 states that once you have removed the needle you should 'immediately apply pressure over the venepuncture site for 2-3 minutes.' Further, the panel noted Ms 1's evidence that Ms White had only recently completed venepuncture training on the 26 July 2016.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White's failure to apply pressure to the puncture site breached part 15 of Venepuncture Supervised Practice Framework. The panel found that Ms White should and/or would have known this requirement, particularly in light of the training which Ms

White completed only five days previously. The panel was therefore satisfied on the balance of probabilities that Ms White did tape the puncture sites without applying pressure or waiting to see if the bleeding had stopped on one or more occasion.

Charge 2 (g) (v)

(v) Did not complete any documentation for one patient, until prompted;

This charge is found PROVED

In reaching this decision, the panel had regard to Ms 1's witness statement, in which she states:

"On one occasion Tania did not complete any of the documentation until I reminded her, but I cannot recall for what patient. The phlebotomy room keeps paper records of all the patients who have blood samples taken, including identity, hospital number, type of tests, whether the patient has previously had a kidney transplant or not."

It is the evidence of Ms 1 that Ms White's failure to complete the relevant documentation amounted to a failure of the Venepuncture Supervised Practice Framework. The panel had sight of the framework and noted that part 23 states that one must 'complete minimal documentation: time, site of specimen, explanation given to the patient, complications.'

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White's failure to complete the relevant documentation breached part 23 of the Venepuncture Supervised Practice Framework. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not complete any documentation for one patient, until prompted.

Charge 2 (h) (i)

(h) On 1 August 2016, while undertaking a medication OSCE assessment (attempt 3) for Lactulose and Amlodipine:

(i) Did not carry out the necessary safety checks, in that you gave Amlodipine without checking the patient's blood pressure;

This charge is found PROVED

When considering this charge, the panel referred to the evidence of Ms 1. Ms 1 explained that on 1 August 2016, Ms White attempted a further medication administration OSCE assessment. Present were Ms White, Ms 1 and Ms 5. Ms 5 posed as the patient. Ms 1 explains her witness statement:

"There was no limit to the number of attempts Tania could have, but the PIP specified that Tania had to pass 5 attempts to be [sic] successfully pass that element…Tania was able to successfully navigate her way around EPR drug charts and located the drugs she was due to give. However, Tania did not carry out the necessary safety checks – she gave Amlodipine without checking the patient's blood pressure."

The panel had before it the OCSE checklist which confirms that Ms White did not pass the exam on 1 August 2016, despite this having been Ms White's third attempt at doing so. The OCSE confirms Ms 1's statement. In light of the evidence before it, the panel was satisfied on the balance of probabilities that on 1 August 2016, while undertaking a medication OSCE assessment (attempt 3) for Lactulose and Amlodipine, Ms White did not carry out the necessary safety checks, in that she gave Amlodipine without checking the patient's blood pressure.

Charge 2 (h) (ii)

(ii) Inappropriately tried to advise a renal patient about alternative remedies when discussing Lactulose;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

“Whilst talking to the patient about lactulose, Tania correctly identified that this was for constipation. She then tried to advise the patient about alternative remedies. Tania’s suggestions might have been useful for patients in other areas, but not for renal patients.”

The panel had before it the OCSE checklist which confirms that Ms White did not pass the exam on 1 August 2016. The OCSE confirms Ms 1’s statement. In light of its previous determination at charge 2 (h) (i) and the evidence before it, the panel was satisfied on the balance of probabilities that on 1 August 2016, while undertaking a medication OSCE assessment (attempt 3) for Lactulose and Amlodipine, Ms White inappropriately tried to advise a renal patient about alternative remedies when discussing Lactulose.

Charge 2 (i) (i)

(a) On 2 August 2016:

(i) Did not obtain informed consent from a patient by explaining why they needed a cannula and what blood tests were being taken and why;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“Tania did not explain to her patient why he needed a cannula and what blood tests she was taking or why, and therefore did not receive informed consent. It is important that patients have full information before undergoing any tests or procedures as they have the right to refuse.”

When questioned about the incident, Ms White stated that the patient ‘knew’ why he had to have his bloods taken. It is the evidence of Ms 1 that Ms White’s failure was a breach of part 4 of the Peripherally Inserted Venous Cannulation Supervised Practice Framework.

The panel had sight of the Peripherally Inserted Venous Cannulation Supervised Practice Framework which at Part 4 states that one should 'ensure patient…receives explanation of the procedure and gains verbal consent.' Further, the panel noted Ms White's Daily Review for the 2 August 2016, within which Ms 1 provides a contemporaneous account of the incident.

The panel accepted the evidence of Ms 1. It found that her Daily Review notes corroborated her witness statement. The panel accepted that Ms White would and/or should have known that she was to explain to the patient what the blood samples were for, and why. The panel was determined that Ms White did not fulfil this requirement. It was therefore satisfied, on the balance of probabilities, that Ms White did not obtain informed consent from a patient by explaining why they needed a cannula and what blood tests were being taken and why.

Charge 2 (i) (il)

(ii) Inadequately delegated a task of taking patient observations to a colleague;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she states:

"As Tania arrived back, the Student Nurse [Ms 6] informed me that Tania's car had been brought back following a service, but that she needed to go and park it properly. Immediately Tania said to Ms 6 'can you go and do obs [observations] on this patient?' and left. I was present during the conversation between Tania and Ms 6. Tania was about to leave the unit after asking Ms 6 to take the patient's observations. She had not explained to Ms 6 what procedure the patient had undergone, whether or not the patient could not eat and drink, whether or not they needed to remain on bed rest, whether or

not they had already received or needed analgesia. I believed this was an unsatisfactory delegation."

Having found Ms 1 to be a credible and reliable witness, the panel accepted the evidence of Ms 1, a direct witness to the incident. The panel found that Ms White prioritised parking her car over patient safety. In light of this, the panel was satisfied on the balance of probabilities that Ms White inadequately delegated a task of taking patient observations to a colleague.

Charge 2 (i) (iii)

(iii) Did not pass a maths assessment in respect of drugs calculations;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"In relation to injectables, as part of Tania's PIP she was asked to complete a maths assessment (deadline 2 August 2016) and was given a week to complete it. Tania submitted the test that day and scored 10/18 for drug calculations and therefore did not pass this element."

The panel had before it a copy of Ms White's maths assessment which confirms that she did not pass the exam on 2 August 2016. The assessment before the panel confirms Ms 1's statement. In light of the evidence before it, the panel was satisfied on the balance of probabilities that on 2 August 2016, Ms White did not pass a maths assessment in respect of drugs calculations.

Charge 2 (j) (i)

(b) On 3 August 2016:

(i) Did not close the curtains and window blind before Patient H got undressed;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

"I observed Tania preparing a patient, Patient H, for venoplasty…Tania was polite and introduced herself to the Patient. The patient looked very uncomfortable and Tania helped her reposition onto a chair. However, I observed Tania with the patient whilst the patient was getting changed into a gown. The patient was sitting on a bed which was closest to the window facing in to the rest of the unit. She had removed her top and just had a bra and skirt on, with the curtains and blinds open. The patient did not complain herself but I went and spoke with Tania about this afterwards."
It is the evidence of Ms 1 that Ms White's failure was contrary to the Trust's values.

The panel had sight of Ms White's Daily Review for the 3 August 2016, within which Ms 1 provides a contemporaneous account of the incident.

The panel accepted the evidence of Ms 1. It found that her Daily Review notes corroborated her witness statement. The panel accepted that Ms White would and/or should have known that she was to close the curtains and window blinds whilst Patient H undressed. It determined that her actions did not respect the patient's privacy and/or dignity. It was therefore satisfied, on the balance of probabilities, that Ms White did not close the curtains and window blind before Patient H got undressed.

Charge 2 (j) (il)

(i) Indicated that you would return a controlled drug (Oxycodone) to a patient after administration rather than store it securely;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she states:

“I asked Tania what she was going to do with it and she told me she was going to give the patient some and that the doctor was about to prescribe it. I cannot recall the name of the doctor. I then asked her what she was going to do with the bottle afterwards. Tania told me she was going give it back to the patient. I explained to Tania that Trust Policy regarding medicine management was that all controlled drug (of which Oxynorm is one) should be locked away in the controlled drugs cupboard.”

It is the evidence of Ms 1 that Ms White’s actions amounted to a breach of both the Trust’s Policy regarding medicines management and the Standard Operating Procedure for Controlled Drugs. The panel had sight of both documents. It noted that at point 15 of the Trust’s Policy regarding medicine management, it states that the drug(s) should be ‘placed in a see through re-usable security bag and sealed with a tamper evident security seal’.

The panel accepted the evidence of Ms 1. It had already found her to be a credible and reliable witness and her witness statement was supported by the Trust documentation before the panel. It determined that Ms White failed to recognise the risks associated with not securing the drug correctly. In light of this, the panel was satisfied on the balance of probabilities that Ms White did indicate that she would return a controlled drug (Oxycodone) to a patient after administration rather than store it secure

Charge 2 (j) (iii)

(ii) While undertaking a medication OSCE assessment (attempt 4) for Doxazosin and Amoxicillin:

a. did not check the patient’s wristband before dispensing medications;
b. gave Doxazosin without checking the patient’s blood pressure;
c. were unclear when explaining how many times a day Amoxicillin should be taken;
d. incorrectly stated that Amoxicillin was contraindicated for renal patients;
e. did not explain adequately the cautions for Amoxicillin;

This charge is found PROVED in its entirety

In reaching this decision, the panel had regard to the witness statement of Ms 1, within which she explains that on 3 August 2016, Ms White undertook a medication OSCE assessment for Doxazosin and Amoxicillin.

The panel had before it the OCSE checklist which confirms that Ms White did not pass the exam, despite this occasion been the fourth attempt in doing so. The OCSE confirms Ms 1's statement that Ms White did not check the patient's wristband, did not check the patient's blood pressure, was unclear as to how many times a day the medication should be taken, incorrectly explained the purpose of Amoxicillin and did not explain the cautions for the said drug. In light of the evidence before it, the panel was satisfied on the balance of probabilities that on 3 August 2016, while undertaking a medication OSCE assessment (attempt 4) for Doxazosin and Amoxicillin, Ms White failed the five areas as stated within the charge.

Charge 2 (j) (iv)

(iii) While undertaking a further medication OSCE assessment for Paracetamol and Furosemide:

a. Did not check whether a patient had already taken Paracetamol before administering Furosemide;
b. Did not explain what Paracetamol was for or whether the patient required it;
c. Did not verbalise the contraindications of Paracetamol and/or Furosemide;

This charge is found PROVED in its entirety

When considering this charge, the panel had regard to the witness statement of Ms 1 in which she explains that on 3 August 2016, Ms White undertook a further medication OSCE assessment for Paracetamol and Furosemide.

The panel had before it the OCSE checklist which confirms that Ms White did not check whether the patient had already taken paracetamol, did not explain what the drug was for or whether the patient required it and did not verbalise the contraindications of the drugs. In light of the evidence before it, the panel was satisfied on the balance of

probabilities that on 3 August 2016, while undertaking a further medication OSCE assessment for paracetamol and furosemide, Ms White failed the three areas as stated within the charge.

Charge 2 (k) (i)

(c) Between 15 and 18 November 2016:

(i) Dispensed 280mg of Frusemide for Patient I, when 240mg was prescribed;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Mr 1, in which he states:

“I asked Tania how many tablets she had to dispense to reach the prescribed level of 240mg. Tania clearly told me that she would need 6 x 40mg tablets which was correct. As Tania was dispensing the Furosemide tablets, I noticed that she had 7 tablets in the medicine cup rather than 6. I am not sure if she miscounted or not, but it was a drug error because 280mg furosemide had been dispensed when 240mg furosemide had been prescribed. Taking too much furosemide can lower blood pressure or make a patient vomit or feel nauseous.”

The panel had before it an EPR screen shot of Patient I’s prescription. The panel also had sight of Mr 1’s contemporaneous report detailing the shift on the 15 and 18 November 2016.

The panel accepted the evidence of Mr 1. It had already found him to be a credible and reliable witness and noted that his report corroborated his witness statement. It was therefore satisfied, on the balance of probabilities, that Ms White did dispensed 280mg of Frusemide for Patient I, when 240mg was prescribed

Charge 2 (k) (ii)

(ii) On one or more occasion, took an excessive amount of time to complete a drugs round;

This charge is found PROVED

When determining this charge, the panel took into account the witness statements of both Ms 1 and Mr 1. Ms 1 states:

"[Mr 1] has documented that it took Tania 2 hours to administer medication to 5 patients. There is no way it should take 2 hours to complete a medication round for 5 patients. Bear in mind some of our patients are acutely unwell and will have nursing needs other than medication…Taking two hours would means you would almost be finishing one round before needing to start the next."

Mr 1 states:

"…I think Tania lacked confidence because she hadn't administered medication to patients in a long time, having previously worked in an outpatient setting. The drug round on 15 November 2016 took 2 hours to complete whereas it would normally only take 1 hour to 1.5 hours, depending on the number of medications a patient has"

The panel accepted the evidence of Ms 1 and Mr 1. It had already found both witnesses to be credible and reliable and noted that both of their statements supported each other. In light of this, the panel was satisfied on the balance of probabilities that on one or more occasion, Ms White took an excessive amount of time to complete a drugs round.

Charge 2 (k) (iii)

(iii) Required prompting to check blood pressure readings before giving antihypertensive medications;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"On 18 November 2016, Tania worked with [Ms 4]…I was glad to see that Tania was checking indications, side effects and contra indications before giving medicines, but Ms 4 reported that Tania still needed reminding to check blood pressure readings before giving antihypertensive medications."

The panel had before it the contemporaneous report, completed by Ms 4 on 18 November 2016, detailing Ms White's failings.

The panel accepted the evidence before it. It found that the contemporaneous report of Ms 4 supported Ms 1's written statement. In light of this, the panel was satisfied on the balance of probabilities that Ms White required prompting to check blood pressure readings before giving antihypertensive medication.

Charge 2 (l) (i)

(d) On 22 November 2016:

(i) On one or more occasion, had to be prompted to check the correct time/date on the drug chart when administering medication;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the evidence before it, including an email from Ms 7 to Ms 1 on 22 November 2016, stating:

"I am unsure whether she identified the time and date of each medication correctly. There were 2 occasions where medications from a previous day/shift remained on the drug chart and she needed to be reminded to check the time and date."

The panel accepted the evidence before it. The panel found that the email sent by Ms 7 was a contemporaneous account of Ms White's actions on 22 November 2016. In light of this, and when considering its previous findings, the panel was satisfied on the

balance of probabilities that Ms White did have to be prompted to check the correct time/date on the drug chart when administering medication.

Charge 2 (l) (ii)

(ii) When administering insulin to Patient J:

a. did not prime the insulin pen until prompted;

b. prepared the wrong dose for administration;

c. did not wait 10 seconds before removing the needle;

This charge is found PROVED in its entirety

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

"On 22 November 2016, Tania worked with Ms 7, Senior Band 6 Staff Nurse…Firstly Tania was asked if she knew how to prime and use the insulin pen and she told Ms 7 she did. However, she did not prime it. Priming ensures that the pen delivers liquid insulin immediately... Having primed the insulin, Tania then attempted to deliver the dose to the patient. However she had set the pen to the wrong dose…Finally having injected the insulin into Patient J's skin it is advisable to leave the needle in place for a count of 10 seconds. This allows the liquid to be absorbed. Removing the needle too quickly means the liquid leaks out of the injection site and the patient therefore does not get their full dose."

The panel had before it evidence of Patient J's prescription. It also had sight of the action logs in relation to Patient J which confirms Ms White's involvement.

The panel accepted the evidence of Ms 1 and found that her witness statement was supported by the contemporaneous email sent by Ms 7 to Ms 1 on 22 November 2018, detailing Ms White's actions on that day. The panel determined that despite Ms White providing reassurance to Ms 7 that she was capable of using an insulin pen, she made three separate errors whilst caring for Patient J. In the light of this, the panel was satisfied on the balance of probabilities that Ms White did not prime the insulin pen until

prompted, prepared the wrong dose for administration and did not wait 10 seconds before removing the needle.

Charge 2 (m) (i)

(e) On 25 November 2016:

(i) Misread the hospital number of Patient K and interpreted it as correct;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement if Ms 1, in which she states:

"For the first patient, [Patient K], Tania correctly checked the patient's name and date of birth. However, I noted that when she was checking his hospital number from the wrist band to the computer the numbers she verbalised didn't match what was written, though she said it was correct…The Medical Records Number ('MRN') was 10319000 but she actually said 1041900."

The panel had before it a copy of Patient K's MRN, which confirms his hospital number as '10319000'.

The panel also had sight of Ms White's Daily Review for the 25 November 2016, within which Ms 1 provides a contemporaneous account of the incident.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It found that her Daily Review notes corroborated her witness statement and that her statement is supported further by the screen shot of Patient K's hospital number. The panel found that Ms White's actions in misreading the hospital number demonstrated that she was not comprehending what she was doing. In light of this, the panel was satisfied on the balance of probabilities that Ms White did misread the hospital number of Patient K and interpret it as correct.

Charge 2 (m) (ii)

(ii) Having dropped a 500mg Calcium Carbonate tablet while dispensing it, did not recognise without prompting that a further tablet was required for a 1000mg prescription;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

"The prescription read 1000mg and each tablet contained 500mg. as Tania was dispensing the medication she dropped one tablet, which she retrieved and threw away, and then only put one tablet in the pot. She then went on to the next medication (for the same patient) so I stopped her and asked her to recheck her medications. She said 'oh yes, he needs two of those'. This was a drug error and I was concerned that if I had not been there the patient would not have received his full dose."

The panel had before it a screenshot of Patient K's prescribed medication.

The panel accepted the evidence of Ms 1. It had already found her to be a credible and reliable witness. The panel was therefore satisfied, on the balance of probabilities, that Ms White did not recognise without prompting that a further tablet was required for a 1000mg prescription.

Charge 2 (m) (iii)

(iii) While administering insulin:

a. incorrectly primed a needle for insulin administration;
b. released the insulin before waiting for the safety needle to click;
c. did not wait 10 seconds before removing the needle;

This charge is found PROVED in its entirety

When determining this charge, the panel took into account the witness statement of Ms 1, in which she provides an account if Ms White's alleged failings that day, specifically:

“I stopped Tania and explained that she should prime the needle with 1 – 2 units first to ensure the pen was working and then to dial up to 20 units to give the patient…In order to deploy the needle through the patient’s skin, you must firmly press the shield against the skin. Once the shield is fully raised and therefore the needle fully deployed, it clicks to signify that you can now administer the medication. It didn’t click because Tania had not pressed the device firmly enough against the skin…In addition to this, she did not wait 10 seconds before removing the device. When she had finished, I could clearly see insulin liquid on the Patient’s skin.”

It is the evidence of Ms 1 that when questioned, Ms White stated that she ‘had never used this type of needle before’.

The panel accepted the evidence of Ms 1. It reminded itself that Ms White made these errors, despite the procedure been explained to her by Ms 7 on 22 November 2016. The panel determined that had Ms White never used the said type of needle before, as a registered nurse, she had a duty to raise this prior to attempting to use the equipment. In light of this, and when considering its determination at charge 2 (i) (ii), the panel was satisfied on a balance of probabilities that Ms White, while administering insulin, incorrectly primed a needle for insulin administration, released the insulin before waiting for the safety needle to click and did not wait 10 seconds before removing the needle.

Charge 2 (m) (iv)

(i) Did not ask questions or for further information following an inadequate handover from a colleague about a patient;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she explains:

“I asked Tania twice if she was happy and if she had received all of the information she needed. She told me she was. I asked her if she was sure and she said yes. I can’t

remember exactly what was said, but I remember that Tania had not received any information regarding the patient's previous medical history."

The panel accepted the evidence of Ms 1. It had already found her to be a credible and reliable witness. The panel determined that Ms White should have and/or would have known the importance of receiving full information about the patients they are caring for in order for appropriate care to be given. In light of this, the panel determined that on the balance of probabilities, Ms White did not ask questions or for further information following an inadequate handover from a colleague about a patient.

Charge 2 (n) (i)

(f) On 13 December 2016:

(i) Demonstrated poor communication when dealing with one or more patients;

This charge is found PROVED

When making a decision in relation to this charge, the panel referred to the witness statement of Mr 1, in which he states:

"Tania communicated very abruptly to patients/was not very polite at times in speaking to patients. Sometimes this could upset the patients. I observed this once on 13 December 2016 around 14.00."

Mr 1 produced a report of this event. The panel had before it a copy of the report, which was sent by Mr 1 to Ms 1 on the day of the incident.

The panel accepted the evidence of Mr 1, it had already found him to be a credible and reliable witness and determined that his witness statement was corroborated by the contemporaneous report he sent Ms 1 on 13 December 2016. The panel was therefore satisfied, on the balance of probabilities, that Ms White did demonstrate poor communication when dealing with a patient.

Charge 2 (o) (i)

(o) On 14 December 2016:

(i) Did not prepare a care plan or refer a patient to a dietician, who had scored 4 on a Malnutrition Universal Screening Tool (MUST) risk assessment;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

"The patient had scored a 4 which is high risk of malnutrition however Tania had not written a care plan or referred the patient to the dietician. The height and weight are entered to give a BMI score…A score of 0 means the patient is not at risk, but a score of 2 or more means the patient is at high risk…Having identified the patient was at risk, she should have put a plan in place to minimise the risk of further harm."

It is the evidence of Ms 1 that when questioned, Ms White seemed 'unsure of what to do' and that it wasn't until she was prompted that Ms White was able to give the correct management plan.

The panel had before it Ms White's Daily Review for the 27 July 2016, within which Ms 1 provides a contemporaneous account of the incident.

The panel accepted the evidence of Ms 1. It found that her Daily Review notes corroborated her witness statement. The panel was therefore satisfied, on the balance of probabilities, that Ms White did not prepare a care plan or refer a patient, who had scored 4 on a Malnutrition Universal Screening Tool (MUST) risk assessment, to a dietician.

Charge 2 (o) (ii)

(i) Did not check Patient N's blood pressure before dispensing Ramipril;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she states:

“Tania checked her patient’s identity, both verbally and in accordance with the drug chart and she also asked about any allergies. She noted the patient was prescribed Ramipril, which she dispensed. Ramipril lowers your blood pressure. However, she did not check the patient’s blood pressure before doing so. It was important for Tania to have checked the patient’s blood pressure because Ramipril lowers your blood pressure (and) it is important to check that the patient’s blood pressure wasn’t already too low.”

The panel accepted the evidence of Ms 1, having already found her to be a credible and reliable witness. The panel was therefore satisfied, on the balance of probabilities that Ms White did not check Patient N’s blood pressure before dispensing Ramipril.

Charge 2 (o) (iii)

(i) Signed to say that a Becotide inhaler had been administered to Patient N, when this was a Salbutamol inhaler;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she states:

“Tania saw an inhaler on the patient’s locker and asked if that was the one. He said it was and so Tania then signed as having given the medication. Tania did not give the medication as the patient said they had already taken that inhaler. However Tania signed that it had been given. I pointed out that the medication on the locker was actually Salbutamol. Salbutamol is an inhaler used to relieve the symptoms of an

asthma attack…Apart from the fact they are both labelled with the names of the medication, the becotide inhaler is brown and the salbutamol inhaler is blue. Tania had therefore signed for the wrong medication."

The panel had before it both a screenshot of Patient N's prescription, confirming Patient N was prescribed a Becotide inhaler and also a copy of Patient N's action log which confirms Ms White's recording that she had administered this medication.

The panel accepted the evidence of Ms 1. It had already found her to be a credible and reliable witness and determined that her witness statement was corroborated by both of the supporting documents it had before it. In light of this, the panel was satisfied on the balance of probabilities that Ms White did sign to say that a Becotide inhaler had been administered to Patient N, when this was a Salbutamol inhaler.

Charge 2 (o) (iv)

(ii) Administered Morphine to Patient N but did not observe that it had been taken;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"The same patient was then prescribed a controlled drug, Morphine (20mg) which had been prescribed for cancer related pain. Tania dispensed the drug correctly, with me acting as the second checker. Her process and documentation for this was correct. However, Tania gave the tablets to the patient and then turned her back, so she did not see whether the patient had actually taken the medication. I reminded Tania that she must always observe patients taking controlled medication."

The panel had before it both a screenshot of Patient N's prescription, confirming Patient N was prescribed Morphine and also a copy of Patient N's action log which confirms Ms White's recording that she had administered this medication. Further, the panel had sight of the Trust's controlled Drugs Procedure policy, which confirms that controlled drugs should be witnessed by two registered nurses from the point of removal from the drugs cupboard to the patient taking the medication.

The panel accepted the evidence of Ms 1. It found that her witness statement was corroborated by the supporting documentation before it. The panel determined that on the balance of probabilities, Ms White did administer Morphine to Patient N and did not observe that it had been taken, breaching the Trust Policy in relation to controlled drugs.

Charge 2 (o) (v)

(iii) Dispensed Furosemide without checking a patient's blood pressure first;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

"At lunch time, Tania administered the lunch time medications. The first patient was prescribed furosemide but I do not recall the patient's name. These were not the same patients from the previous day. Tania dispensed the medication without checking the blood pressure and again I reminded her that this should be done before dispensing in order to save wastage."

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. The panel was therefore satisfied on the balance of probabilities, that Ms White did dispense Furosemide without checking a patient's blood pressure first.

Charge 2 (p)

(p) On one or more occasion, did not dispose of sharps correctly;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“I advised Tania that she should use a cannulation tray with a sharps bin, rather than a blue tray, in order that she can dispose of sharps immediately…At that moment, her sharps were mixed with packaging, used gloves etc and this posed a risk to Tania or someone else. By mixing needles with gloves and packaging, there is the danger that when sorting items for disposal someone may not realise there is a sharp there and grab all the items together and therefore prick themselves.”

On another date, Ms 1 states:

“After cannulating, Tania did not dispose of her sharps correctly. She dropped her needle into the blue tray rather than the sharps bin. This was something I had already spoken to her about on 25 July 2016. After being reminded again, Tania said that she hadn’t used the sharps bin because she couldn’t reach it. I explained this was unacceptable.”

It is the evidence of Ms 1 that on 1 August 2016, Ms White again did not dispose of her needle correctly.

The panel had sight of Ms 1’s Daily Reviews of Ms White for 25 July 2016, 27 July 2016 and1 August 2016.

The panel accepted the evidence of Ms 1. It found that her contemporaneous notes, made within her daily review of Ms White, corroborated her witness statement. The panel was therefore satisfied, on the balance of probabilities that Ms White did not dispose of sharps correctly on three separate occasions.

Charge 3 (a) (i)

3. While subject to a formal Performance Improvement Plan between 15 December 2016 and 22 December 2016, you failed to demonstrate that you were capable of working safely with supervision, in particular:
   (a) On 20 December 2016:
      (i) On one or more occasion, did not verbally confirm a patient's identity before dispensing medications;

This charge is found PROVED

In reaching this decision, the panel had regard to the evidence before it that on 15 December 2016, a formal meeting took place under the Managing Work Performance Policy with Ms White and Ms 1. The panel had before it the First Formal Stage Checklist. Ms White confirmed that she understood why the informal Performance Improvement Plan (PIP) had been put in place, that she had received support to help achieve the objectives in the informal PIP and that due processes had been followed.

After the meeting, a formal PIP was compiled. All of the objectives remained the same as the informal PIP with the addition of venepuncture and cannulation. Ms White was provided with a copy of the PIP and the expectations were explained to her. A letter was sent to Ms White on 15 December 2016, confirming the situation. The panel had a copy of the letter before it.

It is the evidence of Ms 1 that on 20 December 2016, whilst subject to the formal PIP, Ms White failed to introduce herself to Patient O and did not check the patient's identity. Further, in Ms 1's written statement she explains:

"At lunchtime, Tania and I went to the first patient, whose name I cannot recall. She did not verbally check the patient's identity and although she did scan the wristband, she didn't check these details against the drug chart."

The panel had sight of Ms 1's Daily Review of Ms White for 20 December 2019.

The panel accepted the evidence of Ms 1. It found that her contemporaneous notes made within her daily review of Ms White, corroborate her witness statement. The panel determined that, after having had the formal PIP explained to her both verbally and by way of a letter on 15 December 2016, Ms White would have and/or should have understood the standards expected of her. In light of this, the panel was satisfied on the balance of probabilities, that Ms White did not verbally confirm a patient's identity before dispensing medications on at least two occasions.

Charge 3 (a) (ii)

(ii) Did not clean your hands before dispensing medications;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"Tania also did not clean her hands before dispensing medications and she thanked me for reminding her. Good hand hygiene is recommended by the Patient Safety Agency as a way of minimising hospital acquired infections."

The panel accepted the evidence of Ms 1 having already found her to be a credible and reliable witness. The panel determined that, after having had the formal PIP explained to her both verbally and by way of a letter on 15 December 2016, Ms White would have and/or should have understood the standards expected of her. In light of this, the panel was satisfied on the balance of probabilities, that Ms White did not clean her hands before dispensing medications.

Charge 3 (a) (iii)

(iii) Signed for medication which had not yet been administered;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

“Tania was unable to give the nebulisers because the Acute Dialysis Team were trying to connect the patient to the dialysis machine. This should not be interrupted as an error may occur. Also, there simply isn’t any space for two dialysis nurses, a dialysis machine, Tania and me to get to the patient. However, Tania had already signed for the medications she had dispensed on EPR. I advised Tania that she would need to go back and give them as soon as possible. Tania should not have signed for the medication beforehand.”

The panel accepted the evidence of Ms 1 having already found her to be a credible and reliable witness. The panel determined that, after having had the formal PIP explained to her both verbally and by way of a letter on 15 December 2016, Ms White would have and/or should have understood the standards expected of her. In light of this, the panel was satisfied on the balance of probabilities, that Ms White did sign for medication which had not yet been administered.

Charge 3 (a) (iv)

(iv) Did not check for allergies when speaking to Patient P;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“Tania correctly checked the identity of the next patient, [Patient P] but did not introduce herself or check for allergies. It was important for Tania to have checked for allergies to ensure that she did not expose the patient to anything he was allergic to.”

The panel accepted the evidence of Ms 1 having already found her to be a credible and reliable witness. The panel determined that, after having had the formal PIP explained

to her both verbally and by way of a letter on 15 December 2016, Ms White would have and/or should have understood the standards expected of her. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not check for allergies when speaking to Patient P.

Charge 3 (a) (v)

(v) While undertaking a medication OSCE assessment for Paracetamol 1g, Amlodipine 5mg, Senna 7.5mg and Gliclazide 80mg:

a. Did not check the patient's hospital number at the time of administration;
b. Did not identify the requirements for the drugs;
c. Repeated the patient's blood glucose level incorrectly on one or more occasions;
d. Did not sign for the administration of Senna;
e. Said that Paracetamol had expired in 2001 and then dispensed it;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, within which she explains that on 28 July 2016, Ms White undertook an OSCE assessment for Paracetamol 1g, Amlodipine 5mg, Senna 7.5mg and Gliclazide 80mg. Ms 1 posed as the patient.

The panel had before it the OCSE checklist which confirms that Ms White did not pass the assessment. The OCSE confirms Ms 1's statement that Ms White did not did not check the patient's hospital number at the time of administration, did not identify the requirements for the drugs, repeated the patient's blood glucose level incorrectly on one or more occasions, did not sign for the administration of Senna and said that Paracetamol had expired in 2001 and then dispensed it. In light of the evidence before it, the panel was satisfied on the balance of probabilities that on 20 December 2016, while undertaking a medication OSCE assessment, Ms White failed the five areas as stated within the charge.

Charge 3 (a) (vi)

(vi) When preparing IV medications, did not complete a Visual Infusion Phlebitis (VIP) score for the patient's cannula;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she states:

"Regarding IV medication, I observed Tania preparing IV medications three times. The first time practice was satisfactory, although unsuccessful, as she did not VIP score the patient's cannula."

It is the evidence of Ms 1 that Ms White's failure to complete a VIP score amounted to a failure of the IV Supervised Assessment. The panel had sight of the IV Supervised Assessment and noted that part 11 states 'demonstrates risk awareness and safe practice on the assessment on the intravascular device (cannula), Visual Infusion Phlebitis (VIP) assessment (score and insertion date)'.

The panel accepted the evidence of Ms 1, a direct witness to the incident. It determined that Ms White's failure to complete a VIP score breached part 11 of the IV Supervised Assessment. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not complete a Visual Infusion Phlebitis (VIP) score for the patient's cannula.

Charge 3 (a) (vii)

(vii) Indicated that you would leave a second flush for a cannula unattended for approximately 20 minutes until after the infusion;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

“When I asked Tania why she was preparing a second flush, she replied that it was one for before the infusion and one for after. The infusion was going to take 20 minutes, so I asked what she was going to do with the second flush until then. She said she would leave it in the room. I informed Tania that this was unacceptable as she could not be certain that the flush would not be tampered with.

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. In light of this, the panel was satisfied on the balance of probabilities that Ms White did indicate that she would leave a second flush for a cannula unattended for approximately 20 minutes until after the infusion.

Charge 3 (a) (viii)

(viii) Did not scan Patient Q’s wristband and/or check for allergies when preparing IV medications;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“The second time Tania prepared and administered the IV medications, however this attempt was failed as Tania carried out the whole process without scanning the patient’s, [Patient Q’s] wristband, or checking for allergies.”

It is the evidence of Ms 1 that Ms White’s failure to scan the wristband and/or check for allergies amounted to a failure of parts 7, 8, 16 and 19 of IV Supervised Assessment. The panel had sight of the IV Supervised Assessment.

The panel accepted the evidence of Ms 1, having already found her to be a credible and reliable witness. The panel determined that Ms White's failure to scan the wristband and/or check for allergies amounted to a failure of parts 7, 8, 16 and 19 of IV Supervised Assessment. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not scan Patient Q's wristband and/or check for allergies when preparing IV medications.

Charge 3 (a) (ix)

(ix) Were unable to calculate the correct rate for an infusion pump;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she states:

"Tania also struggled to work out the correct rate for the infusion pump. This has been discussed earlier. It is the electronic infusion device that is used to deliver an infusion at a set rate of mls per hour and over a pre-programmed time period. The dose was 110mls over 30 minutes. Tania initially said this would be 200ml/hr, then changed it to 205ml/hr and then gave up. I informed Tania that the correct rate should be 220mls/hr."

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. In light of this, the panel as satisfied on the balance of probabilities, that Ms White was unable to calculate the correct rate for an infusion pump.

Charge 3 (a) (x)

(x) Administered medication to Patient Q without obtaining informed consent;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"…Patient Q was very drowsy. While Tania woke him up enough to tell him she was going to give some drugs she did not specify what she was giving or why. Tania did not gain informed consent before administering the medication."

It is the evidence of Ms 1 that Ms White's failure to obtain informed consent amounted to a failure of part 2 of IV Supervised Assessment. The panel had sight of the IV Supervised Assessment and noted that part 2 states 'can discuss the requirement for informed patient consent and actions to be taken if there is concerns about capacity to consent/patient cannot consent.'

The panel accepted the evidence of Ms 1. The panel determined that Ms White's failure to obtain full consent amounted to a failure of part 2 of IV Supervised Assessment. In light of this, the panel was satisfied on the balance of probabilities that Ms White did not obtain full consent before administering medication to Patient Q.

Charge 3 (b) (i)

(b) On 22 December 2016:

(i) Offered Patient R a nutritional supplement which had been discontinued on the drugs chart;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she explains:

"The name of the patient was [Patient R]. Tania introduced herself and checked her patient's identity correctly. She then located the first item of the drug chart, which was for a nutritional supplement (Fortisip) and asked the patient if he would like it. I then asked Tania to recheck her drug chart as this item had actually been discontinued on the drug chart. Luckily the patient replied that he didn't want it, but I was concerned that if he had said yes and I hadn't been there, Tania would have dispensed an item inappropriately."

The panel had before it a copy of Ms White's Daily Review, completed by Ms 1 for 22 December 2016.

The panel accepted the evidence of Ms 1. It found that her contemporaneous notes made within the daily review corroborated her witness statement. In light of this, the panel was satisfied on the balance of probabilities that Ms White did offer Patient R a nutritional supplement which had been discontinued on the drugs chart.

Charge 3 (b) (ii)

(ii) Marked that you had dispensed Bumetanide for Patient R when you had not;

This charge is found proved

When determining this charge, the panel took into account the witness statement of Ms 1, in which she states:

"Tania then started dispensing other items from the patient's drug chart, however her procedure was very haphazard. For example, the patient had approximately 10 items due, but Tania dispensed them 1, then 3, then 7 then back to 2. When I asked Tania why and what her thought process was, she told me she was doing all the tablets first and then the insulins…I advised her that I was very concerned that doing things in that way would make a mistake more likely. In fact, this was exactly what happened, as Tania marked that she had dispensed Bumetanide when she hadn't. If I had not been there, this would have been a drug error."

The panel had before it both a screenshot of Patient R's prescription, confirming Patient R was prescribed Bumetanide and also a copy of Patient R's action log which confirms Ms White's recording that she had administered this medication.

The panel accepted the evidence of Ms 1 and found that the documentary evidence before it, supported her witness statement. The panel was therefore satisfied, on the balance of probabilities that Ms White did mark that she dispensed Bumetanide for Patient R when she had not.

Charge 3 (b) (iii)

(iii) Dispensed Lactulose from an open bottle with no date indicating when it was opened;

This charge is found PROVED

When determining this charge, the panel took into account the witness statement of Ms 1, in which she explains:

“At lunch time Tania was dispensing lactulose but I cannot recall for which patient. She correctly observed that although the bottle was opened, there was no date indicating when. However, she dispensed anyway. I advised her that this was not safe as it could be an old bottle. She then asked whether or not she should throw it away. I advised her that she should and she did.”

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. The panel was therefore satisfied, on the balance of probabilities that Ms White did dispense Lactulose from an open bottle with no date indicating when it was opened.

Charge 3 (b) (iv)

(iv) Did not administer Ensure to Patient R as prescribed;

This charge is found PROVED

In reaching this decision, the panel had regard to the witness statement of Ms 1, in which she states:

“After giving the patient his medications, I asked Tania if she had finished with the patient. She said she had so I asked her to recheck the drug chart. There was Ensure showing as outstanding from 10.00. Ensure is a nutritional supplement drink. It is prescribed to patients who are/are at risk of malnutrition…Tania had previously

attempted to give this to the patient at 08.00 but I advised her she should wait and allow the patient to have his breakfast first and then see whether he needed it or not, as Ensure is supposed to be a nutritional supplement and not a replacement. However, Tania did not go back to the patient after breakfast so this was not offered. Yet at lunch time Tania had disregarded this item on the drug chart completely."

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. The panel was therefore satisfied, on the balance of probabilities that Ms White did not administer Ensure to Patient R as prescribed.

Charge 3 (b) (v)

(v) Did not identify without prompting that it was too early to administer Meropenem to a patient;

This charge is found PROVED

When considering this charge, the panel referred to the witness statement of Ms 1, in which she explains:

"…Tania checked the drug chart and told me that the patient was due Meropenem and she bent down to the drug drawer to retrieve it. Meropenem is an antibiotic used to treat infection. At this point I asked Tania to recheck her drug chart. She couldn't see a problem with it, so I pointed out to her that although the patient was due to receive the drug at 08:00, he had not received his previous dose until 03:30. This would mean he couldn't have any more until 15:30. I pointed out to Tania that giving another dose now would be too early and potentially too much for the patient."

It is the evidence of Ms 1 that administering a dose of Meropenem too early can put a patient at risk of overdose and cause side effects such as allergic reactions, anaphylaxis, diarrhoea, nausea.

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. The panel found that the evidence before it demonstrated that Ms White had not realised her error until she was prompted by Ms 1. In light of this, the panel were satisfied, on the balance of probabilities that Ms White did not identify without prompting that it was too early to administer Meropenem to a patient.

Charge 3 (b) (vi)

(vi) Did not check a patient's wristband details against the drug chart when identifying them before administering IV Metronidazole;

This charge is found PROVED

When making a decision in relation to this charge, the panel considered the witness statement of Ms 1, in which she states:

"I then supervised Tania preparing IV metronidazole. I cannot recall the patient's name… When Tania went to the patient to check his identity, she scanned his wristband correctly, and asked him to verbally confirm his identity but did not check the wristband details against the drug chart."

The panel accepted the evidence of Ms 1, a direct witness to the incident, having already found her to be a credible and reliable witness. In light of this, the panel were satisfied, on the balance of probabilities that Ms White did not check a patient's wristband details against the drug chart when identifying them before administering IV Metronidazole.

Charge 4 (i)

4. Did not keep your mandatory training up-to-date in the following areas:
   (i) IV medication;
   (ii) Anaphylaxis;
   (iii) Cannulation;
   (iv) Venepuncture;

(v) Patient Controlled Analgesia;

This charge is found PROVED in its entirety

When determining this charge, the panel took into account all the documentary evidence before it, including the witness statement of Ms 1 in which she explains;

“During the course of my investigation, I couldn’t find any evidence of Tania having recently completed her IV related training. All training records are now electronically stored… All nurses who give IV medication are required to refresh their training and demonstrate competency every 3 years.”

In light of Ms 1’s investigation the following issues became apparent:

- Anaphylaxis training was last completed on 27 January 2005, despite a requirement that training should be renewed every three years;
- Cannulation training was last completed on 12 September 2005, despite a requirement that training should be renewed every three years;
- Venepuncture training was last completed on 27 November 2003, despite a requirement that training should be renewed every three years;
- Ms White was only able to produce a certificate of attendance in relation to an Analgesia training session, dated 14 April 2010. This certificate was ‘not a recognition of competency’, despite the Trust’s policy for Patient Controlled Analgesia stating that ‘all adult inpatients with a PCA must only be cared for by nurses/ODPs who have completed the OUHFT approved training.

It is the evidence of Ms 1 that when Ms White commenced her employment at the Unit, she was asked by Ms 1 if she was trained in IV’s, venepuncture and cannulation. Ms White confirmed that she was.

The panel accepted the evidence of Ms 1. The panel had before it all the relevant documentation, including the said training certificates. It found that the documentary evidence supported Ms 1’s witness statement. In light of this, the panel was satisfied on

the balance of probabilities that Ms White did not keep her mandatory training up-to-date in the five areas identified in the charge.

Charge (5)

5. Failed to cooperate with an NMC investigation into your fitness to practise, in that you did not respond to requests for medical consent between 3 July 2018 and 28 January 2019.

This charge is found PROVED

In reaching this decision, the panel had regard to all the documentary evidence before it, including the witness statement of Ms 2, in which she states:

“From reviewing our electronic records, the registrant has not responded to any correspondence (telephone, letter or email) since she returned the medical consent forms dated 26 June 20018.”

The panel had before it evidence of the numerous attempts made by the NMC to contact Ms White in relation to her medical consent forms, including:

- An email of 24 October 2017; from Ms White attaching medical consent form dated 19 October 2017 to Investigator;
- A letter to Ms White dated 12 June 2018; enclosing medical consent form and previously signed medical consent form dated 28 June 2017;
- An email of 22 June 2018; Senior Investigator sending cover letter and medical consent form to Ms White by email;
- A signed medical consent form from Ms White dated 26 June 2017;
- Email of 3 July 2018; Case Investigation Assistant sending medical consent form to Ms White by email;
- A letter to Ms White dated 30 August 2018; cover letter and medical consent forms by Investigations Support Assistant;

- A telephone note of call from Senior Investigator to Ms White dated 7 September 2018;
- A letter from Ms 2 to Ms White dated 7 January 2019; enclosing medical consent form;
- A letter from Ms 2 to Ms White dated 14 January 2019; enclosing medical consent form;
- A letter from Ms 2 to Ms White dated 21 January 2019; enclosing medical consent form;
- A telephone note of call from Ms 2 to the Ms White dated 23 January 2019.

Whilst the panel acknowledged that Ms White did provide a medical consent form on 24 October 2017, the panel found that despite numerous attempts by the NMC to contact Ms White, she has chosen to cease all communication with her regulator.

The panel accepted the evidence of Ms 2 and determined that her submission that Ms White has failed to cooperate was supported by the documentary evidence before it. In light of this, the panel was satisfied on the balance of probabilities that Ms White has failed to cooperate with an NMC investigation into her fitness to practise, in that she did not respond to requests for medical consent between 3 July 2018 and 28 January 2019.

Submission on lack of competence and impairment:

Having announced its findings on the facts, the panel then considered whether, on the basis of the facts found proved, Ms White's fitness to practise is currently impaired. The panel took into account all the evidence before it.

The panel noted the submissions made by Mr Jeffs in relation to lack of competency (charges 1 to 3) and misconduct (charges 4 and 5).

In relation to charges 1 to 3, Mr Jeffs submitted that lack of competency needs to be assessed using a three stage process. Firstly, is there evidence that Ms White was made aware of the issues around their competence? Secondly, is there evidence that they were given the opportunity to improve? Finally, is there evidence of further assessment? Mr Jeffs referred the panel to the case of *Holton v General Medical Council [2006] EWHC 2960,* in which the Court stated:

'When judging competence, the standard to be applied is that applicable to the post to which the registrant has been appointed, regardless of the sufficiency of their training. Deficiency is to be judged against the standard of his professional work that is reasonably to be expected of the practitioner."

Mr Jeffs submitted that Ms White has failed to demonstrate the necessary standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Staff Nurse in relation to a wide-range of areas. He stated that the regulatory concerns found proved are basic nursing functions which should be well within the competence of a Band 5 Staff Nurse.

Mr Jeffs accepted that Ms White may not have, at least initially, been familiar with the work on the Renal Unit(s). However, he submitted that a high level of support was provided to facilitate such familiarisation and yet Ms White was unable to demonstrate a requisite standard of competence. Mr Jeffs submitted that such clinical steps and actions should be capable of being executed by a Band 5 Staff Nurse independently and without supervision.

[PRIVATE] He submitted that taking into account the above matters, the allegation of lack of competence at the material time is made out.

In relation to charges 4 and 5, Mr Jeffs invited the panel to take the view that Ms White's actions amount to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Ms White's actions amounted to misconduct.

Mr Jeffs referred the panel to the case of *Roylance v GMC (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.'*

Mr Jeffs submitted that Ms White's failure to keep up to date with mandatory training is a significant failing. He stated that it can be inferred from the word 'mandatory' that the training is of significant importance and not an optional extra to be fitted in, should time permit. Further, Mr Jeffs submitted that Ms White has failed to co-operate with reasonable requests made by the NMC, as her professional regulator, to undergo medical testing relating to her health. He reminded the panel that Ms White's lack of co-operation persisted despite her being reminded of the duty to co-operate under the Code. Mr Jeffs submitted that Ms White's conduct fell below the standards which would be considered acceptable to the profession and that charges 4 and 5 are sufficiently serious so as to amount 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. 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. Mr Jeffs referred the panel to the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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.

Mrs Justice Cox went on to say in Paragraph 76:

> I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.
>
> > 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. …

Mr Jeffs submitted that the first three limbs of the test are engaged in Ms White's case. He stated that Ms White's actions either placed, or had the potential to place, patients at an unwarranted risk of harm. He submitted that the risk to those patients was exacerbated by Ms White's failure to keep up to date with her mandatory training. Mr Jeffs stated that by Ms White's inability to demonstrate an appropriate standard of competence, she has brought the profession into disrepute. Further, Mr Jeffs submitted that by way of her actions, Ms White has breached fundamental tenets of the profession by failing to provide safe and effective care and by failing to co-operate with reasonable requests from her regulator to assist with an investigation.

In relation to remediation, Mr Jeffs submitted that there is no evidence before the panel to suggest that Ms White has remediated the concerns in her practice. He reminded the panel that Ms White stopped working in a registered capacity without successfully completing the formal PIP and has not worked in a registered capacity since.

Further, Mr Jeffs submitted that Ms White lacks insight into the regulatory concerns and that this gives rise to a risk of repetition. He stated that should the concerns be repeated, there is the risk of serious, unwarranted, patient harm.

Mr Jeffs concluded by inviting the panel to find that Ms White's fitness to practise is impaired on both public protection and public interest grounds.

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

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved in charges 1 to 3 amount to a lack of competency and whether charges 4 and 5 amount to misconduct. Secondly, only if the facts found proved amount to misconduct and/or lack of competency, the panel must decide whether, in all the circumstances, Ms White's fitness to practise is currently impaired as a result of that misconduct and or/lack of competency.

Decision on lack of competence

When determining whether the facts found proved at charges 1 to 3 amount to a lack of competence the panel had regard to the terms of the *The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code).*

The panel, in reaching its decision, has had regard to the public interest and accepts that there is no burden or standard of proof at this stage and exercised its own professional judgement.

The NMC has defined a lack of competence as:

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

The panel has taken into account the following paragraphs of the Code:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

2.1 work in partnership with people to make sure you deliver care effectively

4 Act in the best interests of people at all times

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

5 Respect people's right to privacy and confidentiality

5.1 respect a person's right to privacy in all aspects of their care

6 Always practise in line with the best available evidence

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

7 Communicate clearly

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

8 Work co-operatively

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

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

11 Be accountable for your decisions to delegate tasks and duties to other people

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

13 Recognise and work within the limits of your competence

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 complete the necessary training before carrying out a new role

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

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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

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

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

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

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

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

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

20.9 maintain the level of health you need to carry out your professional role

22 Fulfil all registration requirements

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

In considering whether the facts found proved at charges 1 to 3 amount to a lack of competence, the panel concluded that Ms White breached the aforementioned paragraphs of the Code, which is the standard by which every registered nurse is measured.

The panel bore in mind, when reaching its decision, that Ms White should be judged by the standards of the reasonable average band 5 Registered Nurse and not by any higher or more demanding standard. The panel found that the failings in this case had the potential for a real risk of unwarranted patient harm. Further, it noted that the concerns in Ms White's case were not isolated. To the contrary, they were wide ranging, occurring on more than one occasion and related to more than one patient. Taking into account the its reasons for the findings of the facts, the panel has concluded that Ms White's practice was below the standard that one would expect of the average Registered Nurse acting in the role that Ms White was in. In all the circumstances, the panel determined that Ms White's performance demonstrated a lack of competence.

Decision on misconduct

When determining whether the facts found proved amount to misconduct, the panel again had regard to the terms of the code (2015).

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Ms White's 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:

19 Be aware of, and reduce as far as possible, any potential for harm associated with your 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

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

22 Fulfil all registration requirements

22.1 keep to any reasonable requests so we can oversee the registration process

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

23 Cooperate with all investigations and audits

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

24 Respond to any complaints made against you professionally

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms White's failure in keeping up to date with mandatory training, was a significant and sustained failure and one which may have placed patients at an unwarranted risk of harm. Further, the panel found that Ms White's failure to cooperate with reasonable requests made by the NMC, her professional regulator, despite attempts to secure her co-operation, fell seriously short of the conduct and standards expected of a registered nurse. In light of this, the panel determined that the facts found proved at charges 4 and 5 were sufficiently serious and amounted to misconduct.

Decision on impairment

The panel next went on to decide if as a result of this misconduct and lack of competence whether Ms White's fitness to practise is currently 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. To justify that trust, nurses must be honest and open and act with integrity. 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 judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*.

The panel accepted the NMC's submissions that the first three limbs of the test are engaged in Ms White's case. It determined that Ms White's failure to demonstrate the standards of knowledge, skill and judgement required to practice safely without supervision as a Band 5 nurse, had the potential for unwarranted patient harm. Further, it found that Ms White's inability to demonstrate an appropriate standard of competency and her refusal to co-operate with the NMC's investigation, has brought the nursing profession into disrepute and subsequently breached a fundamental tenet of the profession.

When considering remediation, the panel acknowledged the evidence before it demonstrating that Ms White had attended some training courses. However, it did not have any evidence of completion of these courses, nor did it have evidence before it to suggest that Ms White has remedied the concerns relating to her competencies and safety as a practitioner. Further, the panel had no evidence suggesting that Ms White has demonstrated a period of safe and consistent practice to the required standard since the charges arose.

The panel accepted that Ms White has demonstrated some insight by recognising that her personal circumstances at the time the charges arose, impacted upon her ability to

practise safely. Despite this, the panel reminded itself that Ms White continued her clinical practice for some time before removing herself into a non-clinical role, without successfully completing her formal PIP. The panel had no reflective piece before it from Ms White evidencing an understanding of what she did was wrong and how this would have negatively impacted upon the profession. In the absence of any evidence of insight or remediation, the panel determined that there is a risk of repetition in Ms White's case.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that, in this case, a finding of impairment on public interest grounds was also required.

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

Determination on sanction:

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms White off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor. 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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Mr Jeffs invited the panel to impose a 12 month suspension order. He submitted that, in light of the panel's findings, some form of restriction on Ms White's registration is necessary at this time.

The panel considered the following aggravating and mitigating factors:

Aggravating

- Ms White posed a real risk to patent safety, despite the significant support provided**;**
- Ms White's failures relate to wide ranging and basic competence;
- There is a real risk of repetition and patient safety in Ms White's case;
- Ms White has failed to demonstrate any insight or remediation into her failings; and
- Ms White has ceased to engage with the NMC, her regulator.

Mitigating

- Ms White made some initial engagement in relation to these proceedings with the NMC; and
- [PRIVATE].

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

Next, in considering whether a caution order would be appropriate in the circumstances, 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 panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms White's misconduct and lack of competency was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered imposing a conditions of practice order. The panel noted the evidence before it that from July to December 2016, Ms White was subject to an informal PIP. Further, from 15 December to 22 December, Ms White was subject to a formal PIP. Despite this, Ms White continued to demonstrate a lack of competency, including drug errors whilst directly supervised. In light of this, the panel found that there are no practical or workable conditions that could be formulated, given the wide ranging nature of the charges in this case. Further, the panel concluded that the misconduct identified at charges 4 and 5, could not appropriately be addressed through retraining.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel found that a member of the public would be seriously concerned by Ms White's non-engagement with her regulator, particularly in light of the serious and wide ranging nature of her failures. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms White's actions is fundamentally incompatible with her remaining on the register.

The panel noted that a registrant cannot be struck off the register based on lack of competency alone. However, the panel found that the misconduct in Ms White's case was sufficiently serious having regard to all the circumstances, such that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Ms White's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with Ms White remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms White's actions were serious and to allow her to continue practising would present a real risk to patient safety and undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Ms White's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this 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 standards required of a registered nurse.

Determination on Interim Order

The panel has considered the submissions made Mr Jeffs that an interim order should be made in order to allow for the possibility of an appeal. He submitted that such an order 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 Ms White is sent the decision of this hearing in writing.

That concludes this determination.