Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday 21 September 2022,
Friday 23 September 2022 – Friday 30 September 2022

Virtual Hearing

Name of registrant:	Andrea Neag
NMC PIN:	16F0814C
Part(s) of the register:	Nurse - Sub part 1 RN1 - Adult nurse, level 1 - 23 June 2016
Relevant Location:	Northwood, Greater London
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, lay member) Sandra Lamb (Registrant member) Marian Robertson (Registrant member)
Legal Assessor:	Cyrus Katrak
Hearings Coordinator:	Chandika Cheekhoory-Hughes-Jones
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Miss Neag:	Not present and not represented
Facts proved:	Charges 1a, 1b, 2, 3a,3b,3c, 5, 6a, 6c, 7 in relation to charge 6c, 8a, 8b, 8c, 9, 10a, 10b, 10c, 11a(i), 11a(ii), 11a(iii), 12, 13a – 13j, 14a – 14h
Facts not proved:	Charges 4a, 4b, 6b
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Neag was not in attendance and that the Notice of Hearing letter had been sent to Miss Neag's registered email address by secure email on 8 August 2022.

Mr Brahimi, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and link to the virtual venue of the hearing and, amongst other things, information about Miss Neag's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Neag has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Neag

The panel next considered whether it should proceed in the absence of Miss Neag. It had regard to Rule 21 and heard the submissions of Mr Brahimi who invited the panel to continue in the absence of Miss Neag. He submitted that Miss Neag had voluntarily absented herself.

Mr Brahimi referred the panel to two emails from Miss Neag dated 26 July 2022 in response to an email from the NMC case officer. In the first email dated 26 July 2022, Miss Neag which stated the following:

"First I don't know what do you want from me keep sending me this emails! I don't want to take part in any hearings! And stop sending me eamils! [sic] *I hope I made myself clear!*
Do not contact me anymore this is do much [sic] *harassment and bullying you are making a very big mistake!"*

Mr Brahimi referred to the second email dated 26 July 2022 in which Miss Neag stated:

"Also I did not respond anything to you
I have informed you nicely to STOP sending me emails, letters or phonne calls [sic]*.*
Anyway I have nothing to respond to you about!
Delete my email address my phonne number [sic]
I am not in England!
I hope I made myself clear!"

Mr Brahimi submitted that, given the serious nature of the allegations, this case should be dealt with expeditiously and that it is in the public interest and interest of justice to proceed in the absence of Ms Neag. He submitted Miss Neag demonstrated limited engagement with the NMC and that, in light of Miss Neag's responses, an adjournment would serve no purpose.

The panel accepted the advice of the legal assessor.

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 has decided to proceed in the absence of Miss Neag. In reaching this decision, the panel has considered the submissions of Mr Brahimi, the two emails dated 26 July 2022 from Miss Neag in response to the emails of the NMC case officer, and the advice of

the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and 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 Miss Neag,
- Miss Neag has stated that she does not *"want to take part in any hearings"*,
- There is no reason to suppose that adjourning the hearing (which is listed for seven days) would secure her attendance at some future date,
- One witness has attended today to give live evidence and three others are 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,
- The charges relate to events that occurred in 2018,
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events, and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Neag 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 in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, 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 Miss Neag's decisions to absent herself from the hearing, waive her rights to attend, and 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 and in the public interest to proceed in the absence of Miss Neag. The panel will draw no adverse inference from Miss Neag's absence in its findings of fact.

Details of charge (as amended)

That you, a Registered Nurse:

1) On 21 May 2018 administered an incorrect dose of 12.5mg Midazolam to Resident X at;

    a) 13:01 **[PROVED]**

    b) 18:00 **[PROVED]**

2) On 22 May 2018 administered an incorrect dose of 12.5mg Midazolam to Resident X at 11:00 **[PROVED]**

3) On or around 21/22 May 2018 did not record a rationale for the administration of Midazolam in Resident ~~***A***~~ **X**'s Care Plan in that you;

    a) Did not record what medication had been administered. **[PROVED]**

    b) Did not record why Midazolam had been administered. **[PROVED]**

    c) Did not record what effect the Midazolam had on Resident ~~***A***~~ **X**. **[PROVED]**

4) On or around 21/22 May 2018 inaccurately recorded Resident X's name in;

    a) Resident X's MAR Charts **[NOT PROVED]**

    b) Resident X's Controlled Drug Book **[NOT PROVED]**

5) On or around 8 December 2018 recorded inappropriate/unprofessional remarks in Resident C's care plan/daily notes regarding Colleague A. **[PROVED]**

6) On or around 8 December;

a) Did not change Resident D's wound dressing, as required by Resident D's care plan. **[PROVED]**

b) Inaccurately recorded that Resident D had refused to change their wound dressing. **[NOT PROVED]**

c) Inaccurately recorded that Resident D would prefer to have their dressing changed on 10 December 2018. **[PROVED]**

7) Your actions in charges 6 a) **and/or,** ~~&~~ 6 b)**, and/or 6c)** above were dishonest, in that you sought to misrepresent that Resident D had refused to change their wound dressing. **[PROVED in relation to Charge 6c]**

8) On 24 November 2018, did not change one or more of Resident E's wound dressings, in that you did not change the dressing on;

a) Resident E's right leg **[PROVED]**

b) Resident E's left leg **[PROVED]**

c) Resident E's right hand **[PROVED]**

9) On 24 November 2018, on one or more occasion did not record an entry in Resident E's wound tracker, to identify why Resident E's wound dressings had not been changed. **[PROVED]**

10) On or around 21 November 2018 applied an incorrect dressing to Resident D's leg wound in that you;

a) Applied K-soft directly on to Resident D's leg wound. **[PROVED]**

b) Taped a surgipad onto the wound using micro-pore tape. **[PROVED]**

c) Taped micro-pore tape around Resident D's leg. **[PROVED]**

11) On or around 24 November 2018;

a) In relation to Resident D's leg wound, inaccurately recorded that you had applied;

i) Manuka honey **[PROVED]**

ii) Alginate dressing **[PROVED]**

iii) Biotin dressing **[PROVED]**

12) Your actions in charge 11 a) above were dishonest in that you falsified an entry in Resident D's wound care evaluation, to conceal that you had applied an incorrect dressing to Resident D's leg wound. **[PROVED]**

13) On 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;

In relation to Resident F's left leg;

a) Incorrectly applied K-soft directly onto Resident F's wounds. **[PROVED]**

b) Did not use Urgotol SSD bandaging **[PROVED]**

c) Did not use a surgical pad/surgipad **[PROVED]**

d) Incorrectly applied atrauman dressing **[PROVED]**

e) Incorrectly recorded that you had applied;

i) Urgotol SSD **[PROVED]**

ii) Surgipad **[PROVED]**

iii) K soft **[PROVED]**

iv) K light **[PROVED]**

In relation to Resident F's right leg;

f) Incorrectly applied un-prescribed manuca honey **[PROVED]**

g) Incorrectly applied atrauman dressing **[PROVED]**

h) Did not use a surgical/surgipad **[PROVED]**

i) Did not use Urgotol SSD bandaging **[PROVED]**

j) Incorrectly applied K-soft directly onto Resident F's wounds **[PROVED]**

14) Between 21 November 2018 and 20 December 2018, failed to complete audit tasks for one or more Residents, in that you;

a) On or around/by 19 December 2018 in relation to Resident D, did not;

i) Evaluate the 'My Portrait' document monthly. **[PROVED]**

ii) Evaluate the 'Moving Around' care plan. **[PROVED]**

iii) Complete a 'Moving & Handling Risk Assessment' in full. **[PROVED]**

iv) Complete a monthly review of the 'Moving & Handling Risk Assessment' **[PROVED]**

v) Complete a 'Falls Risk Assessment' in full. **[PROVED]**

vi) Complete a monthly review of the 'Falls Risk Assessment' **[PROVED]**

vii) Evaluate the 'Skin Care' care plan **[PROVED]**

viii) Update the 'Waterlow Assessment' **[PROVED]**

ix) Record the type of bed and mattress/air mattress setting. **[PROVED]**

x) Update the ‘Body Map’ monthly or when a new concern is reported. **[PROVED]**

xi) Take photographs of Resident D’s wounds. **[PROVED]**

xii) Evaluate the ‘Oral Health’ care plan **[PROVED]**

xiii) Evaluate the ‘Eating and Drinking’ care plan **[PROVED]**

xiv) Evaluate the monthly ‘MUST’ **[PROVED]**

xv) Obtain the monthly weight record **[PROVED]**

xvi) Evaluate the ‘Physical Health’ care plan **[PROVED]**

xvii) Check/obtain monthly vital signs **[PROVED]**

xviii) Evaluate the ‘Mental Health’ care plan **[PROVED]**

xix) Evaluate the ‘Sleeping’ care plan **[PROVED]**

xx) Evaluate the ‘Dementia/Delirium’ care plan **[PROVED]**

xxi) Ensure ‘My Day, My Future’ plan was in place **[PROVED]**

xxii) Evaluate the ‘Future Decisions’ care plan **[PROVED]**

b) On or around/by 25 November 2018, in relation to Resident D, did not;

i) Evaluate/Create the ‘Pain & Medication’ care plan **[PROVED]**

ii) Evaluate the ‘Safety’ care plan **[PROVED]**

iii) Complete the bedrail measurements **[PROVED]**

iv) Evaluate the ‘Moving Around’ care plan **[PROVED]**

v) Complete a ‘Moving & Handling Risk Assessment’ in full **[PROVED]**

vi) Complete a review of the ‘Falls Risk Assessment’ in full **[PROVED]**

vii) Complete/write a ‘Skin Care’ care plan **[PROVED]**

viii) Evaluate a ‘Going to the Toilet’ care plan **[PROVED]**

ix) Complete a ‘Continence Assessment’ in full **[PROVED]**

x) Evaluate the monthly ‘MUST’ **[PROVED]**

xi) Obtain the monthly weight record **[PROVED]**

xii) Complete/write a ‘Eating & Drinking’ care plan **[PROVED]**

xii) Complete/write a ‘Physical Health’ care plan **[PROVED]**

xiii) Complete/write a ‘Mental Health’ care plan **[PROVED]**

xiv) Complete/write a ‘Sleeping’ care plan **[PROVED]**

xv) Complete/write a ‘Dementia/Delirium’ care plan **[PROVED]**

xvi) Complete/write a ‘My Day, My Future ’ care plan **[PROVED]**

xvii) Put Resident D’s folder in order **[PROVED]**

c) On or around/by 19 December 2018 in relation to Resident G, did not;

i) Evaluate a ‘Pain & Medication’ care plan **[PROVED]**

ii) Evaluate the monthly ‘MUST’ **[PROVED]**

iii) Obtain the monthly weight record **[PROVED]**

iv) Evaluate a ‘Sleeping’ care plan **[PROVED]**

v) Review medication protocols/Zerobase in place **[PROVED]**

iv) Archive the old medication protocols **[PROVED]**

d) On or around/by 16 December 2018 in relation to Resident H, did not;

i) Complete a professional log for the ‘Senses and Communication’ care plan **[PROVED]**

ii) Complete a care plan for ~~***Apicibon***~~ **Apixaban** **[PROVED]**

iii) Evaluate a ‘Skin Care’ care plan **[PROVED]**

iv) Update the ‘Waterlow Assessment’ **[PROVED]**

v) Update ‘Body Map’ monthly or when a new concern is reported **[PROVED]**

vi) Evaluate the ‘Washing & Dressing’ care plan **[PROVED]**

vii) Complete/write an ‘Oral Health’ care plan **[PROVED]**

viii) Evaluate a ‘Oral Health’ care plan **[PROVED]**

ix) Complete a monthly ‘Continence Assessment’ **[PROVED]**

x) Evaluate a ‘Constipation’ care plan **[PROVED]**

xi) Evaluate an ‘Eating & Drinking’ care plan **[PROVED]**

xii) Evaluate a ‘Physical Health’ care plan **[PROVED]**

xiii) Evaluate hypertension **[PROVED]**

xiv) Evaluate oxygen **[PROVED]**

xv) Evaluate a ‘Mental Health’ care plan **[PROVED]**

xvi) Complete a monthly ‘Cognitive Assessment’ **[PROVED]**

xvii) Evaluate a ‘Sleeping’ care plan **[PROVED]**

xviii) Evaluate a ‘Dementia/Delirium’ care plan **[PROVED]**

xix) Evaluate a ‘Future Decisions’ care plan **[PROVED]**

xx) Complete medication protocols **[PROVED]**

xxi) Complete topical medication protocols **[PROVED]**

xxii) Complete/check/sign off fluid and diet charts **[PROVED]**

xxiii) Complete/check/sign off positional charts **[PROVED]**

e) On or around/by 22 November 2018 in relation to Resident I, did not;

i) Update Resident/Relative log for the ‘Senses & Communication’ section. **[PROVED]**

ii) Create professional log for the ‘Senses & Communication’ section. **[PROVED]**

iii) Complete a consent form in full for the ‘Choices & Decision’ section. **[PROVED]**

iv) Evaluate a ‘Oral Health’ care plan **[PROVED]**

v) Evaluate a ‘Sleeping’ care plan **[PROVED]**

vi) Evaluate a ‘Dementia/Delirium’ care plan **[PROVED]**

vii) Evaluate a ‘Future Decisions’ care plan **[PROVED]**

f) On or around/by 27 November 2018 in relation to Resident J, did not complete/create a ‘Malnutrition’ care plan. **[PROVED]**

g) On or around/by 27 November 2018 in relation to Resident H, did not complete/create a ‘Malnutrition’ care plan. **[PROVED]**

h) On or around/by 27 November 2018 in relation to Resident K, did not refer Resident K to a dietician. **[PROVED]**

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

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

At this stage of the hearing, Mr Brahimi made a request that this case be partially held in private on the basis that he will be referring to the health and family matters of Witness 1. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session in connection with the health of Witness 1 as and when such issues are raised in order to protect the privacy of Witness 1.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Brahimi under Rule 31 to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to [PRIVATE].

Mr Brahimi informed the panel that [PRIVATE] and she will not be available to attend the hearing to give evidence. He referred to email exchanges dated 14 September 2022 between Witness 1 and the NMC case officer and submitted that there is sufficient information before the panel to determine that there is a good reason for Witness 1 being unable to attend to give evidence today. He stated that, in the preparation of this hearing, the NMC had indicated to Miss Neag by way of emails, that it was the NMC's intention for Witness 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 1, Miss Neag made the decision not to attend this

hearing and did not engage effectively with the NMC regarding this hearing. Mr Brahimi relied on the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565. Mr Brahimi submitted that the evidence of Witness 1 is relevant to charges 1 and 2 predominantly and there is no lack of fairness to Miss Neag in allowing Witness 1's hearsay testimony into evidence.

The panel accepted the advice of the legal assessor.

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and signed by her.

The panel considered whether Miss Neag would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 1 to that of allowing hearsay testimony into evidence.

The panel considered that as Miss Neag had been provided with a copy of Witness 1's statement and, as the panel had already determined that Miss Neag had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any event. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel noted that Miss Neag has been informed by way of email by the NMC case officer of this application. It noted that there has been no response from Miss Neag in relation to this email. It also noted that Miss Neag's engagement with the NMC has been limited. At this stage, there is no reason for the panel to doubt the credibility of Witness 1. Witness 1 has engaged with the local investigations process. It determined that the NMC has taken reasonable steps to secure the attendance of Witness 1 but that Witness 1 had a valid reason for not attending. The panel has seen the local investigation report which reflects the witness statement of witness 1. It considered that the evidence of Witness 1

does not stand alone and that there is other evidence before it which test and corroborate the evidence of Witness 1. The panel considered that there is nothing before it to suggest that Witness 1 is not being credible regarding the reason for her non-attendance.

The panel determined that an adjournment at this stage to try and secure the attendance of Witness 1 by way of summons would serve no real purpose. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 1 and the opportunity of questioning and probing that testimony. There was also 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 hearsay evidence of Witness 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend charges 3, 3(c), 7, and 14(d)(ii)

At this stage, the panel heard an application under Rule 22 made by Mr Brahimi, on behalf of the NMC, to amend the wording of charges 3, 3(c), 7, and 14(d)(ii).

Charges 3 and 3(c)

The proposed amendment was to amend simple administrative typing errors. It was submitted by Mr Brahimi that the proposed amendment would provide clarity and more accurately reflect the witness statement of Witness 2.

> *"That you, a registered nurse:*
>
> *3) On or around 21/22 May 2018 did not record a rationale for the administration of Midazolam in Resident ~~A~~ **X**'s Care Plan in that you;*
>
> *a) Did not record what medication had been administered.*

b) Did not record why Midazolam had been administered.

*c) Did not record what effect the Midazolam had on Resident ~~A~~ **X.***

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

The panel heard submissions from Mr Brahimi who stated that the charges 3 and charge 3c should have read *"Resident X"* and not *"Resident A"*. He submitted that this was an administrative typing error which is not in accordance with the schedule of anonymity. He submitted that this is a case of correcting a letter in order to provide clarity on the charges, that there is no change to the allegation itself and that no injustice is being caused to Miss Neag. He referred to the unredacted witness statement of Witness 2 which he stated clarified the identity of the resident.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Neag 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 rectify the administrative typing error in order to ensure clarity and accuracy of the identification of the resident referred to in charges 3 and 3c and to ensure consistency.

Charge 7

Before making any decision on the facts, the panel, out of its own volition, raised an issue in relation to Charge 7. It observed that Charge 7 currently charges dishonesty in relation to the actions in charges 6a and 6b only. The panel were concerned that in making no

reference of dishonesty to charge 6c, this could amount to undercharging, given the panel's overarching duty to protect the public. It invited the submissions of Mr Brahimi as to whether, in interest of public protection and public interest, charge 7 should be amended to address the actions in charge 6c as well.

Mr Brahimi agreed with the observation of the panel and made an application under Rule 28. He stated that charge 7 currently reads:

> *"7) Your actions in charges 6 a) & 6 b) above were dishonest, in that you sought to misrepresent that Resident D had refused to change their wound dressing."*

Mr Brahimi proposed that the new charge 7 reads as follows:

> *"7) Your actions in charges 6 a)* ***and/or****, 6 b),* ***and/or 6c)*** *above were dishonest, in that you sought to misrepresent that Resident D had refused to change their wound dressing."*

The panel accepted advice from the legal assessor. It was advised that the panel may amend the charge for notice of hearing at any stage before findings of fact are made. Even if the panel raises an issue out of its own volition, it still needs to consider carefully whether the application will be of any unfairness to all parties, including Miss Neag. The panel needs to consider the consequences which be caused to Miss Neag if the application is allowed as well as the consequences on the NMC if the application is not allowed. In its decision-making process, the panel needs to bear in mind its overriding objective towards the public protection. The panel was advised to retire to reconsider the aspects raised.

The panel decided to allow the application to amend charge 7 as proposed by Mr Brahimi. It determined that charge 7 needed to reflect the potential seriousness of the allegations and to make clear that the charges were disjunctive. It noted that the residents of Erskine Hall Care Home Bupa (the Home) include potentially vulnerable people. It took into

account the potential impact on the residents of the Home, members of the public and public protection if it did not include the actions of charge 6c to be considered under charge 7 in respect of the dishonesty element. It took into account that the evidence provided by the witnesses so far support this amendment and observed that the NMC ought to have included charge 6c under the ambit of charge 7 in the first place.

Charge 14(d)(ii)

The panel also heard an application to amend Charge 14 (d)(ii).

"That you, a registered nurse:

d) On or around/by 16 December 2018 in relation to Resident H, did not;

ii) Complete a care plan for ***~~Apicibon~~ Apixaban"***

During the testimony of Witness 4, the panel heard that the use of the word *"Apicibon"* was an error and that the correct name of the medication was *"Apixaban"*. Mr Brahimi agreed that the wording of Charge 14(d)(ii) should be amended to identify the correct medication.

The panel adopted the legal advice previously given by the legal assessor in relation to Rule 28.

The panel was of the view that such an amendment, as applied for, was in the interest of justice, to rectify a typing error and ensure clarity.

Decision and reasons on application to admit documentary evidence

Before calling Witness 4, Mr Brahimi made an application under Rule 31 to admit the diary entries of three pages as documentary evidence before the panel.

Mr Brahimi submitted that the purpose of this application is to allow Witness 4 to exhibit these diary entries. He submitted that the diary entries are relevant to the issues of the case and the charges in dispute. He stated that it is fair for the diary entries to be introduced, even at this stage, as these are records which Miss Neag would have seen herself, given that she was responsible for amending and updating those entries. He reminded the panel that it had decided that Miss Neag had voluntarily absented herself and that it had decided to proceed in her absence.

The panel accepted advice from the legal assessor. The panel was advised that in considering whether or not to admit the documentary evidence, it should take into account the relevance of the documents and the principle of fairness. It would assist the panel to consider why the documents had not been produced until now. The panel was invited to carry out a careful assessment of the competing factors and issues of the case and to consider whether the evidence is demonstrably reliable or whether there is another way of testing its reliability. It was reminded that Miss Neag is not available to make representations on this application, but that a registrant, in the usual process, can expect applications of this nature to occur.

The panel determined to allow the application. It considered that the diary entries are relevant to the case and that it would be fair and in the public interest to allow them to be admitted. It noted that had Miss Neag not voluntarily absented herself, she would have seen the diary entries and been able to make representations on the application.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Brahimi and the evidence of the witnesses. The panel had no submission, written or otherwise, from or on behalf of Miss Neag.

The panel has drawn no adverse inference from the non-attendance of Miss Neag.

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

The panel heard live evidence from the witnesses 2, 3, 4 and 5 called on behalf of the NMC.

- Witness 1: Registered Nurse Unit Manager at the Home at the time of the allegations
- Witness 2: Registered Nurse, undertook local investigation into the allegations at the Home
- Witness 3: Registered Nurse, Unit manager of the ground floor of the Home at the time of the allegations
- Witness 4: Registered Nurse and Specialist mental health nurse, Registered Manager of the Home
- Witness 5: conducted the local Disciplinary Hearing against Miss Neag

Background

The background to the case is as follows:

The charges arose whilst Miss Neag was employed as a registered nurse by BUPA ('BUPA'). Miss Neag came onto the register on 23 June 2016 and started her employment as a Registered Nurse with BUPA on 18 December 2017.

It is alleged that on 21 May 2018, Miss Neag and Witness 1 made two medication errors by administering 12.5mg Midazolam to Resident X, one at 13.05 and another at 18.00. The correct prescription was 2.5mg Midazolam.

It is alleged that on 22 May 2018, Miss Neag and Witness 1 made a further medication error with regards to Resident C by administering 12.5mg Midazolam rather than the prescribed 2.5mg, at 11.00. Witness 1 left work at 13.00 and realising her error at 15.00, drove back to the Home and reported the error to the Clinical Manager and the Home Manager (Witness 4). Family, safeguarding and CCG were informed that day. Resident X passed away within 72 hours of this event as expected and the overdose of Midazolam did not have any adverse effect on the Resident X's health.

In or around May and June 2018, Witness 2 is asked to look into the allegations at the Home. On 25 June 2018, Miss Neag is invited to a disciplinary hearing to hear the allegations against her. On 26 June 2018, Miss Neag attended the disciplinary hearing and was given a final written warning.

It is alleged that:

(a) on 24 November 2018, Miss Neag:

(i) failed to change Resident E's dressing as per the care plan,

(ii) failed to follow the care plan for Resident D,

(iii) applied an incorrect dressing to Resident D.

(b) On 25 November 2018, Miss Neag failed to follow the care plan for Resident F and applied an incorrect dressing.

Witness 3 discovered these failings of Miss Neag and reported her concerns to the Home Manager.

It is alleged that on 8 December 2018:

(a) Miss Neag recorded unprofessional entries into the care plan and the communication diary of Resident C, and
(b) Failed to change the dressing of Resident D as per the care plan. This failing was discovered by a trainee nurse practitioner and reported to Witness 3.

On 14 December 2018, the Home Manager spoke to Resident D about the failing to change the dressing who reported that Miss Neag did not offer to change her dressings and that she would not have refused as she recognise the importance of the dressing being changed.

It is alleged that:

(a) On 17 December 2018, Miss Neag failed to update multiple parts of the Resident D's care plan,
(b) On 20 December 2018, Miss Neag still had not completed the care plan of Resident D and failed to provide a rationale as to why this had not been done.

After local investigations were completed, Miss Neag was invited to a disciplinary hearing scheduled for 17 January 2019.

Miss Neag was dismissed by BUPA on 28 January 2020.

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

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

Charges 1a and 1b

"That you, a Registered Nurse:

1) On 21 May 2018 administered an incorrect dose of 12.5mg Midazolam to Resident X at;
a) 13:01
b) 18:00"

These charges are found proved.

In reaching this decision, the panel considered the meaning of 'administration'. It considered the written evidence of Witness 1 and heard live evidence from Witness 2 that the administration process of Midazolam, a controlled drug, is a two-person activity and that the whole process is two-staged. It heard that the administration process of Midazolam is a shared responsibility between two nurses regardless of which nurse physically injects the patient.

The panel took into account the written statement of Witness 1 in which she admitted to administering Resident X with 12.5mg of Midazolam rather than the correct dosage of 2.5mg on 21 May 2018 at *"13.00 and 18:00"*. The panel was satisfied that the hearsay evidence of Witness 1 is corroborated by the Medicines Administrations Record Chart (MAR Chart). The panel noted that whilst both Witness 1 and Miss Neag signed the MAR Chart regarding the administration process of Midazolam to Resident X, it was unclear as to who actually injected Midazolam into Resident X. The panel relied on the meaning of

‘administration’ and considered that both Witness 1 and Miss Neag were collectively responsible for the full administration process. It also noted that Miss Neag was the nurse responsible for Resident X on that shift.

On the basis of the evidence before it and that Miss Neag was responsible for Resident X on that shift, the panel found that it is highly likely that Miss Neag was the one to administer Resident X with Midazolam.

The panel therefore found charges 1a and 1b proved.

Charge 2

> *“That you, a registered nurse, on 22 May 2018 administered an incorrect dose of 12.5mg Midazolam to Resident X at 11:00”*

This charge is found proved.

In reaching this decision, the panel took into account the hearsay evidence of Witness 1 in which Witness 1 stated that *“on 22nd May 2018…at 11:00, a further dose of 2.5ml of Midazolam was administered”* and elaborated on how she realised that *“there had been an error as we were meant to administer 2.5mg of Midazolam to the patient but instead we administered 2.5mls of Midazolam”*. The panel was satisfied that this was corroborated by the MAR Chart.

The panel therefore found charge 2 proved on the basis of the evidence before it and the reasoning outlined under charges 1a and 1b.

Charge 3a

> *“That you, a registered nurse, on or around 21/22 May 2018 did not record a rationale for the administration of Midazolam in Resident **X**’s Care Plan in that you;*
> *a) Did not record what medication had been administered.”*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. It heard that the care plan is a document which is supposed to document *"anything that happens in the life of the resident on that day, for example a change of condition requiring medication".* It heard that Witness 2 would expect that an entry be made in the care plan regarding the administration of medication to be given, and any reactions or effects on the resident. It heard that Miss Neag was responsible for recording what medication had been administered as Miss Neag was the nurse in charge of that floor.

The panel noted that except for the Controlled Drug signing book (CD book) and the MAR Chart, the administration of Midazolam to Resident X was not documented anywhere else and not recorded in the care plan.

On the basis of the evidence before it, the panel found Charge 3a proved.

Charge 3b

> *"That you, a registered nurse, on or around 21/22 May 2018 did not record a rationale for the administration of Midazolam in Resident **X**'s Care Plan in that you; b) Did not record why Midazolam had been administered."*

This charge is found proved.

In reaching this decision, the panel took into account the live evidence of Witness 2 and the documentary evidence before it, including the MAR Chart.

The panel therefore found Charge 3b proved on the same reasoning as outlined under Charge 3a.

Charge 3c

> *"That you, a registered nurse, On or around 21/22 May 2018 did not record a rationale for the administration of Midazolam in Resident **X**'s Care Plan in that you;*

*c) Did not record what effect the Midazolam had on Resident **X**."*

This charge is found proved.

In reaching this decision, the panel took into account the live evidence of Witness 2 and the documentary evidence before it, including the MAR Chart.

The panel therefore found Charge 3c proved on the same reasoning as outlined under Charge 3a.

Charge 4a

"That you, a registered nurse, on or around 21/22 May 2018 inaccurately recorded Resident X's name in;
a) Resident X's MAR Charts"

This charge is found NOT proved.

In reaching this decision, the panel took into account the live evidence of Witness 2. It heard that the correct procedure is for a resident's first name to be recorded first and then the surname. It heard that it was unclear as to who completed the MAR Chart as it was not signed. It heard that Miss Neag would have been responsible for identifying an incorrect version of the name recorded and to correct that entry.

The panel took into account that the charge states *"recorded"*. Whilst there is evidence before it showing that Miss Neag is responsible to verify and correct an incorrect entry of a resident's name, it determined that there is no evidence before it as to who actually recorded Resident X's name in the first place. The panel therefore determined that, on the balance of probabilities, there is no evidence before it to show that Miss Neag has in fact inaccurately recorded Resident X's name in the MAR Chart.

The panel therefore found Charge 4a not proved.

Charge 4b

"That you, a registered nurse, on or around 21/22 May 2018 inaccurately recorded Resident X's name in;
b) Resident X's Controlled Drug Book"

This charge is found NOT proved.

In reaching this decision, the panel took into account the live evidence of Witness 2. The panel relied on its reasoning under Charge 4a and therefore found Charge 4b not proved.

Charge 5

"That you, a registered nurse, on or around 8 December 2018 recorded inappropriate/unprofessional remarks in Resident C's care plan/daily notes regarding Colleague A."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and Witness 4. It bore in mind the definition of *"inappropriate/unprofessional"* provided by the legal assessor, namely that which falls below the standards of behaviour expected of a registered nurse.

The panel took into account the purpose of a care plan as laid out under Charge 3a by Witness 2 and determined that a resident's care plan and daily notes should only reflect the clinical condition of a resident. It noted that there is a complaints procedure to be followed should it be required. The panel noted the exhibit from Witness showing the entry made by Miss Neag in Resident C's notes which appeared to amount to a complaint about Witness 3.

The panel heard from the evidence of Witness 3 that there was obvious tension between Witness 3 and Miss Neag. However, the panel determined that the remarks made by Miss

Neag did not concern or have any bearing on Resident C's care. It also determined that Resident C's care plan/daily notes was not the right place to record remarks regarding Miss Neag's colleague.

On the basis of the evidence before it, the panel was satisfied that the remarks made by Miss Neag in the care plan/daily notes of Resident C regarding her colleague fell below the expected standards of behaviour.

The panel therefore found Charge 5 proved.

Charge 6a

> *"That you, a registered nurse, on or around 8 December;*
> *a) Did not change Resident D's wound dressing, as required by Resident D's care plan."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4 and Witness 3.

The panel heard from Witness 4 that Miss Neag did not change Resident D's dressing on 8 December 2018 and she had made a diary entry on 11 December 2018 that Resident D would prefer to have the dressing changed on 10 December 2018.

The panel heard that Witness 4 spoke to Resident D who had capacity and stated that *"she knows that her dressings need to be done every four days and knows why they need to be done every four days…although she does not like to have them done she knew they were important and so would not refuse"*. The panel also heard that when Witness 4 spoke to Miss Neag, she told Witness 4 that she checked the dressing and that *"they were intact and dry…she used her clinical judgment as they were ok and the Resident wanted to leave the bandages for longer…".*

The panel heard from Witness 3 that Resident D's condition causes a *"quite offensive smelling"* and consequently, Resident D *"likes the dressing to be done more than is necessary to remove this odour"*. Witness 3 further stated that she had *"a conversation with Resident D…she said to me that she had not refused having her dressings changed and had not even been asked about it"* by Miss Neag.

The panel noted that Resident D has a long-standing condition and is known to the Tissue Viability Nurse (TVN). It noted that the care plan of Resident D required the dressing to be changed on 8 December. It noted that Miss Neag admitted to not changing the wound dressing and that Miss Neag provided a rationale for not doing so to Witness 5, that is, that Resident D *"agreed to not having the dressing changed"*. It heard from Witness 5 that Miss Neag was allocated to change the dressing on that day. Given the nature of Resident D's wound, had Resident D refused to have the dressing changed, Witness 5 would have expected Miss Neag to verbally inform a senior staff member or the unit manager, or she would have expected Miss Neag to try changing the dressing later in the shift.

The panel determined that on the balance of probabilities, Miss Neag knew that the wound dressing needed to be changed every four days as per the care plan. It took into account that Miss Neag admitted to not changing the dressing and attempted to provide a justification for not doing so.

The panel therefore found Charge 6a proved.

Charge 6b

> *"That you, a registered nurse, on or around 8 December;*
>
> *b) Inaccurately recorded that Resident D had refused to change their wound dressing."*

This charge is found NOT proved.

In reaching this decision, the panel took into account Miss Neag's version provided to Witness 4 and Witness 5, as well as the evidence of Witness 3 and Witness 4.

The panel noted that from the evidence of Witness 5, that during the interview, Miss Neag stated that she had asked Resident D if she wanted the dressing changed and that Resident D refused. It relied on the evidence of Witness 3 and Witness 4 as laid out under Charge 6a. It noted that even as per Miss Neag's version, she asked Resident D to change the dressing only once during her shift. It also noted that from the evidence of Witness 4 that Miss Neag provided a different explanation for not changing the dressing, namely that *"they were intact and dry…she used her clinical judgment as they were ok and the Resident wanted to leave the bandages for longer…".*

However, there is insufficient information before the panel to find this charge proved. It heard that Miss Neag did not document anything on 8 December in relation to Resident D. It had sight of a diary entry made on 8 December that said *"way G6 – finished CP please make sure this is completed"* and next to it, the word *"refused"*. It noted the NMC's suggestion that the resident in room G6 who expressed the refusal is Resident D. However, it heard from Witness 4 that Resident D was not in room G6.

On the balance of probabilities and the evidence before it, the panel therefore found charge 6b not proved.

Charge 6c

> *"That you, a registered nurse, on or around 8 December;*
> *c) Inaccurately recorded that Resident D would prefer to have their dressing changed on 10 December 2018."*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 6b.

The panel noted that on 11 December, Miss Neag wrote an entry that Resident D wanted to have the dressing changed on 10 December. It took into account the evidence of Witness 4 and Witness 3 as laid out under charge 6b, the seriousness of Resident D's condition, and Resident D's care plan, the panel found that it was highly likely that

Resident D would have wanted the dressing changed on 8 December. It was satisfied that this was not a true reflection of what Resident D wanted and is therefore inaccurate.

The panel therefore found charge 6c proved.

Charge 7

> *"That your actions in charges 6 a) and/or, 6 b) and/or 6 c) above were dishonest, in that you sought to misrepresent that Resident D had refused to change their wound dressing."*

This charge is found proved in relation to charge 6c.

In reaching this decision, the panel relied on its reasoning under charge 6a, 6b and 6c. The panel found charge 6a proved, however did not find that it amounted to dishonesty for the reasons laid out under 6a. It found charge 6b not proved.

In relation to Miss Neag's actions in charge 6c, the panel found that, on the evidence before it, it is likely that Miss Neag deliberately misrepresented Resident's D intention.

The panel heard from Witness 5 that during the interview, Miss Neag alleged that she was very busy on that day. It also heard that if Miss Neag were very busy, she had the opportunity to escalate not being able to change the dressing to the unit manager or a senior member of staff.

The panel heard from Witness 4 that there was the correct level of staff on that day, that Miss Neag told him that Resident D did not agree to have the dressing changed, and that during the interview with Witness 4, Resident D disputed that she refused to have the dressing changed.

The panel noted that Miss Neag never denied in the disciplinary hearing that she did not change the dressing. It noted that there is no information before it documenting why Miss

Neag was not able to change the dressing on 8 December or the reason for which she did not do so. It also noted that it was only on 11 December that Miss Neag documented that Resident D wanted the dressing changed on 10 December.

The panel is concerned as to why Miss Neag made the entry three days after 8 December, the date on which the dressing was due to be changed. The panel is also concerned about the conflicting and different justifications which Miss Neag provided to Witness 4 and Witness 5 for not changing the dressing on 8 December. It also noted that on one hand, Miss Neag made an entry stating that Resident D wanted to have the dressing changed on 10 December. On the other hand, Miss Neag informed Witness 4 and Witness 5 that the reason for which she did not change the dressing was because it was dry and intact.

On the basis of the evidence before it, the panel was of the view that it is likely that Miss Neag made a dishonest entry in order to convey to the reader that it was Resident D's decision to not have the dressing done on 8 December.

The panel therefore found this charge proved in relation to charge 6c.

Charge 8a

> *"That you, a registered nurse, on 24 November 2018, did not change one or more of Resident E's wound dressings, in that you did not change the dressing on;*
> *a) Resident E's right leg"*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4 and Witness 5 and the documentary evidence before it.

The panel noted that the Resident D's dressing was due to be changed on 24 November 2018. It noted that Miss Neag was on duty on that day. It heard the evidence of Witness 4 who stated that Miss Neag could not remember why the dressing had not been changed

and why she did not document it. It noted, on the other hand, the interview of Witness 5 that Miss Neag stated during the interview that she was not on a shift that day. It heard from Witness 5 that it is likely that, during the interview, Miss Neag was mistaken about not being on shift on 24 November 2018 and that the Home usually keep nurses' shifts rota history.

On the evidence before it, the panel was satisfied that Miss Neag was on shift on 24 November 2018. It took into account that the wound tracker clearly demonstrates that the dressing was due to be changed on 24 November 2018 but noted that these were all not changed until 27 November 2018 by Witness 3.

The panel therefore found charge 8a proved.

Charge 8b

> *"That you, a registered nurse, on 24 November 2018, did not change one or more of Resident E's wound dressings, in that you did not change the dressing on;*
> *b) Resident E's left leg"*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 8a.

The panel therefore found charge 8b proved.

Charge 8c

> *"That you, a registered nurse, on 24 November 2018, did not change one or more of Resident E's wound dressings, in that you did not change the dressing on;*
> *c) Resident E's right hand"*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 8a.

The panel therefore found charge 8c proved.

Charge 9

"That you, a registered nurse, on 24 November 2018, on one or more occasion did not record an entry in Resident E's wound tracker, to identify why Resident E's wound dressings had not been changed."

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 8a.

The panel therefore found charge 9 proved.

Charge 10a

"That you, a registered nurse, on or around 21 November 2018 applied an incorrect dressing to Resident D's leg wound in that you;
a) Applied K-soft directly on to Resident D's leg wound."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3, Witness 4 and Witness 5.

The panel heard that Witness 3 first raised the issue that the incorrect dressing was applied. Witness 3 explained that *"when I changed the bandaging of Resident D I found that the Registrant had applied K-Soft directly onto the leg of Resident D, then placed K light and yellow line on top. Finally, the Registrant had taped a surgipad on the leg of the Resident taped with micro-pore tape".* Witness 3 stated that the incorrect dressing had been used and that this was not in line with care plan.

The panel heard from both Witness 3 and Witness 4 that Resident D had a complex and long-standing condition which required wounds advice by TVN and prescriptions from the General Practitioner (GP).

The panel took into account the wound evaluation by Witness 3 and the photographic evidence of the tape used on the wound. It noted that the care plan was clear about the

prescription, the type of dressing to be used and the order in which the dressing should be used.

On the basis of the evidence before it, the panel was satisfied that Miss Neag did not apply the correct dressing as advised by the care plan.

The panel therefore found charge 10a proved.

Charge 10b

> *"That you, a registered nurse, on or around 21 November 2018 applied an incorrect dressing to Resident D's leg wound in that you;*
> *b) Taped a surgipad onto the wound using micro-pore tape."*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 10a. The panel also heard from Witness 5 that Miss Neag *"admitted to putting micropore directly onto Resident's frail skin".*

The panel therefore found charge 10b proved on the basis of the evidence before it.

Charge 10c

> *"That you, a registered nurse, on or around 21 November 2018 applied an incorrect dressing to Resident D's leg wound in that you;*
> *c) Taped micro-pore tape around Resident D's leg."*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charges 10a and 10b.

The panel therefore found charge 10c proved.

Charge 11a) i), ii), iii)

> *"That you, a registered nurse, on or around 24 November 2018;*
> *a) In relation to Resident D's leg wound, inaccurately recorded that you had applied;*
> *i) Manuka honey*
> *ii) Alginate dressing*
> *iii) Biotin dressing"*

This charge is found proved.

The panel noted that the dressing at charge 11a(iii) should be spelt *"biatain"* but considered that an amendment was not necessary as it was clear to everyone concerned what the charge was.

In reaching this decision, the panel took into account the evidence of Witness 3 and the documentary evidence before it, including the wound care evaluation and the photograph of the dressing which Miss Neag applied to Resident D's leg wound.

The panel heard that Witness 3 works opposite shifts to Miss Neag. They both work 12-hour long day shifts and another nurse was doing the night shifts. When Witness 3 was changing Resident D's dressing, she noted that the documentation did not correspond to the dressing applied. She stated *that "it was stated on the leg a biatain was applied with alginate dressing, however on removal it was a surgipad taped to the skin, the whole way around the leg, K-soft, klite and yellow line on top. Again without the protection before k-soft id adhered to her legs. The tape has caused the skin to peel on removal despite soaking".* Witness 3 stated she did not see that manuka honey was applied but saw that it was documented as applied. She stated that on 27 November 2018, she raised the issue as poor practice with the home manager, Witness 4, as she wanted to make sure that Miss Neag had the correct training and no knowledge gap.

On the basis of the evidence before it, the panel found charges 11a (i), (ii), and (iii) proved.

Charge 12

> *"That you, a registered nurse, Your actions in charge 11 a) above were dishonest in that you falsified an entry in Resident D's wound care evaluation, to conceal that you had applied an incorrect dressing to Resident D's leg wound."*

This charge is found proved.

In reaching this decision, the panel took into account the wound evaluation tracker before it, the evidence of Witness 3 as laid out under charges 11a (i), (ii), and (iii) and the evidence of Witness 4.

The panel heard from Witness 4 that when he spoke to Miss Neag about this matter, she insisted that what she documented was the dressing that she had applied. Witness 4 showed Miss Neag the photograph of the dressing taken by Witness 3 and Miss Neag would not comment on the photograph insisting that she applied what she wrote down in the wound care evaluation.

The panel noted that what Miss Neag wrote in the wound care evaluation appears to be in line with the care plan. However, on the basis of the evidence before it, the panel determined that what Miss Neag applied to Resident D's leg was not what she documented as having been applied in the wound tracker evaluation.

It also noted the evidence of Witness 4 that the home had the correct level of staffing on that day and there is no information before it to show that Miss Neag escalated having difficulties doing the dressing.

The panel determined that, on the evidence before it, it appears that Miss Neag made a deliberate entry to look like she followed the care plan and that she did so dishonestly.

The panel therefore found charge 12 proved.

Charge 13a

"That you, a registered nurse, On 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;
In relation to Resident F's left leg;
a) Incorrectly applied K-soft directly onto Resident F's wounds."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and the documentary evidence before it, including the wound evaluation tracker, the care plan of Resident F and the photograph taken by Witness 3 of Resident F's left leg.

The panel also heard from Witness 3 that when she changed the dressing on 27 November 2018, the dressings were unusually wet. She noticed that the dressing was stuck to the wound and that the dressing was of a different colour. When she took off the dressing, she found that Miss Neag had applied a white netting dressing, which she believes to be atrauman. She found that Miss Neag had also applied K-soft directly onto the wounds and that Miss Neag had documented that she had applied to the left leg, Urgotol SSD, K-soft and K light. She stated that what should have been applied was Urgotol SSD, Surgipad, K-soft and then k light. She stated that what Miss Neag applied was wrong and that the documentation of what she had applied did not match the care plan. She also noticed that the wound was deteriorating and raised the matter with the Home manager, Witness 4, on 27 November 2018.

The panel heard from Witness 4 that the dressing applied had white netting, which did not correspond to the colour of Urgotol SSD, which is brown. He stated that Witness 3 reported that there was no surgipad in place to protect the skin of Resident F and that K-soft dressing had adhered to the wound. When Witness 4 raised the issue with Miss Neag, she stated that she had used Urgotol SSD and when asked as to why the dressing was white when Urgotol SSD was brown, she stated that the colour for Urgotol SSD can be brown. He stated that Miss Neag denied doing anything wrong and denied not adhering to the wound care plan.

The panel heard from Witness 5 that during the interview Miss Neag denied not adhering to the wound care plan and stated that the dressing was out of stock. Witness 5 stated that using any available alternative to the prescribed dressing was against good practice. If the dressing prescribed was out of stock, the advice of the TVN or the GP would have to be sought so that another dressing could be prescribed.

On the basis of the evidence before it, the panel found Charge 13a proved.

Charge 13b

> *"That you, a registered nurse, On 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;*
> *In relation to Resident F's left leg;*
> *b) Did not use Urgotol SSD bandaging "*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 13a.

On the basis of the evidence before it, the panel found Charge 13b proved.

Charge 13c

> *"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;*
> *c) Did not use a surgical pad/surgipad"*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 13a.

On the basis of the evidence before it, the panel found Charge 13c proved.

Charge 13d

"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;

d) Incorrectly applied atrauman dressing"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 13a.

On the basis of the evidence before it, the panel found Charge 13d proved.

Charge 13e

"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;

e) Incorrectly recorded that you had applied;

i) Urgotol SSD

ii) Surgipad

iii) K soft

iv) K light"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 13a.

On the basis of the evidence before it, the panel found Charge 13e proved.

Charge 13f

"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;

In relation to Resident F's right leg;

f) Incorrectly applied un-prescribed manuca honey"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 13a.

The panel also heard from Witness 3, who referred to the photographs which she took of the dressing, that Miss Neag had documented that she applied Urgotol SSD, surgipad, k soft and k light with manuca honey. She stated that manuca honey was not prescribed for this wound. She found a white netted dressing which she stated could have been atrauman but was certainly not Urgotol SSD which is a brown netted dressing. She did not find surgipad and found that the K-soft dressing which Miss Neag had applied had adhered to the open wounds of Resident F. She stated that Miss Neag should have followed the advice of the TVN and also correctly documented what she had applied.

On the basis of the evidence before it, the panel found charge 13f proved.

Charge 13g

> *"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;*
> *In relation to Resident F's right leg;*
> *g) Incorrectly applied atrauman dressing"*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charges 13a and 13f.

On the basis of the evidence before it, the panel found charge 13g proved.

Charge 13h

> *"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;*
> *In relation to Resident F's right leg;*
> *h) Did not use a surgical/surgipad"*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charges 13a and 13f.

On the basis of the evidence before it, the panel found charge 13h proved.

Charge 13i

"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;
In relation to Resident F's right leg;
i) Did not use Urgotol SSD bandaging"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charges 13a and 13f.

On the basis of the evidence before it, the panel found charge 13i proved.

Charge 13j

"That you, a registered nurse, on 25 November 2018 you failed to follow Resident F's care plan in relation to their wounds, in that you;
In relation to Resident F's right leg;
j) Incorrectly applied K-soft directly onto Resident F's wounds"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charges 13a and 13f.

On the basis of the evidence before it, the panel found charge 13j proved.

Charge 14a

"That you, a registered nurse, between 21 November 2018 and 20 December 2018, failed to complete audit tasks for one or more Residents, in that you;
a) On or around/by 19 December 2018 in relation to Resident D, did not;

i) Evaluate the 'My Portrait' document monthly.
ii) Evaluate the 'Moving Around' care plan.
iii) Complete a 'Moving & Handling Risk Assessment' in full.
iv) Complete a monthly review of the 'Moving & Handling Risk Assessment'
v) Complete a 'Falls Risk Assessment' in full.

vi) Complete a monthly review of the 'Falls Risk Assessment'

vii) Evaluate the 'Skin Care' care plan

viii) Update the 'Waterlow Assessment'

ix) Record the type of bed and mattress/air mattress setting.

x) Update the 'Body Map' monthly or when a new concern is reported.

xi) Take photographs of Resident D's wounds.

xii) Evaluate the 'Oral Health' care plan

xiii) Evaluate the 'Eating and Drinking' care plan

xiv) Evaluate the monthly 'MUST'

xv) Obtain the monthly weight record

xvi) Evaluate the 'Physical Health' care plan

xvii) Check/obtain monthly vital signs

xviii) Evaluate the 'Mental Health' care plan

xix) Evaluate the 'Sleeping' care plan

xx) Evaluate the 'Dementia/Delirium' care plan

xxi) Ensure 'My Day, My Future' plan was in place

xxii) Evaluate the 'Future Decisions' care plan"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4 and Witness 5 and the audit documentation of the care plans.

The panel heard from Witness 4 that action plans are developed and delegated to staff throughout the home and that the action plans need to be signed off as completed by the nurse in charge of those residents.

The panel heard from Witness 5 that Miss Neag indicated in the disciplinary interview that she was probably busy, however that Miss Neag could not expect someone to help if she did not communicate. Communication was done verbally during handover. The Home manager, Witness 4, was responsible for checking if the allocated work was carried out and would usually verify this at the end of the day. Individual care plans were not checked

on a day-to-day basis unless a problem was notified. Witness 5 stated that there was also a communication diary for the handover process. Staff were given training as to when documents should be completed and were mentored until they were deemed able to work independently. She stated that there is a unit manager on duty on every shift, and that the unit manager was not made aware of any problems encountered by Miss Neag. She stated that these were only discovered during the audit process.

The panel noted that Miss Neag had been assigned to various tasks after the audit of care plans and that when those tasks were completed, she had to sign the check sheet to mark the tasks as completed. It had sight of the *"resident of the day"* documents which were not signed by Miss Neag. It considered that if Miss Neag was struggling to complete the tasks, she had the option of escalating the matter to the unit manager and noted that there is no information before it to show that Miss Neag did so.

On the basis of the evidence before it, the panel found Charge 14a proved.

Charge 14b

> *"That you, a registered nurse, b) On or around/by 25 November 2018, in relation to Resident D, did not;*
>
> *i) Evaluate/Create the 'Pain & Medication' care plan*
> *ii) Evaluate the 'Safety' care plan*
> *iii) Complete the bedrail measurements*
> *iv) Evaluate the 'Moving Around' care plan*
> *v) Complete a 'Moving & Handling Risk Assessment' in full.*
> *vi) Complete a review of the 'Falls Risk Assessment' in full*
> *vii) Complete/write a 'Skin Care' care plan.*
> *viii) Evaluate a 'Going to the Toilet' care plan*
> *ix) Complete a 'Continence Assessment' in full.*
> *x) Evaluate the monthly 'MUST'*
> *xi) Obtain the monthly weight record*

xii) Complete/write a 'Eating & Drinking' care plan

xii) Complete/write a 'Physical Health' care plan

xiii) Complete/write a 'Mental Health' care plan

xiv) Complete/write a 'Sleeping' care plan

xv) Complete/write a 'Dementia/Delirium' care plan

xvi) Complete/write a 'My Day, My Future ' care plan

xvii) Put Resident D's folder in order"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under Charge 14a.
The panel therefore found Charge 14b proved.

Charge 14c

"That you, a registered nurse, c) On or around/by 19 December 2018 in relation to Resident G, did not;

i) Evaluate a 'Pain & Medication' care plan.

ii) Evaluate the monthly 'MUST'

iii) Obtain the monthly weight record

iv) Evaluate a 'Sleeping' care plan

v) Review medication protocols/Zerobase in place

iv) Archive the old medication protocols"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.

The panel therefore found charge 14c proved.

Charge 14d

"That you, a registered nurse, d) On or around/by 16 December 2018 in relation to Resident H, did not;

i) Complete a professional log for the 'Senses and Communication' care plan.
ii) Complete a care plan for Apicibon
iii) Evaluate a 'Skin Care' care plan
iv) Update the 'Waterlow Assessment'
v) Update 'Body Map' monthly or when a new concern is reported
vi) Evaluate the 'Washing & Dressing' care plan
vii) Complete/write an 'Oral Health' care plan.
viii) Evaluate a 'Oral Health' care plan
ix) Complete a monthly 'Continence Assessment'
x) Evaluate a 'Constipation' care plan
xi) Evaluate an 'Eating & Drinking' care plan
xii) Evaluate a 'Physical Health' care plan
xiii) Evaluate hypertension
xiv) Evaluate oxygen
xv) Evaluate a 'Mental Health' care plan
xvi) Complete a monthly 'Cognitive Assessment'
xvii) Evaluate a 'Sleeping' care plan
xviii) Evaluate a 'Dementia/Delirium' care plan
xix) Evaluate a 'Future Decisions' care plan
xx) Complete medication protocols
xxi) Complete topical medication protocols
xxii) Complete/check/sign off fluid and diet charts
xxiii) Complete/check/sign off positional charts"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.

The panel therefore found charge 14d proved.

Charge 14e

"That you, a registered nurse, e) On or around/by 22 November 2018 in relation to Resident I, did not;

i) Update Resident/Relative log for the 'Senses & Communication' section.
ii) Create professional log for the 'Senses & Communication' section.
iii) Complete a consent form in full for the 'Choices & Decision' section.
iv) Evaluate a 'Oral Health' care plan
v) Evaluate a 'Sleeping' care plan
vi) Evaluate a 'Dementia/Delirium' care plan
vii) Evaluate a 'Future Decisions' care plan"

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.
The panel therefore found charge 14e proved.

Charge 14f

"That you, a registered nurse, f) On or around/by 27 November 2018 in relation to Resident J, did not complete/create a 'Malnutrition' care plan."

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.
The panel therefore found charge 14f proved.

Charge 14g

"That you, a registered nurse, g) On or around/by 27 November 2018 in relation to Resident H, did not complete/create a 'Malnutrition' care plan."

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.
The panel therefore found charge 14g proved.

Charge 14h

> *"That you, a registered nurse, h) On or around/by 27 November 2018 in relation to Resident K, did not refer Resident K to a dietician."*

This charge is found proved.

In reaching this decision, the panel relied on its reasoning under charge 14a.
The panel therefore found charge 14h proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Neag's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Miss Neag's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Brahimi referred to the case of *Calhaem v GMC [2007]* EWHC 2006 (Admin) and *Nandi v GMC [2004]* EWHC 2317 (Admin) and invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Brahimi identified the specific, relevant standards where Miss Neag's actions amounted to misconduct as:

"1: Treat people as individuals and uphold their dignity;
2: Listen to people and respond to their preferences and concerns;
3: Make sure that people's physical, social and psychological needs are assessed and responded to;
8: Work cooperatively;
10: Keep clear and accurate records relevant to your practice;
11: Be accountable for your decisions to delegate tasks and duties to other people;
16: Act without delay if you believe there is a risk to resident safety or public protection;
17: Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection;

20: Uphold the reputation of your profession at all times."

Mr Brahimi made the following submissions collectively in respect of the proved charges; he submitted that the administration of drugs was the responsibility of Miss Neag and that she was required to follow a care plan which had specific details of what was prescribed to residents. She was also informed, by the care plan, of the product to be administered to a resident and of the volume and quantity of that product and submitted that Miss Neag failed to follow this. Miss Neag did not follow the correct procedure for complaints and in recording her dissatisfaction towards her colleague, Witness 3. He submitted that this was not what would be expected as a standard of behaviour from a registered nurse and that Miss Neag fell below the standard.

Mr Brahimi further submitted that residents were directly put at risk by the way in which the wound dressing was applied, or not applied in some circumstances. He reminded the panel that it heard that Miss Neag had training in respect of conducting these exercises and that it would be expected of a registered nurse to complete the dressing changes correctly. He stated that the misapplication of improper process reflects a serious breach on the part of Miss Neag. Miss Neag was aware of the periodic requirements of changing wound dressing and that she chose not to follow this process. Her justifications were not sufficient and went against the desires of how a resident wanted to be treated.

Mr Brahimi submitted that Miss Neag recording a dishonest entry reflects that her conduct amounts to a serious breach as her entry not only covered what had not been done but also challenged the truthfulness of a resident. The failure to keep up to date with audits has a detrimental impact on both Miss Neag and the residents of the Home. He stated that Miss Neag being out-of-date with regards to her own training is reflective of the nursing profession in that they hold inadequate knowledge within their workplace. This will then directly have an effect on the residents whom Miss Neag is seeing to as they may be (as was proved in this case) treated to otherwise in accordance to their care plans and instructions set out by other medical professionals, such as GPs.

Overall, Mr Brahimi further submitted that Miss Neag's actions as proven fall far short of what would be expected of a registered nurse which the public, residents and colleagues would certainly not expect. The public would expect that the profession will have staff that uphold a professional reputation. He therefore invited the panel to find misconduct.

Submissions on impairment

Mr Brahimi moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Brahimi submitted Miss Neag is currently impaired and that all limbs of *Grant* are engaged. He submitted that the first limb is engaged as a result of Miss Neag putting residents in unwarranted risks of harm in relation, but not limited, to:

a. Resident instructions not being followed; where the wrong dosage was administered to residents, and incorrect dressing was applied, and
b. Records were not updated.

Mr Brahimi submitted that the second limb is engaged as a result of Miss Neag's behaviour which, as found proven, plainly brings the profession into disrepute. He submitted that it is unsatisfactory that a nurse does not follow a care plan and does not keep up to date with audits. Miss Neag is a reflection of the nursing profession, particularly given her registered status.

Mr Brahimi submitted that the third limb is engaged, where Miss Neag has plainly breached fundamental tenets of the profession in numerous areas of the Code of Conduct as referred to above, in particular:
a. Keep clear and accurate records relevant to her practice,

b. Act without delay if she believes there is a risk to resident safety or public protection, and
c. Uphold the reputation of her profession at all times.

Mr Brahimi submitted that fourth limb is engaged as a result of Miss Neag's behaviour which, as found proven, presents the risk that she has, and may continue, to act dishonestly. He stated that the act of dishonesty occurred on at least two occasions and that it is likely that she may continue to be dishonest in any future employment. He submitted that there is a serious departure from the standards expected of a nurse and invited the panel to consider impairment on the ground of public protection and otherwise in the public interest.

In relation to the ground of public protection, Mr Brahimi submitted that there is a real risk of harm to residents given how wide-ranging the proven concerns are. The residents are old and vulnerable, and they relied on specific support from nurses. He further submitted that there is a real risk of repetition. The charges occurred over a period of time and the various misconducts demonstrate that these were not corrected even though guidance and supervision were put in place. Miss Neag has not sufficiently engaged with the NMC and has voluntarily absented herself and therefore there is no evidence before the panel that similar breaches would not be repeated in another relevant workplace.

In relation to the ground of public interest, Mr Brahimi submitted that a member of the public would be concerned to learn that Miss Neag is allowed to practise unrestricted given the risks identified. The grave errors would affect the reputation and the public's confidence in the professions and the public would expect that Miss Neag can only return to practice once a panel is fully satisfied that they can be monitored safely.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

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

   To achieve this, you must:

   1.2 Make sure you deliver the fundamentals of care effectively

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

2. **Listen to people and respond to their preferences and concerns**

   To achieve this, you must:

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

8. **Work co-operatively**

   To achieve this, you must:

   8.2 Maintain effective communication with colleagues

   8.3 Keep colleagues informed when you are sharing the care of individuals with

other health and care professionals and staff

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

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.3 Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10. Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

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

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

To achieve this, you must:

18.2 Keep to appropriate guidelines when giving advice on using controlled drugs … or administration of controlled drugs

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

To achieve this, you must:

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

20. Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 Act with honesty and integrity at all times…

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 the allegations found proved involve serious, numerous and repeated failures which cover a wide scope of practice. These range from medication errors which included controlled drugs, poor dressing techniques, poor product supply, failure to follow care plans, to inaccurate recording. The panel took into account that Miss Neag was responsible for a vulnerable group of people, namely

residents in a nursing home, some of which lacked capacity. It also took into account that after the first disciplinary review at the Home, Miss Neag had the opportunity to strengthen her practice. However, the panel has no evidence before it to show that Miss Neag developed insight, sought support or otherwise remediated her practice.

The panel therefore found that Miss Neag's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Neag'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 judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel finds that residents of the Home were caused actual harm in that an overdose was caused and that the wrongly applied dressings set back the healing process. Residents of the Home were also at risk of further harm as a result of Miss Neag’s misconduct. Miss Neag’s misconduct, which included allegations relating to dishonesty found proved, is serious, has breached the fundamental tenets of the nursing profession, and is likely to bring its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty serious.

The panel carefully considered the evidence before it in determining whether or not Miss Neag has taken any steps to correct or strengthen her practice. The panel had no

information before it to show that Miss Neag has developed insight, or otherwise strengthened her practice, even after the first disciplinary review at the Home. The panel also noted that Miss Neag had little to no effective engagement with the NMC in relation to this hearing. The panel is of the view that there is a real risk of repetition.

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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel therefore determined that a finding of impairment on public interest grounds is required.

The panel took into account that a fully informed member of the public would be concerned to learn that Miss Neag were allowed to practise without restriction. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Neag's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Neag off the register. The effect of this order is that the NMC register will show that Miss Neag has been struck-off the register.

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

Submissions on sanction

Mr Brahimi informed the panel that in the Notice of Hearing, dated 8 August 2022, the NMC had advised Miss Neag that it would seek the imposition of a striking off order if it found Miss Neag's fitness to practise currently impaired. He submitted that the aggravating features are:

"a. Multiple incidents and residents;
b. They were varied incidents;
c. Two charges were of dishonesty;
d. Incidents took place over a 7-month period;
e. The Registrant held a position of seniority namely, managerial;
f. Conduct which put patients at risk of suffering significant harm;
g. The Registrant as demonstrated limited engagement with the NMC;"

Mr Brahimi also submitted that the mitigating features are:

"a. No previous misconduct;
b. No previous referrals since this incident (which was over 3 years ago)."

Mr Brahimi submitted that a striking-off order is appropriate taking into account there are two charges of dishonesty in this case, both linked directly to Miss Neag's clinical practice, which included concerns around record keeping and dishonestly attempting to falsify patient instructions. Where these charges have been found proved they would be fundamentally incompatible with continued registration.

The panel had no submissions or information from or on behalf Miss Neag regarding sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- There are multiple and repeated incidents,
- The incidents are wide-ranging,
- Two charges of dishonesty have been found proved,
- Miss Neag was responsible for multiple vulnerable residents,
- Some residents suffered actual harm; others were exposed to a real risk of harm,
- The Home was adequately staffed, and support was available,
- Miss Neag demonstrated attitudinal issues, in that:
    (a) She demonstrated no sign of remorse or remediation when the issues were first raised within the Home or after the first disciplinary hearing,
    (b) She engaged on a limited level with the NMC regarding this hearing, and
    (c) Her limited engagement with the NMC was far from constructive.

Whilst the panel accepted that there were no previous regulatory matters against Miss Neag, it also was aware that she had only been a registered nurse since 2016. The panel noted that the events giving rising to the charges found proved occurred in 2018. The panel was therefore not satisfied that this amounted to a mitigating feature. The panel could not find any other mitigating features in this case.

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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, the dishonest elements of the charges proved, and the public protection issues identified, an order that does not restrict Miss Neag's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Neag's misconduct 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 whether placing conditions of practice on Miss Neag's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges found proved in this case. The attitudinal and dishonesty aspects of the misconduct identified in this case were not something that could be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Neag's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The conduct, as highlighted by the facts found proved was not a single incident and was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Neag's actions is fundamentally incompatible with Miss Neag remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that a suspension order would not adequately protect the public and address the public interest and dishonesty elements in this case. It took into account that Miss Neag was responsible for vulnerable residents and that the care of residents was compromised as a result of her multiple, repeated and wide-ranging failures. It also took into account the attitudinal issues and dishonest behaviour demonstrated by Miss Neag, in that she deliberately attempted to mislead her colleagues concerning patient care. The panel was also concerned in light of Miss Neag's lack of insight or remorse when the issues were raised within the Home and after the first disciplinary hearing.

Additionally, the panel were further concerned by Miss Neag's limited engagement and non-constructive engagement with the NMC. It was of the view that the tone of her engagement underpins attitudinal issues and a lack of insight and professionalism towards the need for regulatory procedures, particularly in light of her responsibility to engage with her regulator. Miss Neag's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Neag's actions were serious and to allow her to continue practising would 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 effect of Miss Neag'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 standard of behaviour required of a registered nurse.

This will be confirmed to Miss Neag in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Neag's own interest until the striking-off sanction takes effect. The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Brahimi who invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and public interest. Mr Brahimi relied on his previous submissions made under the misconduct and impairment stage. He submitted that, in deciding whether or not to impose an interim suspension order, the panel should consider the principle of proportionality. He submitted that the need to protect the public and the public interest outweighs any hardship which may be caused to Miss Neag. He invited the panel to impose the order for a period of 18 months to cover the appeal period and the appeal process, in the event Miss Neag decides to appeal the current determination.

The panel did not have any information or submissions from or on behalf of Miss Neag.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel decided to impose an interim suspension order for a period of 18 months.

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order.

The panel considered the principle of proportionality. It noted from Miss Neag's email exchanges with the NMC case officer dated 26 July 2022 that Miss Neag is not working as a registered nurse in this country and is not due to return to this country for three months. It noted that there is limited evidence of immediate hardship which may be caused to Miss Neag. However, the panel determined that the need to protect the public and the public interest in this case outweighs any hardship which may be caused to Miss Neag.

The panel noted that an interim order will not take effect until the 28 days period has lapsed. It also noted that Miss Neag is currently out of the country and that if Miss Neag decides to appeal the current determination, any appeal process will take time. The panel therefore imposed an interim suspension order for a period of 18 months

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

That concludes this determination.