Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday 30 September 2022

Virtual Hearing

Name of registrant:	**Ms Anne Price**
NMC PIN:	98C1605E
Part(s) of the register:	Registered Nurse – Adult Nursing (Level 1) (March 2001)
Relevant Location:	Dyfed
Type of case:	Misconduct/Caution
Panel members:	Darren Shenton (Chair, lay member) Louise Poley (Registrant member) Anna Ferguson (Registrant member)
Legal Assessor:	Caroline Hartley
Hearings Coordinator:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Ms Price:	Not present and unrepresented
Consensual Panel Determination:	Accepted
NMC offer no evidence:	Charge 5
Facts proved by admission:	All
Facts not proved:	None
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 Ms Price was not in attendance and that the Notice of Hearing letter had been sent to Ms Price's registered email address on 26 September 2022.

Mr Smalley, on behalf of the Nursing and Midwifery Council (NMC), submitted that the Notice of Hearing letter had not been provided 28 days before the hearing. However, Ms Price had indicated in the Consensual Panel Determination (CPD) that she is aware the hearing is taking place today.

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, date and venue of the hearing and, amongst other things, information about Ms Price's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel also noted that whilst the notice requirement of 28 days had not been fulfilled, in the first paragraph of the CPD signed by Ms Price on 29 September 2022 she specifically waived her rights in relation to that period of notice.

In the light of all of the information available, the panel was satisfied that Ms Price has been served with the Notice of Hearing if not within the Rules, within the spirit of the Rules, and there is no detriment to Ms Price.

Decision and reasons on proceeding in the absence of Ms Price

The panel next considered whether it should proceed in the absence of Ms Price. It had regard to Rule 21 and heard the submissions of Mr Smalley who invited the panel to continue in the absence of Ms Price.

Mr Smalley informed the panel that a provisional CPD agreement had been reached and signed by Ms Price on 29 September 2022.

Mr Smalley also referred the panel to the CPD in which it is stated *“Ms Price does not intend to attend the hearing and is content for it to proceed in their and their representative's absence.”*

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 Price. In reaching this decision, the panel has considered the submissions of Mr Smalley 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:

- Ms Price has engaged with the NMC and has signed a provisional CPD agreement which is before the panel today;
- Ms Price has confirmed her intention not to attend this hearing and has asked the panel to proceed in her absence.
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

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

Consensual Panel Determination

At the outset of this hearing, Mr Smalley informed the panel that a provisional agreement of a CPD had been reached with regard to this case between the NMC and Ms Price.

The agreement, which was put before the panel, sets out Ms Price's full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of misconduct and a police caution. It is further stated in the agreement that an appropriate sanction in this case would be a striking-off order.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

"

1. *Ms Price is aware of the CPD hearing. Ms Price does not intend to attend the hearing and is content for it to proceed in their and their representative's absence. Ms Price and/or her representative will endeavour to be available by telephone should any clarification on any point be required, or should the panel wish to make any amendment to the provisional agreement. Ms Price also agrees to waive the notice period for service of the Notice of Hearing. Ms Price understands that if the panel wishes to make amendments to the provisional agreement that they do not agree with, the panel will reject the CPD and refer the matter to a new substantive hearing.*

Preliminary Issues

2. *The NMC intend to offer no evidence in relation to charge 5 for the reasons referred to below.*

The charges

3. *The charges are as follows:*

That you, a registered nurse:

1) Failed to escalate the care of Resident A on one, or more, occasion(s);

2) Failed to communicate effectively with colleagues regarding the care of Resident A in that you:

a) Did not communicate your belief that the GP had stopped medication for Resident A;

b) Inaccurately recorded that Resident A had received the prescribed level of pain relief;

3) Failed to administer the follm·1ing medication to Resident A and/or ensure that such medication was administered:

a) Oramorph 5mg from on, or around, 31 January 2019;

b) MST medication from on, or around, early February 2019 until on, or around, early March 2019;

4) Inaccurately recorded that you had administered prescribed medication to Resident A;

5) Your conduct at charge 4 above was dishonest in that you:

a) knew that you had not administered the prescribed medication to Resident A;

b) intended to create the misleading impression that you administered the prescribed medication to Resident A;

6) Washed one, or more, residents who lacked capacity at inappropriate hours/times;

7) Inaccurately recorded the hours/times that one, or more, resident(s) were washed:

8) Your conduct at charge 7 above was dishonest in that you:

a) Knew that you had not washed the resident(s) at the time(s) recorded;

b) Intended to create the misleading impression as to the time that you had washed the resident(s) and/or that you had washed the resident(s) at a later time;

9) Failed to use an appropriate/safe method to move Resident Bon one, or more, occasion(s);

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

That you, a registered nurse:

On 03 September 2019 accepted a police caution for the offence of care worker iil-treat/wilfully neglect an individual

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

4. *On 25 August 2022, Ms Price submitted a Case Management Form confirming that she admits all of the charges, except for charge 5, in relation to which the NMC intends to offer no evidence for the reasons set out below.*

Background

5. *Ms Price appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse, specialising in adult care. She has been a registered nurse since 18 March 2001. This case represents the first time Ms Price's fitness to practise has been referred to the NMC.*

6. *On 28 February 2019, the NMC received a referral from Plas Cwncynfelin Nursing Home ("the Home"). At the time of the concerns raised, Ms Price was co-owner and Lead Nurse at the Home. The referral related to Ms Price's failure to preserve safety and treat residents with dignity at the Home, as well as poor record keeping and associated dishonesty. Consequently, on 3 September 2019, Ms Price received a police caution for the offence of care worker ill- treat / wilfully neglect an*

individual. On 5 February 2021, Ms Price's name was added to the Adult's and Children's Barred List by the Disclosure and Barring Service DBS").

7. *The Home is a 55 bed nursing home separated into two separate buildings, the Main House and the Coach House. The Coach House was initially just a residential service, but later provided nursing care also. Staff were split between the two units. Ms Price was based in the Main House.*

8. *As part of the NMC's into Ms Price's fitness to practise, witness statements have been obtained from:*

   8.1 Colleague 1, who was, at the material time, a Staff Nurse at the Home;
   8.2 Colleague 2, who was, at the material time, a Care Assistant at the Home;
   8.3 Colleague 3, who was, at the material time, the Manager of the Adult Safeguarding at Ceredigion Safeguarding; and
   8.4 Colleague 4, who was, at the material Lime, a Long Term Care Specialist Nurse Team Leader for Hywel Oda University Health Board.

Facts rerating to Charges 1 - 3

9. *Resident A was a resident at the Home who had chronic skin ulcers on her left leg that caused her significant levels of pain. Resident A was receiving 10mg of Morphine Sulphate ("MST') (a slow release morphine medicine), 37mcg of Matrifen (a transdermal patch) and 10mg/5ml of Oramorph, for pain relief.*

10. *Resident A was required to have their dressing changed every other day and to be administered Oramorph 20 minutes prior to the dressing change. It was common practice at the Home to give medication beforehand to people who would be in pain when their dressing was being changed.*

11. *The pain relief patches were required to be changed daily at 09:00 and 21 :00 hours to ensure 24 hour pain relief.*

12. *On, or around, 31 January 2019, Ms Price stopped administering Resident A their prescribed Oramorph because it made her "too sleepy".*

13. *On 5 February 2019, Resident A was reviewed by Dr 1, following concerns raised by the Home that the current pain control was inadequate. Dr 1 wrote in Resident A's Medication Administration Record ("MAR") chart "pain not controlled, worsening ulcers, start pregabalin, review opiates after'.*

14. *On, or around, 8 February 2019, Ms Price stopped administering the prescribed MST slow release morphine medicine to Resident A.*

15. *In mid-February 2019, Colleague 1 was working a night shift when Resident A complained of pain during a medication round. During the handover, Ms Price had told Colleague 2 not to give Resident A Oramorph. When Colleague 1 asked the nurse she was working with what was behind the instruction not to give Resident A the Oramorph, the nurse told her just to keep her head down and not say anything.*

16. *Colleague 1 checked Resident A's MAR chart to see if there was any reason why she should not be given her medication, but there was no record of this. Later on in the night, Colleague 1 went through Resident A's notes to check when, and how often, the Oramorph was to be given and discovered that it was supposed to be given 20 minutes prior to their dressing change.*

17. *The following weekend, Colleague 1 was looking after the Controlled Drugs ("CD") cupboard keys and Ms Price was changing Resident A's dressings. At no point did Ms Price ask Colleague 1 for the keys to get the Oramorph. When Colleague 1 questioned Ms Price on this, she responded saying “Iwona said it makes her sleepy, so I'm not giving it to her".*

18. *The following day, Colleague 1 told Ms Price that Resident A was complaining of pain and that there was a let of weeping from her wounds and that Resident A needed a GP review. When Colleague 1 came back into work the following weekend, she saw that a GP review had still not been done.*

19. *By the following weekend, Ms Price had spoken to a GP and Resident A had been prescribed Pregabalin 25mg, a strong pain reliever, three times a day. The GP stated that once the pain relief started working, they would review the need for Oramorph.*

20. *When Colleague 1 went in to see Resident A, she noticed that Resident A was in a lot of pain. Resident A also had a drop in her temperature. This was a big concern as this usually means someone might have a serious infection, possibly even sepsis. Colleague 1 escalated this to an out of hours GP who checked Resident A's MAR charts and noticed that not only had the Oramorph not been given, but that the slow release MST morphine medication had not been given. Such medication should have been given in addition to preganbalin and paracetamol. The GP said to give a dose of MST and increase the dosage to once every 12 hours to sustain this over a 24 hour period.*

21. *On 11 and 18 February 2019, Colleague 2 assisted Ms Price with washing Resident A. On both occasions, Resident A repeatedly told Colleague 2 and Ms Price that she was in pain, and ever/ time she was moved she would cry out, asking them to stop. Ms Price did not respond to this but carried on washing.*

22. *On 27 February 2019, Resident A started deteriorating. Resident A expressed that she was in pain when having their dressing changed but was still not being administered MST even though this had been prescribed on the MAR chart. Resident A's legs were ulcerated and there was noticeable deterioration in their condition. Resident A's legs had blackened and there was less skin. Ms Price was*

typically the person who would wash and change Resident A's dressings. However, Ms Price never escalated this to a GP.

23. *When Ms Price was asked about why she didn't give Resident A her prescribed MST pain medication, she said she had misunderstood what Dr 1 had instructed. However, Ms Price failed to communicate with staff about her belief that the MST must be stopped and continued to record it as being given in the MAR chart.*

24. *On 16 March 2019, Resident A passed away.*

Facts relating to Charge 4

25. *Colleague 1 noticed there was a difference between the MAR charts and the CD records for the MST. On Resident A's MAR chart, Ms Price had signed that she applied both the 25mg and the 12mg pain patch, but when Colleague 1 checked the CD records she saw that the Home did not have the 12mg patches in stock. There was no record that Ms Price, or anyone else, had gone to the pharmacy to get additional patches for Resident A, or that the patches had been obtained elsewhere.*

26. *A CD count was done at the beginning and the end of each shift. Ordinarily, 10 x 25mg patches and 10 x 12mg patches would come in every 28 days, which would be sufficient if applied correctly as prescribed over a 72 hour period.*

27. *When Colleague 1 next did the CD count, it was noted that the count was back to normal. However, when she did the stock check against the MAR chart, there was 8 x 25mg and 6 x 12mg left over.*

28. *Between 11 January 2019 and 25 January 2019, there were entries on the MAR chart for doses given but no corresponding entries in the CD register. On 30 January 2019, a dose was recorded as being given on MAR chart, but again there was no record in CD register.*

29. *Between 8 February 2019 and 3 March 2019, the MAR records indicated that MST continuous 10mg tablets were recorded as being administered, but this did not correspond with the entries in the CD register. According to the records available, 46 tablets had been administered to Resident A between 1 January 2019 and 6 March 2019. However, the Pharmacist for the Home confirmed that the Home had returned 41 x 10mg MST pain medication that had been delivered for Resident A.*

30. *On 25 March 2019, the concerns were investigated and an initial safeguarding meeting was held. Between 23 December 2018 and 10 January 2019 there was no entries for doses of Oramorph given on either the MAR chart or the CD register. There was no evidence in the available MAR chart or CD register that any Oramorph was given to Resident A after 31 January 2019.*

31. *During the investigation, Ms Price admitted recording that Resident A had been given the MST pain medication when it had not been given. Ms Price stated that she had misunderstood Dr 1 's instructions from 5 February 2019. However, at no point had Dr 1 written to stop the MST. Resident A was in obvious pain and screaming. The only reason not to give a prescribed medication would be if the resident was no longer able to physically take it. In that case, the GP should be told immediately.*

32. *MST tablets are a class 2 controlled drug and therefore it is a legal requirement that a record of administration is to be kept in the CD register kept by the Home. Ms Price admits that she inaccurately recorded that she had administered prescribed medication to Resident A, when such medication had not in fact been administered.*

Application to offer no evidence in relation to Charge 5

33. *The NMC intend to offer no evidence in relation to the facts of charge 5. In accordance with the decision of PSA v NMC & X [2018] EWHC 70 Admin at [57]*

the facts are set out for the Panel in this document (see above in relation to charge 4 and below).

34. *Charge 5, alleges that Ms Price's inaccurate recording of the administration of prescribed medication to Resident A as set out in charge 4 was dishonest on the basis that Ms Price knew that she had not administered the prescribed medication to Resident A and intended to create the misleading impression that such medication had been administered.*

35. *The evidence in support of this charge is derived from the evidence of NMC witnesses and specifically referred to above in respect of charge 4.*

36. *Ms Price denies that her actions were motivated by an attempt to cover up or conceal her actions. She has stated that she was going down the list signing for all medications without paying attention to what it was she was signing. Ms Price accepts that this falls significantly below the standards expected of a nurse and accepts her failing for this, but denies doing acting dishonestly. Ms Price reiterated her position in relation to this charge in her response to the NMC Case Examiner's in the following way:*

> *"The MAR charts for resident [A] begin at page 51. The time in question is from 8th February 2019 to 3rd March 2019. The relevant MAR chart for resident [A]'s MST can be found at page 65. On this chart the MST appears in a list of 6 other medications prescribed for the morning. Ms Price instructs that in her haste, she went down the list signing for all the medications without checking what she was signing for. Ms Price accepts that this is poor record keeping, in line with RC4, but denies any intentional dishonesty on her part.*
>
> *For MST to be administered it would need to be signed out in the Controlled Drugs ("CDn) book. The page for the material time can be found at page 72 and it is apparent that between 8th February and 3rd March there are no*

entries for MST being signed out. Ms Price would have nothing to gain by signing the MAR chart only as it would be obvious to anyone that reviewed the CD book that MST had not been administered.

Resident [A] was also prescribed Oramorph to be administered prior to a dressing change. As this was PRN medication it was kept on a separate MAR chart, which can be found at page 63. What is evident from this chart is that Ms Price did not sign to say that Oramorph had been given. We submit that if Ms Price had intended to create a misleading impress/On regarding resident [A]'s medication then she would have signed the Oramorph chart and the CD book too. This is an instance of poor record keeping and Ms Price accepts her actions fell far below the standard expected of her as a nurse, but we submit there is insufficient evidence to support Ms Price acted dishonestly."

37. *Ms Price will say that whilst she accepts the consequences of her actions as referred to in charge 4 was that the MAR chart gives a misleading impression about the prescribed medication, that was not Ms Price's intention. Had Ms Price been intending to do so, she would have amended the other records also.*

38. *The Case Examiner's determined that Ms Price had a case to answer in respect of the regulatory concern relating to charge 5. In referring the matter to the Fitness to Practise Committee, the material part of the Case Examiner's decision states:*

    5.1.- Intended to create a misleading impression that you had administered prescribed medication to Resident MB.

    The witness statements of AH, EU and HL provide evidence to aspects of this regulatory concern.

    In your submissions, you say that in your haste you signed all the medications in Resident MB's list without checkjng what you were signing

for. You accept that this was poor record keeping but deny any intentional dishonesty on your part.

In our view, in light of the evidence we have seen, there is a real possibility the Fitness to Practise Committee would find the facts of this regulatory concern proved.

39. *The status of the evidence, as it presently stands, is that there is a factual dispute in relation to the dishonesty alleged in charge 5. Although this charge is serious in isolation, it does not add to the overall seriousness of the concerns. The reason for offering no evidence is on this basis and not because there is insufficient evidence. This approach is consistent with the NMC's Guidance entitled 'Offering no evidence' Ref: DMA-2 which states:*

    "Where part of the charge doesn't make the case more serious:

    If we 're satisfied that one or more of the alleged facts against the nurse, midwife or nursing associate doesn't add anything to how serious the case against them is, we may decide to offer no evidence on those parts of the charge. We won't do this unless we 're satisfied that the remaining parts of the charge properly reflect the extent of our concerns about the nurse, midwife or nursing associate's fitness to practise, and the evidence about them. We 'If need to consider the risk of harm to patients, or the public's trust in nurses, midwives and nursing associates that could arise from what the nurse. midwife or nursing associate is alleged to have done."

40. *The parties acknowledge that the Fitness to Practise Committee, as disciplinary tribunal, should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it. Additionally, the Committee also has the power to direct that further steps be taken in relation to the obtaining of evidence:*

Professional Standards Authority v (1) Nursing and Midwifery Council and (2) Jozi [2015] EWHC 764 (Admin).

41. *The NMC has had regard to its overarching statutory objectives of the protection of members of the public and upholding the public interest. The overall seriousness of the regulatory concern and conduct in question is not in any way diminished by offering no evidence in relation to charge 5. Conversely, it would be contrary to the public interest to purse such matters in all the circumstances and have a contested hearing in relation to a single issues which does not add to the overall seriousness of the admitted concerns. The panel is invited to agree to the application to offer no evidence in respect of charge 5.*

Facts relating to charges 6 - 8

42. *On 23 September 2019, Colleague 1 witnessed Ms Price washing a resident at 05:00 and 05:10 hours. On the same date, Colleague 1 was informed by Care Assistants at the Home that some residents were turned, repositioned and had their pads changed at 03:00. This meant that such residents would not have another pad change until 10:00, if their 06:00 turns were being Missed. Waiting so long for another tum or pad had the potential to cause harm to the residents who tended to be elderly with frail skin, and could increase the risk of them developing pressure sores.*

43. *Colleague 1 states that Ms Price generally would not wake up the residents by saying good morning. Ms Price would just prepare everything and start undressing the residents, without communicating what she was doing.*

44. *Generally, whoever did the wash would document it on the resident's notes after they had done it. Most of the records indicated that residents were turned or washed between 06:00 and 06:30 hours. However, the evidence provided by Colleague 1 indicates the residents were being washed from 05.00. There had been no entry in the care plans to indicate if the residents preferred being woken*

this early. On 24 February 2019, Colleague 1 took photos of a number of records which showed the time of the wash and tum of the residents occurred before the documented times on their records.

45. *Additionally, Ms Price would often wash Resident Cat unsociable hours. Resident C did not have much capacity, but could see his clock and work out what time it was. 'When Ms Price went in to wash Resident C early, he would scream. Ms Price's position, which is not disputed, is that Resident C had severe contractures of his hands, which required cleaning. She indicates that this was an unpleasant experience for the resident despite the fact he was on regular analgesia to manage the pain and that for this reason he found any sort of personal care to be distressing and would scream whenever anyone went in to wash him.*

46. *Undertaking the tasks referred to above so early, had the potential affect the residents sleep as well as the times that they are fed and taken to the rest room. Ms Price inaccurately recorded that she had washed the residents later than she actually had. This meant that other staff did not know that the residents were being washed so early. Ms Price admits that the recordings in relation to the matters referred to in this charge were do so dishonestly.*

Facts relating to Charge 9

47. *Resident B was a resident based at the Home who had suffered a stroke and was left non-verbal and with weakness on one side of his body.*

48. *On a number of occasions (including the morning of 11 and 17 February 2019), Ms Price used a hoist to move Resident B from the bedroom to the TV room (a distance of around 15 metres, through three doors and around two comers), when the use of a hoist was not appropriate.*

49. *On one occasion, Colleague 1 went to help Ms Price by holding and balancing Resident B, as Resident B was swinging in the slide on the hoist. Ms Price did not*

say anything and carried on pushing Resident B into the lounge. Colleague 1 manoeuvred Resident B to help him be placed into a chair in the lounge safely.

50. *Furthermore, on the occasions this was witnessed by Colleague 2, they asked Ms Price if they should get a wheelchair, to which rv1s Price said no".*

51. *Hoists are not to be used to transport patients other than to move them from their bed to chair and vice versa. The hoist is not weighted so as to transport patients safely throughout the Home. Furthermore, Resident 8 was a larger man who was about 15 to 16 stone (95-101 kg) and Ms Price was doing this on her own. The use of hoists should always be undertaken by two people.*

52. *Using the hoist in the way Ms Price did, risked Resident B falling out, or the hoist over balancing and causing the resident to fall onto the ground and injure themselves.*

Facts relating to Charge 10

53. *On 3 September 2019 at 12:45 hours, Ms Price voluntarily attended Aberystwyth Police Station on suspicion of ill treatment or wilful neglect of an individual by a care worker, during the period of 8 February 2019 and 3 March 2019. The rationale for the decision to offer a simple caution includes the following:*

    > *“The suspect has fully accepted her action in interview that, during the period of 09/02/2019- 03/0212019, owing to DP's misunderstanding of the instructions from the GP and subsequent miscommunication to staff, the IP, [] was subjected to pain and the pain relief administered Vlas not as prescribed. The DP is very apologetic, remorseful, has a clan character and has mitigating circumstances leading me to believe that an adult caution is an appropriate method of disposal in the circumstances.”*

Misconduct

54. *The Parties agree that Ms Price's actions, as outlined in the charges 1-9 above, amounts to misconduct and that her actions and/or omissions fell significantly short of the standards expected of a registered nurse.*

55. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*

    '[331 B-EJ Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rt.1/es and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.

56. *As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin):*

    '[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'

    And

    'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.

57. *Ms Price's actions and/or omission as reflected in the admitted charges are serious and fall short of what is expected of a registered nurse. The misconduct is a serious departure from expected standards, and constitutes a risk to patients and a risk to the reputation of the profession.*

58. *At the relevant time, Ms Price was subject to the prov1s1on of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). The Parties agree that the following provisions of the Code were engaged, and breached, in this case:*

Treat people as individuals and uphold their dignity

To achieve this, you must:

1. 1 treat people with kindness, respect and compassion

1. 2 make sure you deliver the fundamentals of care effectively

1. 4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

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

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

3 Make sure that peoples physical, social and psychological needs are assessed and responded to

To achieve this, you must

3. 1 pay special attention to promoting wellbeing, preventing ill- health and meeting the changing health and care needs of people during all life stages

6 Always practise in line with the best available evidence

To achieve this, you must.-

6. 1 make sure that any information or advice g;ven is evidence-based including information relating to using any health and care products or services

6. 2 maintain the knowledge and skiffs you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

8. 2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work wffh colleagues to e•1aluate the quality of your work and that of the team

8. 5 work with colleagues to preserve the safety of those receiving care

8. 6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. ft 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

10. 5 take all steps to make sure that records are kept securely

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13. 1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

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

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving jn your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

To achieve this, you must:

18. 1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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, treating people fairly and without discrimination, bullying or harassment

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

20.4 keep to the laws of the country in which you are practicing

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

59. *It is acknowledged that not every breach of the Code will result in a finding of misconduct. However, Ms Price accepts that the failings set out above are a serious departure from the professional standards and behaviour expected of a registered nurse. Ms Price acknowledges that her conduct presented a risk of harm to the patients she was tasked with caring for and, in the case of Resident A, there is evidence of actual patient harm.*

60. *The conduct was serious in that in that it relates failures in respect of basic, but important, aspects of nursing which should have at all times been undertaken effectively and appropriately. The failure to undertake such tasks appropriately have the potential for serious, unwarranted, patient harm.*

61. *The withholding of, and the failure to administer, pain relieving medication is manifestly serious. The seriousness of the concerns are reflected by the fact that harm was caused to Resident A.*

62. *Additionally, other residents were placed at risk of harm by Ms Price washing them at inappropriate hours. Ms Price accepts that waking residents so early for the purpose of bathing was a form of psychological abuse. Further, waiting so long for a further turn or pad change could have caused harm to those residents. Being left in a soiled pad could cause skin damage and by not being repositioned as required, residents were a risk of developing pressure sores. Further, there was no dignity in the way that such residents were treated by Ms Price.*

63. *The record keeping concerns are also very serious. Record keeping is an extremely important aspect of nursing which must be undertaken appropriately at all times. Poor and inaccurate record keeping undermines patient safety and confidence in the profession. It has the potential to impact upon effective patient care and accountability.*

64. The admitted concerns involve a failure to escalate the care of Patient A which, as of itself is serious, not least because Resident A's health was deteriorating and she was in pain.

65. In addition to Resident A, the conduct specifically placed resident B at risk of unwarranted ham1 by reason of the Ms Price using an unsafe method and procedure to move him.

66. The dishonesty associated with the misconduct referred to in charge 7 is extremely serious. Dishonesty, however it manifests, is always treated seriously by the profession. Honesty and integrity are fundamental tenets of the nursing profession. The fact that the dishonesty is directly linked to nursing care and sought to conceal inadequacies in care provided to residents, together with the fact that the dishonesty was wide spread and not isolated, adds to the seriousness.

67. The fact that the overall conduct was not isolated in terms of the nature of the concerns, residents involved and dates of incidents, adds to the seriousness and is also relevant to the risk of repetition.

68. Individually, and collectively, the conduct referred to in the charges are sufficiently serious so as to amount to misconduct.

Impairment

69. The Parties agree that Ms Price's fitness to practise is currently impaired by reason of her misconduct and the police caution.

70. 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 arid therefore it is imperative that nurses make sure that their conduct at all times justifies both their patients' and the public's trust in them and in their profession.

71. *A general approach to what might lead to a finding of impairment was provided by Dame Janet Smith in her Fifth Shipman Report. A summary is set out in the case of CHRE v Nursing and Midwifery Council & Grant [2011] EWHC 927 at paragraph 76 in the following terms:*

> *"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 andlor is liable to act dishonestly in the future."*

72. *The Parties agree that all four limbs above can be answered in the affirmative in this case. Dealing with each one in tum:*

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

73. *The misconduct referred to in the charges all had the potential to cause harm to residents. In relation to Resident A, there is evidence of actual harm being sustained. Further; Resident B was placed at risk of unwarranted harm, as were those residents who were affected by the conduct referred to in charge 7.*

74. *The fact that Ms Price accepted a caution for ill-treatment/wilful neglect in relation to Resident A also falls squarely within this limb.*

Has in the past brought and/or is liable in the future to bring the medical profession into disrepute

75. *Registered professionals occupy a position of trust in society. The public, quite rightly, expects nurses to provide safe and effective care, and conduct themselves in ways that promotes trust and confidence. Ms Price's actions and omissions had the potential to cause patients and members of the public to be concerned about their safety and feel unnecessarily anxious about their healthcare treatment. This, the Parties agree, could result in patients, and members of the public, being deterred from seeking medical assistance when they should. Therefore, it is agreed that Ms Price's conduct has brought the profession into disrepute and that she has breached the trust placed in her. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession*

76. *Providing a high standard of care is also a fundamental tenet of the nursing profession. Further the provisions of the Code, as referred to above, constitute tenets of the nursing profession. By failing to provide a high standard of care at all times and comply with the core principles and specific paragraphs of the Code as set out above, Ms Price breached fundamental tenets of the profession. Has in the past acted dishonestly and/or is liable to act dishonestly in the future*
77. *Ms Price acted dishonestly by recording the hours/times that residents were washed in that she knew that the residents had not been washed at the times recorded and intended to create a misleading impression as to the correct times.*

78. *The panel may also find it useful to consider the comments of Cox Jin Grant at paragraph 101:*

> *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a*

finding of impairment of fitness to practise were not made in the circumstances of this case".

Remediation, reflection, training, insight, remorse

79. *In considering the question of whether Ms Price's fitness to practise is currently impaired, the Parties have considered the guidance in the case of Cohen v GMC [2007] EWHC 581 (Admin), in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

a. *Whether the conduct that led to the charge(s) is easily remediable;*
b. *Whether it has been remedied;*
c. *Whether it is highly unlikely to be repeated.*

80. *It is agreed that the conduct is not easily remediable. The nature and extent of the concerns are indicative of an underlying attitudinal concern which is difficult to remediate. It is also agreed that dishonesty is often said to be attitudinal in nature and difficult to remediate.*

81. *It is also agreed that Ms Price has not been able to demonstrate that concerns have been remedied. The NMC has been supplied with testimonials from 17 individuals who either worked with Ms Price or had a relative at the Home. None of the testimonials have raised any concerns about Ms Price's conduct or record keeping, However, the references are not recent and so do not provide an up-to-date picture of Ms Price's practice since the events which led to these proceedings. Copies of the testimonials are produced as "Appendix 1' to this agreement It is acknowledged that Ms Price has been restricted from practicing as a nurse and, as such, is not able to obtain more recent testimonials in relation to her nursing practice.*

82. *Ms Price has demonstrated some insight by way of her acceptance of the charges and that her fitness to practise is currently impaired by reason of misconduct and*

the police caution. She has acknowledged the impact her actions had on patients, the public and her fellow colleagues. Ms Price has expressed remorse for her action. However, Ms Price has not identified relevant training or demonstrated that she is able to practise safely as a nurse consequent to the events referred to in these charges. Further, given the serious nature of the accepted charges they cannot be remediated by reflection or insight.

83. *In relation to whether the conduct is likely to be repeated, it is relevant that concerns appear to have arisen as a result of deep- seated attitudinal concerns. Also relevant is the nature and extent of the concerns and the fact that the same were not isolated. In the absence of evidence of full insight and strengthened practice, it is agreed that there is a risk of repetition. Should such conduct/concerns be repeated, there is a risk of further serious, unwarranted, patient ham.*

Public protection impairment

84. *For the reasons referred to above, it is agreed that a finding of impairment on public protection grounds is necessary.*

Public interest impairment

85. *A finding of impairment is necessary on public interest grounds.*
86. *In CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) Cox J commented as follows:*

"71. It is essential, when deciding whether fitness to pracuse is impaired, not to lose sight of the fundamental considerations ... namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession .."

74. 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."

75. I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment. "

87. Having regard to the serious nature of the misconduct and the police caution, and the principles referred to above, a finding of impairment is necessary on public interest grounds. As recognised above, an important consideration is that a finding of no impairment would lead to no record of these regulatory charges and the conduct being marked, which would be contrary to the public interest.

88. The public would be concerned about the serious failings in this case. The concerns are of such a serious nature the need to protect the wider public interest calls for a finding of impairment to uphold the standards of the profession, maintain confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession and the Nl'v1C would be undermined.

89. The Parties agree that Ms Price's fitness to practice is impaired on public protection and public interest grounds.

Sanction

90. In accordance with Article 3(4) of the Nursing and Midwifery Order the overarching objective of the NMC is the protection of the public.

91. *Article 3(4A) of The Nursing and Midwifery Order 2001 states:-*

The pursuit by the Council of ;ts over-arching objective involves the pursuit of the following objectives-

> *(a) to protect, promote and mainta;n the health, safety and well-being of the public,-*
>
> *(b) to promote and maintain public confidence in the professions regulated under this Order; and*
>
> *(c) to promote and maintain proper professional standards and conduct for members of those professions.*

92. *Whilst sanction is a matter for the panel's independent professional judgement, the Parties agree that the appropriate sanction in this case is a striking-off order. A striking-off order is the most appropriate and proportionate sanction which properly reflects the seriousness of the misconduct.*

93. *In reaching this agreement, the Parties considered the NMC's Sanctions Guidance ("the Guidance"), bearing in mind that it provides guidance and not firm rules_ The panel will be aware that the purpose of sanctions is not to be punitive but to protect the public and public interest. The panel should take into account the principle of proportionality and it is submitted that the proposed sanction is a proportionate one that balances the risk to the public and the public interest with Ms Price's interests*

94. *The aggravating features in this case have been identified as follows:*
    - *Serious misconduct which include a wide-range of clinical and nursing failings*
    - *The conduct was not isolated*
    - *Residents were directly affected*
    - *The residents affected by the conduct were vulnerable*
    - *Ms Price vvas in a position of trust*
    - *The conduct included dishonestly directly associated with Ms Price's role as a nurse*

- *The conduct brought Ms Price into contact with the criminal justice system, resulting in a police caution*
- *The concerns gave rise to a risk of harm to residents and there was evidence of actual harm caused to some residents*
- *The conduct appears to be as a result of underlying attitudinal concerns*
- *The conduct undermines trust and confidence in the profession*

95. The mitigating features of this case have been identified as follows:

- *Ms Price made omissions in relation to all of the charges, except for the charge in which the NMC offers no evidence*
- *Ms Price has produce some positive testimonials*
- *Ms Price has reflected and expressed some remorse*

96. 'With regards to the Guidance, the following aspects have led the Parties to conclude that a striking-off order is appropriate and proportionate. Taking the available sanctions in ascending order starting with the least restrictive:

a) Taking no action or a caution order - The NMC's guidance {SAN-3a and SAN-2b) states that it will be rare to take no action where there is a finding of current impairment and this is not one of those rare cases. The seriousness of the misconduct means that taking no action would not be appropriate. A caution order would also not be in the public interest rior mark the seriousness and would be insufficient to maintain high standards within the profession or the trust the public place in the profession.

b) Conditions of Practice Order - The NM C's guidance (SAN-3c} states that a conditions of practice order may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- no evidence of harmful deep-seated personality or attitudinal problems

- identifiable areas of the nurse, midwife or nursing associate 's practice in need of assessment and/or retraining

- no evidence of general incompetence

- potential and willingness to respond positively to retraining

- the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision

- patients will not be put in danger either directly or indirectly as a result of the conditions

- the conditions will protect patients during the period they are in force

- conditions can be created that can be monitored and assessed.

The misconduct and the concerns behind the misconduct and caution, indicate harmful deep-seated personality or attitudinal problems. The clinical failings alone are very serious_ The fact that some were deliberate and there was associated dishonesty, seriously aggravates the situation. Furthermore, it would not be possible to formulate workable conditions to meet the risks in this case. Conditions are particularly difficult to formulate in cases which involve dishonesty. A conditions of practice order would not reflect the seriousness of the concerns raised or maintain public confidence.

c) Suspension Order - Imposing a suspension order would only temporarily protect the public. It cannot be said that this was a single instance or misconduct or that there is no evidence of harmful deep-seated personality or attitudinal problems. This sanction would not reflect the seriousness of the conduct and therefore public confidence in the profession would not be maintained. According to the NMC guidance (SAN-d), a suspension order would not be appropriate in this case as the misconduct is fundamentally incompatible with Ms Price continuing to be a registered professional. The overarching objective of public protection would not be satisfied by a suspension order and it would not be in the public interest to impose a suspension order in this case. The confidence in the NMC as a regulator would be undermined if Ms Price was allowed to practice once the suspension order comes to an end.

d) Striking-off Order - Resident A was a particularly vulnerable patient and Ms Price's actions caused her actual harm. Harm was also caused to other vulnerable residents. This behaviour has raised fundamental questions about Ms Price's

professionalism and public confidence can only be maintained if she is removed from the register. The conduct brought Ms Price to the attention of the criminal justice system, and involved the administration of a police caution (and her inclusion on the DBS Adults and Children's Barring List). Taking into account all of the factors, the conduct is fundamentally incompatible with ongoing registration as a nurse. Only a striking-off order would be sufficient to protect the public and maintain public confidence in the profession.

Referrer's comments

97. The Horne have confirmed that they are in agreement with the proposed sanction.

Interim order

98. An interim order is required in this case. The interim order is necessary for the protection of the public and is otherwise in the public interest. The interim order should be for a period of 18 months in the event Ms Price seeks to appeal against the panel's decision. The interim order should take the form of an interim suspension order.

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Here ends the provisional CPD agreement between the NMC and Ms Price. The provisional CPD agreement was signed by Ms Price and the NMC on 29 September 2022.

Decision and reasons on the CPD

The panel decided to accept the CPD.

Mr Smalley referred the panel to the ‘NMC Sanctions Guidance’ (SG) and to the ‘NMC’s guidance on Consensual Panel Determinations’. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Ms Price. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel was first asked to consider charge 5. The panel noted that the NMC intend to offer no evidence in relation to the facts of charge 5 because it does not add to the overall seriousness of the concerns, not because there is insufficient evidence. It noted Ms Price admits charge 4 but disputes that her actions were dishonest (charge 5).

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

The panel took into account that Ms Price has admitted to other allegations of dishonesty at charge 8a and 8b relation to charge 7 in the CPD. The panel determined that although charge 5 is serious, in isolation, it does not add to the overall seriousness of the concerns in this case. The inclusion or otherwise of it would not make a material difference to the decision on sanction.

The panel noted that Ms Price admitted the facts of the remaining charges. Accordingly. the panel was satisfied that the charges are found proved by way of Ms Price’s admissions, as set out in the signed provisional CPD agreement.

The panel noted that the CPD had a number of typographical errors within it. In particular, it noted in para 95 that one of the mitigating features refers to Mrs Price’s ‘omissions’ when it should state ‘admissions’. Despite these, the panel reminded itself that it had been signed by Ms Price. The typographical errors were not so significant that the panel were

unable to apply a common sense approach to that contained within, nor did it detract from the principles of the admissions throughout.

Decision and reasons on impairment

The panel then went on to consider whether Ms Price's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Ms Price, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct and the police caution, the panel determined that both individually, and collectively, the conduct referred to is sufficiently serious to amount to misconduct.

In this respect, the panel endorsed paragraphs 54 to 68 of the provisional CPD agreement in respect of misconduct and caution.

The panel then considered whether Ms Price's fitness to practise is currently impaired by reasons of her misconduct and the police caution. The panel determined that Ms Price's fitness to practise is currently impaired due to the serious nature of the misconduct and the police caution both on public protection and public interest grounds. In this respect the panel endorsed paragraphs 69 to 89 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Ms Price'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:

- Serious misconduct which include a wide-range of clinical and nursing failings
- The conduct was not isolated
- Residents were directly affected
- The residents affected by the conduct were vulnerable
- Ms Price was in a position of trust
- The conduct included dishonestly directly associated with Ms Price's role as a nurse
- The conduct brought Ms Price into contact with the criminal justice system, resulting in a police caution
- The concerns gave rise to a risk of harm to residents and there was evidence of actual harm caused to some residents
- The conduct demonstrates underlying attitudinal concerns
- The conduct undermines trust and confidence in the profession

The panel also took into account the following mitigating features:

- Ms Price made admissions in relation to all of the charges, except for the charge in which the NMC offers no evidence
- Ms Price has produced 17 testimonials from allied professionals, colleagues and the families of residents
- Ms Price has reflected and expressed some remorse

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 protect the public nor be 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, and the public protection issues identified, an order that does not restrict Ms Price’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 Ms Price'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 Ms Price'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 in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Ms Price'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 a significant departure from the standards expected of a registered nurse and was not an isolated incident. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Price's actions is fundamentally incompatible with Ms Price 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?*

Ms Price'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 Ms Price'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 agreed with the CPD that the appropriate and proportionate sanction is that of a striking-off order. 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.

Decision and reasons on 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 Ms Price's own interest until

the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

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 agreed with the CPD 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 therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

This decision will be confirmed to Ms Price in writing.

That concludes this determination.