Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 6 March 2023 – Friday, 17 March 2023
and
Resumed on Monday 14 August 2023 – 17 August 2023

Virtual Hearing

Name of Registrant:	**Eleanor Best**
NMC PIN	08I1872S
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing – November 2012
Relevant Location:	Glasgow
Type of case:	Misconduct and Lack of competence
Panel members:	Adrian Smith (Chair, Lay member) Jane Jones (Registrant member) Stacey Patel (Lay member)
Legal Assessor:	Angus Macpherson (6 March – 17 March 2023) Christopher MacKay (14 August – 17 August 2023)
Hearings Coordinator:	Philip Austin (6 March – 17 March 2023) Monsur Ali (14 August – 17 August 2023)
Nursing and Midwifery Council:	Represented by Shekyena Marcelle-Brown, Case Presenter (6 March – 17 March 2023) Julia Saran (14 August – 17 August 2023)
Mrs Best:	Not present and not represented in absence (6 March – 17 March 2023) Present but not represented (14 August – 17 August 2023)
Facts proved:	Charges 1, 3, 4, 5a, 5b(i), 5b(ii), 5b(iii), 5c(i),

	5c(ii), 5c(iii), 5c(iv), 5c(v), 5e(i), 5e(ii), 5e(iii), 5f(i), 5f(ii), 5g(i), 5g(ii), 5h(i), 5h(ii), 5i(i), 5i(ii), 5j, 5l, 5n, 5o(i), 5o(ii), 5o(iii), 6, 7, 8, 9, 11, 12, 13, 14, 15 in part, 16 in part and 17
Facts not proved:	Charges 2a, 2b, 2c, 5d, 5k, 5m, 10a, 10b, 15 in part, 16 in part
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 Mrs Best was not in attendance, nor was she represented in her absence.

Ms Marcelle-Brown, on behalf of the Nursing and Midwifery Council ("NMC"), informed the panel that notice of this hearing was sent to the email address NMC had for Mrs Best on the NMC Register as of 19 January 2023. The panel noted that the statutory instrument in place allows for electronic service of the notice of hearing to be deemed reasonable in the current circumstances, involving Covid-19.

Ms Marcelle-Brown told the panel that the notice of hearing had indicated that this hearing was to be held physically in Edinburgh on the weekdays between Monday, 6 March 2023 and Tuesday, 21 March 2023. However, she submitted that correspondence between the NMC case coordinator and Mrs Best led to this case being rescheduled as a virtual hearing, as Mrs Best had indicated that this would be her preference.

Ms Marcelle-Brown stated that on 27 February 2023, the NMC case coordinator contacted Mrs Best to confirm that this hearing would now be held virtually instead. Furthermore, Ms Marcelle-Brown stated that on 1 March 2023, the NMC case coordinator contacted Mrs Best again, informing her that her hearing was being shortened by two days, so that the hearing would now only be heard on the weekdays between Monday, 6 March 2023 and Friday, 17 March 2023. Ms Marcelle-Brown submitted that whilst Mrs Best had been sent a GoToMeeting link previously by the NMC case coordinator, she had subsequently been informed that the hearing would be held virtually by Microsoft Teams and that she would be sent the link by the NMC hearings coordinator. She submitted that Mrs Best has since been sent the virtual link for Microsoft Teams and has responded to this email, confirming that she had been aware of the change of venue.

Ms Marcelle-Brown 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 had provided details of the time, date and venue of the hearing and, amongst other things, information about Mrs Best’s right to attend, be represented and call evidence, as well as the panel’s power to proceed in her absence. However, this was superseded by correspondence with Mrs Best, whereby the physical hearing that had been listed was made virtual, she had indicated that she would prefer a virtual hearing and that she would be attending and representing herself. Mrs Best had been provided with the joining details relating to this virtual hearing before it started, including the specific link, meeting number, passcode and telephone number, should she wish to participate.

In the light of all of the information available, the panel was satisfied that Mrs Best 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 Mrs Best

The panel next considered whether it should proceed in the absence of Mrs Best. It had regard to Rule 21 and heard submissions from Ms Marcelle-Brown, who invited the panel to continue in the absence of Mrs Best.

Ms Marcelle-Brown submitted that Mrs Best had initially indicated that she would be attending her virtual hearing and that she would be representing herself. However, after being sent the virtual hearing link on 5 March 2023, Mrs Best responded in the morning of 6 March 2023, prior to the hearing starting, saying:

"*I was hoping to attend however my son had an operation on Friday therefore will be home during the hearing. My other son starts nursery at 9am I have no childcare. I will not be able to log on at 9am. I also do not to waste any more time. I will not be attending however eagerly await a decision. My apologies for any inconvenience.*"

In response to this email, the NMC hearings coordinator contacted Mrs Best stating:

"*Thanks for your email and I'm sorry to hear about your current situation.* [PRIVATE].

I will pass your email on to the panel and I acknowledge what you say about non-attendance. However, I'm sure the panel would be willing to accommodate you if you did want to attend? – We could start a bit later in the day, for example. It is of course entirely up to you though.

If you do not want to attend, can you please confirm that you were you aware this hearing was being held virtually, and that you would like the panel to proceed in your absence?"

Mrs Best then responded to this email stating:

"*Thank you for your well wishes. My son was given a cancellation on Friday. I was called on Thursday afternoon. I did hope to attend however I have no childcare for my son. Thank you for understanding and I would like to confirm I was and am aware the hearing is being held virtually and would ask for the panel to proceed in my absence.*".

Taking account of the above, Ms Marcelle-Brown submitted that Mrs Best had voluntarily absented herself from this hearing. She submitted that Mrs Best had been offered

alternative ways she could engage with this hearing, including a later start time. However, Mrs Best has invited the panel to proceed in her absence.

Ms Marcelle-Brown submitted that Mrs Best has not asked for an adjournment of these proceedings, and an adjournment would be unlikely to secure her attendance if it were granted in any event. She submitted that Mrs Best has provided comprehensive written representations in response to the charges within her Case Management Form ("CMF") which the panel can have regard to, should it decide to proceed with this case. Ms Marcelle-Brown submitted that Mrs Best's case can be put to the NMC witnesses who are being called to give live evidence.

Ms Marcelle-Brown informed the panel that eight witnesses have been warned to give live evidence to this panel, and delaying this matter further may have an adverse effect on their recollection in relation to the charges as well as inconvenience them and their employers. She submitted that the public interest elements of this case suggest that this matter should be dealt with expeditiously.

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 Mrs Best. In reaching this decision, the panel has considered the submissions of Ms Marcelle-Brown 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 had regard to the overall interests of justice and fairness to all parties. It noted that:

- The NMC Hearings Coordinator had emailed Mrs Best the day before the hearing was due to start and Mrs Best responded on the day the hearing was due to start stating that she was aware that this hearing was being held virtually but would not be able to attend. Despite being offered alternative ways to engage, Mrs Best had stated that she does not want to "*waste any more time*" and invited the panel to proceed in her absence;
- Mrs Best has provided a comprehensive response to the charges in her CMF document dated 2 November 2022 which the panel can have regard to in the consideration of this matter;
- No application for an adjournment has been made by Mrs Best;
- There is no reason to suppose that adjourning would secure Mrs Best's attendance at some future date;
- Eight witnesses have been warned to give oral evidence;
- Not proceeding may inconvenience the witnesses, their employer and, should they be involved in clinical practice, the patients or those who need their professional services;
- The charges relate to events that occurred as far back as 2018;
- Further delay may have an adverse effect on the ability of the witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel concluded that the NMC has taken all reasonable steps to try and engage Mrs Best in these proceedings.

The panel acknowledged that there is some disadvantage to Mrs Best in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give oral evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel has received Mrs Best's CMF document which contains her written responses in some detail. 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 Mrs Best's decisions to absent herself from the hearing, waive her rights to attend and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

The panel asked the NMC Hearings Coordinator to notify Mrs Best of its decision to proceed in her absence and inform her that she can still provide documentary evidence or attend at a later point if she wishes to do so.

Details of charge (Before amendment)

That you, a registered nurse failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

1. Failed to visit Patient A on 18 December 2018.

2. On 18 December 2018 in relation to Patient B:
    a. Discharged them from the district nurses' caseload when their wound had not completely healed or in the alternative discharged the incorrect patient.
    b. Discharged a patient when this was outside your scope of practice
    c. Copied and pasted the previous care plan into the notes.

3. Printed off Patient A's notes on 14 January 2019.

4. On 17 September 2020 you drew up 10mgs when making up a syringe driver as opposed to 5mgs.

5. Whilst subject to a Stage 1 formal capability process between 16 Feb 2021 and 15 Dec 21:

   a. In week 1, scored 0 out of 6 for record keeping activities.

   b. In week 2:

      i. Scored 1 out of 6 for record keeping activities.

      ii. Overstretched a Ktwo compression bandage.

      iii. Failed to draw up the correct amount of insulin.

   c. In week 2 and/or 3:

      i. Scored 2 out of 6 for record keeping activities.

      ii. Recorded two wounds on one careplan.

      iii. Documented a wound when the skin was not broken.

      iv. Did not complete a care plan for mood.

      v. Incorrectly graded a pressure ulcer.

   d. In week 4 received scores of 3 and 4 for diabetes management and/or medication administration.

   e. In week 8:

      i. Received a score of 1 for wound assessment and management.

      ii. Received a score of 2 for record keeping.

      iii. Received a score of 0 for drug calculations.

   f. In week 9:

      i. Received a score of 3 out of 6 for wound assessment and/or wound management and/or drug calculations and/or record keeping.

      ii. Missed an appointment with a diabetic patient.

   g. In week 10:

i. Received a score of 3 out of 6 for record keeping and/or wound management and/or diabetes management and/or medication administration.

ii. Intended to draw up a dose of 10mgs of morphine sulphate when the correct dose was 2mgs.

h. In week 11:

i. Received a score of 3 out of 6 for record keeping and/or wound management.

ii. Received a score of 1 out of 6 for medication administration and/or diabetes management.

i. In week 12:

i. Received a score of 3 out of 6 for record keeping and/or wound management.

ii. Received a score of 1 out of 6 for diabetes management and/or diabetes management.

j. Did not provide reflective pieces on a weekly basis.

k. Did not provide reflective pieces that met the required standards.

l. Did not ensure that you had the correct equipment for visits between 26 May 2021 and 9 June 2021.

m. Did not provide any evidence of self-directed learning and/or complete a reading list.

n. Failed to visit Patient D on 15 December 2021.

o. In relation to Patient F:

i. Recorded in the notes that you had visited them at 12.10 on 15 December when you attended after 14:00.
ii. Did not send the wound swab to the laboratory.
iii. Did not document Patient F’s temperature or oxygen saturations.

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

That you, a registered nurse:

6. Recorded in the notes that you had visited Patient A on 18 December 2018 when you had not.

7. In a meeting on 20 December 2018 stated that you had visited Patient A when you had not.

8. Told Colleague 1 on 10 January 2019 that you had visited Patient A when you had not.

9. On 14 January 2019 told Colleague 2 that Colleague 1 had given you permission to print out the notes relating to Patient A.

10. At a disciplinary hearing on 12 November 2020 stated that:
    a. You had visited Patient A on 18 January 2018 when you had not.
    b. You had discussed the discharge of Patient B with Colleague 3 when you had not.

11. Recorded in the notes that you had a face to face appointment with Patient D on 15 December 2021 when you had not seen them.

12. In a meeting with Colleague 4 on 21 December 2021 stated that you had visited Patient D on 15 December 2021 when you had not.

13. Recorded in the notes of Patient E that a referral had been made on 15 December 2021 to SPHERE when it had not been.

14. Recorded in the notes of Patient G that a referral had been made on 16 December 2021 to SPHERE when it had not been.

15. Your actions at charge 6 and/or 7 and/or 8 and/or 10a and/or 11 and/or 12 were dishonest in that you intended to create the impression that you had seen a patient when you had not.

16. Your actions at charges 9 and 10b were dishonest in that you intended to create the impression you had permission to carry out a certain task when you did not.

17. Your actions at charges 13 and/or 14 were dishonest in that you intended to create the impression that a referral had been made when it had not been.

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

Ms Marcelle-Brown made a request that parts of the hearing be held in private on the basis that proper exploration of this case may involve reference to Mrs Best's health and the personal circumstances of an NMC witness. She submitted that any public interest in these parts of the case being aired in public session is outweighed by the need to protect their privacy in this respect. This application was made pursuant to Rule 19.

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.

Rule 19 states:

> 19 (1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.
>
> (2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee
>
> (a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and
>
> (b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.
>
> (3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied
>
> (a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and
>
> (b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, “in private” means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there may be reference to Mrs Best’s health and the personal circumstances of an NMC witness, the panel determined to hold relevant parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

NMC Opening

The NMC received a referral from NHS Greater Glasgow & Clyde (“the Board”) on 17 February 2021 in relation to Mrs Best. It is alleged that a number of concerns were raised in respect of Mrs Best’s nursing practice, whilst she was employed in the role of Community Staff Nurse at the Board, South Sector. Mrs Best also sent a self-referral to the NMC on 3 March 2021.

The regulatory concerns are said to amount to either misconduct or a lack of competence. It is alleged that a number of incidents occurred whilst Mrs Best was subject to her capability plan on 15 December 2021, involving Patient D, Patient E and Patient F. It is also alleged that there was an incident that took place on 16 December 2021 involving Patient G, and two incidents involving Patient A and B on 18 December 2018.

In November 2015, there were some concerns about whether Mrs Best could perform to the required standard as a registered nurse and there was a formal investigation into her practice. At that time, there was an allegation about Mrs Best not attending a patient; she was placed on a capability programme following a disciplinary hearing, which she successfully completed. Mrs Best had allegedly been given further support from Colleague 1, the Nurse Team Leader at the Board, in the form of a supportive framework. She was also allegedly mentored by another nurse after she had completed the capability programme.

In respect of Patient A, on 17 December 2018, it is alleged that Patient A phoned the District Nursing Team ("DNT") to request a visit. Patient A was a bedbound/chairbound young person with capacity, who had a suprapubic catheter in situ (i.e. in their abdomen) and was worried that the insertion site had become infected. Mrs Best was allegedly allocated to visit Patient A on the following day, 18 December 2018.

On 20 December 2018, it is alleged that Colleague 1 was alerted by two other nurses, Colleague 3 and Colleague 5, band 6 District Nurses, that Mrs Best had not carried out the visit. On closer inspection, it seemed that Mrs Best had unallocated the visit on 18 December 2018 from her workload. When Colleague 3 asked Mrs Best about the visit, Mrs Best allegedly told her that she had visited Patient A but had not recorded the visit. Mrs Best had also allegedly told Colleague 1 that she had visited Patient A.

Colleague 6, a band 5 Community Nurse, allegedly visited Patient A on 19 December 2018 and asked Patient A if they had received a visit the day before from Mrs Best. Patient A allegedly stated that they had not received any visits the previous day.

When Mrs Best was informed that Colleague 3 could allegedly see that she had unassigned the visit from herself on the electronic system ("CNIS"), Mrs Best allegedly then said that she made telephone contact with Patient A. Mrs Best was allegedly asked to retrospectively document this, which she did. However, the notes allegedly made by Mrs Best said that she had visited Patient A, and that she was sitting in a chair and declined any intervention. This did not make sense to some of the staff at the Board as they had understood that Patient A was bedbound and not able to sit in a chair. Furthermore, Patient A had allegedly stated that she had not received any visits or contact from the DNT.

On 14 January 2019, it is alleged that Mrs Best printed off Patient A's notes and left them on the printer. When challenged about this, Mrs Best allegedly said that Colleague 1 had given her permission to do this, which Colleague 1 refutes.

Additionally, on 18 December 2018, Mrs Best was allegedly scheduled to visit Patient B at Hector House ("the Home"). It is alleged that Patient B's wound had not healed, and they were not able to be discharged for around another three months. However, Mrs Best allegedly discharged Patient B before their leg wound had healed.

When asked about the above incident, Mrs Best was allegedly adamant that she had discussed the matter with Colleague 3 prior to discharging Patient B. However, Colleague 3 allegedly said that the matter was not discussed with her.

As Patient B was on Colleague 3's (a band 6 District Nurse) caseload, it is alleged that it should have been Colleague 3's responsibility to make the decision whether to discharge Patient B when needed. As a band 5 Community Nurse, it is allegedly not Mrs Best's role to discharge patients. Mrs Best was allegedly asked to readmit Patient B onto CNIS; however, Mrs Best allegedly copied and pasted care plans that were no longer pertinent to Patient B's care when she did this.

It is also alleged that approximately one year later, Mrs Best had a near miss medication error on 17 September 2020. Mrs Best allegedly informed the DNT in the daily handover that she had an issue with a palliative syringe driver when making up the syringe driver. Mrs Best had allegedly drawn up 10mgs of Midazolam instead of the required 5mgs. As Mrs Best was working/shadowing another colleague, they had allegedly asked Mrs Best how much medication had been drawn up, and the error was then allegedly noticed and rectified.

At Mrs Best's disciplinary hearing on 12 November 2020, it is alleged that she stated that she had visited Patient A when she had not, and that she had also discussed discharging Patient B with Colleague 3 when she had not.

Following her disciplinary hearing, Mrs Best received a written warning and was required to complete a capability programme. The programme was delayed from 2020 until 16 February 2021 and was scheduled to last for 12 weeks.

On 16 February 2021, Mrs Best did start the capability process, and she was asked to work alongside Colleague 7, the band 7 District Nurse and Practice Teacher, with the support of Colleague 8, the Practice Development Nurse (“PDN”).

During this process, it had allegedly been agreed that Mrs Best would provide weekly reflections using the Gibb’s model of reflection. Although Mrs Best did complete some reflections, they allegedly did not follow the agreed model, nor were these submitted on a weekly basis.

On week 3 of the capability programme, it emerged that Mrs Best would allegedly need extra training around tissue viability. A one-to-one meeting was allegedly arranged between Mrs Best and the Tissue Viability Nurse (“TVN”), and Mrs Best was supposed to carry out some research into tissue viability issues which she allegedly did not complete.

During the weeks 4, 5, 6 of the capability programme, Mrs Best was allegedly showing signs of improvement.

On week 7 of the capability programme, Mrs Best allegedly handed in nine reflections; however, these were said not to reach the standard expected.

Between 22 February 2021 and 1 April 2021, Mrs Best had some periods of [PRIVATE] and annual leave.

On 13 April 2021, a mid-point review was held, and a decision was made to extend the capability process by two weeks. Mrs Best was allegedly given administration time to complete the required reflections that were due. However, Mrs Best was allegedly [PRIVATE] from 18 April 2021 until 14 May 2021.

When Mrs Best returned to work (week 8), her nursing practice had allegedly deteriorated. Mrs Best was allegedly unable to complete a simple drugs calculation, which she said she had always had difficulty with. It was suggested that Mrs Best [PRIVATE]. [PRIVATE].

During week 9, concerns were raised that several pieces of Mrs Best's essential nursing equipment were not working properly. It is alleged that Mrs Best was asked to collect replacements, which she did not immediately do, thereby putting patients at risk.

[PRIVATE]. When she returned to work in November 2021, the capability programme recommenced on 28 November 2021 (week ten).

On 1 December 2021, there was allegedly another near miss medication incident with a palliative care patient. Mrs Best allegedly drew up the incorrect amount of morphine sulphate to be given for break through pain.

On 15 December 2021, Mrs Best allegedly attended a final review of the capability process. As Mrs Best had not successfully completed stage 1 of the process, it was decided to move her to stage 2 of the capability process as she had failed to demonstrate that she was competent enough to complete her responsibilities to a safe level and she had repeatedly failed to score over three out of six on a number of the key competencies.

On 15 December 2021, Mrs Best was allegedly allocated to visit Patient D, but this visit appeared to have been missed. Patient D allegedly stated that a registered nurse had telephoned on that day to advise that there was a problem with the IT system so the visit would be postponed until the 16 December 2021. However, the alleged visit did not occur on 16 December 2021 either. When Colleague 4 reviewed Patient D's records, it was noted that Mrs Best had allegedly recorded a face-to-face appointment at 09:30 hours on 15 December 2021, when it did not take place.

As a result of this, Colleague 4 allegedly reviewed other visits that Mrs Best said she had completed on 15 December 2021. Mrs Best had allegedly recorded a face-to-face visit for Patient E at 09:00 hours for 15 minutes and stated that she had made a continence referral to SPHERE. Colleague 4 allegedly contacted the SPHERE service and they confirmed that they had not received any referral for Patient E.

Mrs Best also allegedly recorded a face-to-face visit with Patient F at 12:10 hours lasting for 25 minutes. The case load holder for Patient F allegedly said that the patient had told

them that Mrs Best visited after 14:00 hours that day. Mrs Best had allegedly also contacted the case load holder to tell them that the swab she had taken from Patient F's wound was still in her car, and therefore it was not processed in the laboratory.

On 22 December 2021, Colleague 4 was informed that Mrs Best had allegedly recorded care for Patient G on 16 December 2021 and that a continence referral had been forwarded to SPHERE. Colleague 4 allegedly phoned SPHERE who confirmed that they had not received a referral.

A meeting was allegedly held on 21 December 2021, where Colleague 4 met with Mrs Best to discuss the incidents involving Patient D, Patient E and Patient F.

At the meeting, Mrs Best was allegedly adamant that she had visited Patient D and had provided the care that was recorded in Patient D's notes. Colleague 4 allegedly noted that Mrs Best had documented this visit 30 minutes prior to attending the final capability meeting. Colleague 4 said that Mrs Best would not have had sufficient time to complete the care as recorded and still be able to meet with them. Mrs Best then allegedly said that the time may have been recorded incorrectly. Colleague 4 considered that Mrs Best's entry into Patient D's records was false and that the face-to-face visit had not taken place.

In respect of Patient E, Mrs Best allegedly advised that a telephone consultation had taken place and not a face-to-face visit which had been recorded in error. Mrs Best was alleged to have said that she had sent the referral to SPHERE via email, and when Colleague 4 asked her to produce this, this was not forthcoming.

In respect of Patient F, Mrs Best allegedly advised Colleague 4 that she had visited the patient at the time documented at 12:10 hours. However, Colleague 4 had allegedly noted that Mrs Best had recorded another visit for a patient at 11:50 hours for 25 minutes, so Mrs Best would still have allegedly been in that patient's house at 12:10 hours when she said she had visited Patient F. Mrs Best allegedly said that the times recorded must have been wrong and allegedly admitted that the wound swab for Patient F was still in her car.

When Colleague 4 asked if Mrs Best had undertaken any observations for Patient F, Mrs Best allegedly said that she had taken temperature and oxygen saturation checks, neither of which had allegedly been documented.

Mrs Best was allegedly advised that the matters would need to be escalated further and that she was to work in a supernumerary capacity only from that point on.

The NMC alleges that Mrs Best was dishonest in falsifying clinical records in saying that she has visited patients and carried out certain tasks when she had not.

On 23 December 2021, it is alleged that Mrs Best told Colleague 4 by telephone that she wanted to make a statement after being in contact with her union representative. At this point, Mrs Best allegedly informed Colleague 4 that she had not visited Patient D or sent the referrals to SPHERE.

Mrs Best resigned from the Board on 23 December 2021.

Decision and reasons on the admissibility of Patient A's evidence

Ms Marcelle-Brown invited the panel to admit the hearsay evidence of Patient A, referring to the telephone notes setting out a conversation had between an officer on behalf of the NMC and Patient A. She submitted that the evidence provided by Patient A is what she reported to the other registered nurses at the Board.

Ms Marcelle-Brown referred the panel to Rule 31, stating that this permits the admission of evidence in so far as it is 'fair and relevant'. She also invited the panel to have regard to the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*.

Ms Marcelle-Brown informed the panel that Patient A will not be called to give live evidence at this hearing, but there is a good reason for her non-attendance. She submitted that Patient A was contacted and asked to provide a witness statement in relation to the alleged incident. However, Patient A notified the officer of the NMC that she had a limited recall, did not want to mislead, and she was unable to remember Mrs Best

specifically. Therefore, Ms Marcelle-Brown submitted that the decision was made not to pursue Patient A for the purposes of a witness statement for these proceedings.

Ms Marcelle-Brown submitted that Patient A's evidence relates to charge 1, and it is not the sole and decisive evidence in relation to this allegation. She submitted that this is a serious charge amongst other serious charges, and there is key evidence provided by other NMC witnesses in support of it.

Ms Marcelle-Brown submitted that, in respect of charge 1, Mrs Best has provided a number of different accounts in relation to this allegation. Furthermore, she submitted that Mrs Best did not submit a mileage claim for attending Patient A's home address on 18 December 2021, which could be an indication that she did not make the visit.

Ms Marcelle-Brown submitted that Patient A communicated to other nurses at the Board that Mrs Best did not visit her on 18 December 2021.

Ms Marcelle-Brown submitted that Mrs Best was informed about the NMC's intention to make a hearsay application to adduce the evidence of Patient A at this hearing. She said that Mrs Best was sent the hearsay bundle on 24 February 2023.

Ms Marcelle-Brown submitted that Mrs Best has provided an account of a dialogue she says took place between her and Patient A. She submitted it will therefore be fair to admit the hearsay evidence of Patient A as Mrs Best has tried to rely on a conversation that was had between her and Patient A. Despite Patient A's non-attendance at this hearing, she submitted that Patient A's evidence is capable of being tested through other witnesses being called to give evidence at this hearing.

Ms Marcelle-Brown invited the panel to exercise its discretion and admit Patient A's evidence in the particular circumstances of this case.

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

In determining this application, the panel had regard to the factors set out in the case of *Thorneycroft*.

The panel considered the evidence provided by Patient A to be clearly relevant to charge 1. It was of the view that due consideration would need to be given to whether it would be fair to admit Patient A's evidence.

The panel accepted the reasons behind Patient A's non-attendance at this hearing, and why the NMC did not pursue her for the purposes of a witness statement. Patient A had informed an officer of the NMC on 15 October 2021 that "*she cannot remember the particular incident nor the individual as she must not have been one of her regular nurses*".

Furthermore, the panel noted that Mrs Best has sought to rely on the evidence provided by Patient A in providing her own account at different times throughout the investigation. It considered charge 1 to be a serious charge, and it recognised that Patient A's evidence was not the sole and decisive piece of evidence. There is other information before the panel which corroborates the hearsay evidence of Patient A which can be tested at this hearing.

In taking account of the above, the panel decided that it would be fair to admit Patient A's evidence. However, it determined that it would attach the appropriate weight to this evidence once all of the evidence has been reviewed and evaluated.

Therefore, the panel accepted Ms Marcelle-Brown's application to admit Patient A's evidence.

Decision and reasons on the admissibility of Colleague 3's evidence

During witness evidence, Ms Marcelle-Brown invited the panel to admit the hearsay evidence of Colleague 3. She again referred the panel to the case of *Thorneycroft* and Rule 31 of the Rules.

Ms Marcelle-Brown submitted that the evidence provided by Colleague 3 goes to charges 1, 2a, 2c and 10b. She submitted that Colleague 3's evidence is not the sole and decisive evidence in relation to these charges.

Ms Marcelle-Brown submitted that there is a good reason for this witness' non-attendance. She stated that there was a serious incident in Colleague 3's personal life around the time the NMC was investigating this matter, and this meant that the NMC made the decision to not pursue her.

Ms Marcelle-Brown acknowledged that the local witness statement of Colleague 3; which is included in the paperwork, is both unsigned and undated. However, contemporaneous evidence from around the time of the alleged incidents corroborate her accounts. She acknowledged that whilst Mrs Best is not here to challenge the evidence provided by Colleague 3, this is a consequence of her own non-attendance. Ms Marcelle-Brown submitted that, in any event, Mrs Best has provided comprehensive written representations for the panel to have regard to in considering this matter. She submitted that whilst Mrs Best seems to be of the view that Colleague 3 disregarded her opinion and often '*nit-picked*' at her work, there has been no suggestion from Mrs Best that Colleague 3's evidence is fabricated.

Ms Marcelle-Brown submitted that the NMC has taken steps to inform Mrs Best that Colleague 3 will not be attending this hearing, and that it is seeking to make an application to adduce Colleague 3's evidence. She submitted that in response to being notified of this, Mrs Best responded stating "*that is good news*", so she does not appear to oppose the

application. Ms Marcelle-Brown submitted that Mrs Best has also been sent all of the paperwork the NMC intends to rely on at this hearing, so she would be aware of what Colleague 3 says in her evidence.

Ms Marcelle-Brown submitted that there is a public interest in fully exploring the evidence before the panel. She invited it to accept her application and admit Colleague 3's evidence as it is both fair and relevant.

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

In determining this application, the panel had regard to the factors set out in the case of *Thorneycroft*.

The panel considered the evidence provided by Colleague 3 be clearly relevant to the charges. It also considered it to be important and decisive evidence, despite it not being the sole evidence in support of some of these charges. The panel was aware that Colleague 3's evidence was the sole evidence in support of charge 2 as Colleague 3 was allegedly a direct witness to this incident, when no one else was.

The panel noted that Colleague 3's witness statement was unsigned and undated, so there is nothing to say that she agrees with the content of it. It is not entirely clear who wrote the statement, which is not on headed paper and has annotations across it. The sentences within this statement are also quite fragmented and there is no indication of how contemporaneous the account was given.

Whilst the panel had no evidence of alleged fabrication, this, in itself, does not exclude the possibility that it could have been. There is some information before the panel to suggest that Colleague 3 and Mrs Best did not always get on well with each other when at work. The panel noted that Mrs Best feels that Colleague 3 had a tendency to dismiss her professional opinion, and this cannot be tested in evidence as Colleague 3 is not attending the hearing.

The panel was not satisfied that Colleague 3 had a good reason for her non-attendance at this hearing. Whilst it accepted the NMC's decision not to pursue Colleague 3 for the purposes of a witness statement at the time it was investigating due to her personal circumstances, this was approximately 18 months ago, and the panel considered it to be unclear if she was unwilling to attend today as the last communication the NMC had with her was on 7 October 2021.

Furthermore, the panel noted that Mrs Best was only informed today about the NMC's intention to adduce Colleague 3's evidence without intending to call her to give oral evidence. Therefore, Colleague 3's evidence was not specifically brought to Mrs Best's attention before now. The panel noted that, despite Mrs Best's response saying that this was '*good news*', she is unrepresented, and may not fully appreciate the rules around admitting hearsay evidence.

In taking account of the above, the panel was not satisfied that Colleague 3's evidence should remain in evidence. The panel did not consider this to fundamentally damage the NMC's case against Mrs Best as Colleague 3's evidence only speaks to some of the allegations against her. There are other witnesses being called to testify on behalf of the NMC.

The panel refused Ms Marcelle-Brown's application to admit Colleague 3's evidence.

Decision and reasons on application to amend the charge

During witness evidence, the panel, of its own volition, made an application to amend the wording of charge 4. The proposed amendment was to include the specific drug referred to in the evidence, namely, Midazolam, as this would provide clarity and more accurately reflect the information the panel had received.

The panel noted that charge 4 currently reads:

"*4. On 17 September 2020 you drew up 10mgs when making up a syringe driver as opposed to 5mgs.*"

The panel proposed that charge 4 should read as follows:

4. On 17 September 2020 you drew up 10mgs **of Midazolam** when making up a syringe driver as opposed to 5mgs.

Ms Marcelle-Brown did not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules, which states:

"*28 (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend*

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue."

The panel was of the view that such an amendment, as applied for, was in the interests of justice.

The panel determined that amending charge 4 in the way proposed would not fundamentally alter the case against Mrs Best. It was aware that she had been sent all of

the paperwork relating to this case and it concluded that she should have known from that what medication was being referred to in the evidence to support charge 4.

The panel noted that the proposed amendment could not be said to prejudice or disadvantage Mrs Best in any way. It was simply to provide clarity and accuracy based on the information it had received.

Therefore, the panel decided to exercise its own discretion and amend charge 4 in the manner proposed, of its own volition.

Details of charge (After amendment)

That you, a registered nurse failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

1. Failed to visit Patient A on 18 December 2018.

2. On 18 December 2018 in relation to Patient B:
    a. Discharged them from the district nurses' caseload when their wound had not completely healed or in the alternative discharged the incorrect patient.
    b. Discharged a patient when this was outside your scope of practice
    c. Copied and pasted the previous care plan into the notes.

3. Printed off Patient A's notes on 14 January 2019.

4. On 17 September 2020 you drew up 10mgs of Midazolam when making up a syringe driver as opposed to 5mgs.

5. Whilst subject to a Stage 1 formal capability process between 16 Feb 2021 and 15 Dec 21:
    a. In week 1, scored 0 out of 6 for record keeping activities.

b. In week 2:

   i. Scored 1 out of 6 for record keeping activities.

   ii. Overstretched a Ktwo compression bandage.

   iii. Failed to draw up the correct amount of insulin.

c. In week 2 and/or 3:

   i. Scored 2 out of 6 for record keeping activities.

   ii. Recorded two wounds on one careplan.

   iii. Documented a wound when the skin was not broken.

   iv. Did not complete a care plan for mood.

   v. Incorrectly graded a pressure ulcer.

d. In week 4 received scores of 3 and 4 for diabetes management and/or medication administration.

e. In week 8:

   i. Received a score of 1 for wound assessment and management.

   ii. Received a score of 2 for record keeping.

   iii. Received a score of 0 for drug calculations.

f. In week 9:

   i. Received a score of 3 out of 6 for wound assessment and/or wound management and/or drug calculations and/or record keeping.

   ii. Missed an appointment with a diabetic patient.

g. In week 10:

   i. Received a score of 3 out of 6 for record keeping and/or wound management and/or diabetes management and/or medication administration.

   ii. Intended to draw up a dose of 10mgs of morphine sulphate when the correct dose was 2mgs.

h. In week 11:

   i. Received a score of 3 out of 6 for record keeping and/or wound management.

   ii. Received a score of 1 out of 6 for medication administration and/or diabetes management.

i. In week 12:

   i. Received a score of 3 out of 6 for record keeping and/or wound management.

   ii. Received a score of 1 out of 6 for diabetes management and/or diabetes management.

j. Did not provide reflective pieces on a weekly basis.

k. Did not provide reflective pieces that met the required standards.

l. Did not ensure that you had the correct equipment for visits between 26 May 2021 and 9 June 2021.

m. Did not provide any evidence of self-directed learning and/or complete a reading list.

n. Failed to visit Patient D on 15 December 2021.

o. In relation to Patient F:

   i. Recorded in the notes that you had visited them at 12.10 on 15 December when you attended after 14:00.

   ii. Did not send the wound swab to the laboratory.

   iii. Did not document Patient F’s temperature or oxygen saturations.

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

That you, a registered nurse:

6. Recorded in the notes that you had visited Patient A on 18 December 2018 when you had not.

7. In a meeting on 20 December 2018 stated that you had visited Patient A when you had not.

8. Told Colleague 1 on 10 January 2019 that you had visited Patient A when you had not.

9. On 14 January 2019 told Colleague 2 that Colleague 1 had given you permission to print out the notes relating to Patient A.

10. At a disciplinary hearing on 12 November 2020 stated that:
    a. You had visited Patient A on 18 January 2018 when you had not.
    b. You had discussed the discharge of Patient B with Colleague 3 when you had not.

11. Recorded in the notes that you had a face to face appointment with Patient D on 15 December 2021 when you had not seen them.

12. In a meeting with Colleague 4 on 21 December 2021 stated that you had visited Patient D on 15 December 2021 when you had not.

13. Recorded in the notes of Patient E that a referral had been made on 15 December 2021 to SPHERE when it had not been.

14. Recorded in the notes of Patient G that a referral had been made on 16 December 2021 to SPHERE when it had not been.

15. Your actions at charge 6 and/or 7 and/or 8 and/or 10a and/or 11 and/or 12 were dishonest in that you intended to create the impression that you had seen a patient when you had not.

16. Your actions at charges 9 and 10b were dishonest in that you intended to create the impression you had permission to carry out a certain task when you did not.

17. Your actions at charges 13 and/or 14 were dishonest in that you intended to create the impression that a referral had been made when it had not been.

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took account of all the oral and documentary evidence in this case, including Mrs Best's CMF document, and the submissions made by Ms Marcelle-Brown.

The panel has drawn no adverse inference from the non-attendance of Mrs Best.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Colleague 1: A Nurse Team Leader at the Board.
- Colleague 2: A band 6 District Nursing Sister at the Board.
- Colleague 4: A Nurse Team Leader at the Board.
- Colleague 5: A band 6 District Nurse at the Board.
- Colleague 6: A band 5 Community Staff Nurse.
- Colleague 7: A band 7 District Nurse and Practice Teacher at the Board.
- Colleague 8: A Nurse Team Leader and a Practice Development Nurse at the Board.
- Colleague 9: Service Manager for the Board.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

That you, a registered nurse failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

1. Failed to visit Patient A on 18 December 2018.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, Colleague 2, Colleague 5, Colleague 6, and Colleague 9, as well as the evidence provided by Mrs Best.

The panel noted from the evidence before it that there was a visit scheduled for Patient A on 18 December 2018 and that Mrs Best was the registered nurse who was assigned to it. Whilst it did not have an NMC witness statement from Patient A, or hear oral evidence from them at this hearing, it considered the actions they took in telephoning the Board to be consistent with someone who was expecting a visit but did not receive one.

The panel noted from the audit trail that Mrs Best had unassigned herself from the visit to Patient A on 18 December 2018. It was of the view that Mrs Best had provided no clear rationale for why she had unassigned herself from visiting Patient A. To the contrary, Mrs Best had given a number of differing accounts of the incident involving Patient A; initially telling the Board that she did visit Patient A but had failed to document the notes of her visit. Then, after Mrs Best was informed by the Board that the audit trail showed that she had unassigned herself from the visit, Mrs Best changed her story to say that she had telephoned Patient A who had informed her that she did not want a visit. Furthermore, at an even later point, Mrs Best told the Board that she did visit the patient at her address, but the patient refused medical care that was on offer. In taking this into account, the panel was not satisfied that Mrs Best's accounts were plausible or reliable due to the inconsistent nature of them.

There was no evidence before the panel to suggest that Patient A bore any ill-will towards Mrs Best. Colleague 6 who visited Patient A on 19 December 2018 clearly recalled asking Patient A if she had had a visit on the day before. Patient A was sure that she had not although she did not raise any concerns about that.

Therefore, the panel determined that Mrs Best had failed to visit Patient A on 18 December 2018 and, on the balance of probabilities, it found charge 1 proved.

Charge 2a)

2. On 18 December 2018 in relation to Patient B:
   a. Discharged them from the district nurses' caseload when their wound had not completely healed or in the alternative discharged the incorrect patient.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 5, Colleague 9 and Colleague 10, as well as the evidence provided by Mrs Best.

The panel noted from Mrs Best's CMF document and the notes from the investigatory meeting on 27 March 2019 that Mrs Best appears to admit discharging Patient B from Colleague 3's caseload. Therefore, the question that remained for the panel was whether Patient B was discharged before their wound had completely healed or, in the alternative, whether Mrs Best had discharged the incorrect patient.

The panel was aware that it had refused to admit the hearsay evidence of Colleague 3, which was the only direct evidence in support of this charge. It noted that Colleague 5, Colleague 9 and Colleague 10 could only give indirect evidence as they had acted on what Colleague 3 had informed them.

The panel had sight of the Daily Notes concerning Patient B completed by staff at the care home as follows:

> "*11/12 2018 15:19*
> *District Nurse Visit*
> *District Nurse in to dress wound and they are pleased with [their]*

progress, and will be back out of [sic] Friday to re-dress the wound…

14/12 2018 11:54
District Nurse Visit
District Nurse out to re-dress wound, it is healing well and has reduced in size. was co-operative with the nurse and a new dressing has been applied…".

These entries suggested that the wound had been healing well in the days before Mrs Best's attendance upon Patient B on 18 December 2018.

The panel noted that it appears that Colleague 3 assumed that Mrs Best's assessment was wrong as Patient B's wound could not have healed at that point. However, Colleague 3 had not assessed the wound on that date. There was no direct evidence as to the condition of the wound after Mrs Best had discharged Patient B save for that of Colleague 3. Colleague 3 allegedly visited Patient B on 19 December 2018, but the panel could not be certain that this was the case as the patient's notes indicated that it was a retrospective record which was undated. In any event, there was some evidence to suggest that Patient B was on the toilet when Colleague 3 arrived at the Home, so it was not possible for Colleague 3 to fully assess their wound. The next record of a District Nurse's attendance in the care home was in fact dated 28 December 2018. Therefore, the panel could not be satisfied that there was any evidence before it to confirm or deny that Patient B's wound had completely healed when Mrs Best discharged Patient B. Colleague 9 had stated in his NMC witness statement that there were signs of infection, but this was not supported by any other evidence, so the panel did not rely on this.

From the evidence before it, the panel was not satisfied that on 18 December 2018, Mrs Best discharged Patient B from the District Nurse's caseload when their wound had not completely healed or discharged them incorrectly. The panel determined that the NMC had not provided sufficient evidence to discharge its burden of proof as to whether Patient B's wound had healed or not. Furthermore, there was no clear evidence to suggest that Mrs Best discharged the incorrect patient.

Therefore, on the balance of probabilities, the panel found charge 2a not proved.

Charge 2b

b. Discharged a patient when this was outside your scope of practice

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, Colleague 5 and Colleague 9, as well as the evidence provided by Mrs Best.

The panel noted that in her CMF document, Mrs Best provides an account whereby she explains that if a patient's wound had healed and there were no other nursing requirements, then band 5 registered nurses were advised to discharge them from the caseload.

Mrs Best appears to be of the impression that she was permitted to discharge patients, and the panel was not provided with any definitive evidence to show that she was not permitted to do so.

The panel heard inconsistent oral evidence from the NMC witnesses in respect of whether a band 5 registered nurse was able to discharge patients from the Board. In his oral evidence, Colleague 9 was adamant that discharging patients was fundamentally outside of a band 5 registered nurse's scope of practice. However, Colleague 5 told the panel during her oral evidence that it was possible for a band 5 registered nurse to discharge patients, but they should usually do so in discussion with a band 6 registered nurse or case load holder; '*it was a judgment call*'. Colleague 1 also stated during her oral evidence that a band 5 registered nurse had authority to discharge if they had had a discussion with a band 6 registered nurse.

The panel considered there to be no conclusive evidence to confirm that band 5 registered nurses were not permitted to discharge patients at the Board. It had no objective evidence as to what the Board's discharging policy was; it appeared to be opinion based and the opinions differed depending on the situation. The panel therefore could not be certain that discharging a patient was outside of the scope of practice for a band 5 registered nurse at the Board.

The panel determined that the NMC had not provided sufficient evidence to discharge its burden of proof as to whether discharging a patient was outside Mrs Best's scope of practice.

The panel found charge 2b not proved.

Charge 2c

c. Copied and pasted the previous care plan into the notes.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 5 and Colleague 9, as well as the evidence provided by Mrs Best.

The panel noted from Mrs Best's CMF document and the notes from the investigatory meeting on 27 March 2019 that Mrs Best appears to admit copying and pasting the previous care plan into the notes for Patient B.

In her CMF document, Mrs Best explained to the panel that, from what she remembers, she specifically asked Colleague 3 if she should put the patient's notes back on the CNIS as they were before discharge, and Colleague 3 responded by saying "*put them back the*

way they were". Mrs Best also described a situation where Colleague 3 was shouting at her because of it.

The panel did not receive any evidence from Colleague 3, so it was unclear whether she had indeed said this; nonetheless, the panel considered there to be a theme developing that Mrs Best was asked or instructed to reinstate Patient B to CNIS. This was also apparent in the notes from the investigatory meeting on 27 March 2019 as Colleague 9 indicated that Mrs Best had done what was asked of her. Mrs Best stated at that meeting "*I did exactly what I was told*". The panel was of the view that the instruction could have been interpreted quite widely, which could explain why Mrs Best copied and pasted the care plan into Patient B's notes.

In taking account of the above, and in having regard to the stem of the charges, the panel was not satisfied that Mrs Best had failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in copying and pasting Patient B's previous care plan into the notes.

Therefore, the panel found charge 2c not proved.

Charge 3

3. Printed off Patient A's notes on 14 January 2019.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, Colleague 2, Colleague 6, and Colleague 9, as well as the evidence provided by Mrs Best.

The panel had sight of Colleague 6's NMC witness statement in which she stated that she found Patient A's notes left at the printer which had been printed off from CNIS. Colleague

6 thought these belonged to Colleague 2 so she delivered them to her. Upon it being brought to Colleague 2's attention, Colleague 2 asked Mrs Best whether it was she who had printed Patient A's notes and Mrs Best confirmed that she had, as her union wanted her so to do. The panel noted that there did not appear to be any issue to resolve in relation to this incident; Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge.

Therefore, the panel was satisfied that Mrs Best did print off Patient A's notes on 14 January 2019.

The panel found charge 3 proved.

Charge 4

4. On 17 September 2020 you drew up 10mgs of Midazolam when making up a syringe driver as opposed to 5mgs.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

The panel had sight of Colleague 7's NMC witness statement in which she stated that Mrs Best had notified her of a near miss medication error that occurred on 17 September 2020; specifically that Mrs Best made up a syringe driver containing 10mgs of Midazolam (the full vial) instead of the 5mgs which was required. The panel noted that Colleague 7 expanded on the severity of this charge in her oral evidence, as she stated that if this error had not been spotted, a dose of that size could have been fatal for the patient in question. The panel noted that there did not appear to be any issue to resolve in relation to this

incident; Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge.

Therefore, the panel was satisfied that on 17 September 2020, Mrs Best drew up 10mgs of Midazolam when making up a syringe driver as opposed to 5mgs.

The panel found charge 4 proved.

Charge 5a

5. Whilst subject to a Stage 1 formal capability process between 16 February 2021 and 15 December 2021:
    a. In week 1, scored 0 out of 6 for record keeping activities.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

The panel had sight of Mrs Best's competency statement dated 20 February 2021 which showed that Mrs Best had been given the score of '0' in the 'Mentor Rating Scale Outcome'. Colleague 7 attributed this score to Mrs Best's overall record keeping abilities in her oral evidence. This competency statement had also been signed by Colleague 7.

The panel noted that Mrs Best seems to contradict herself in her CMF document in relation to this charge. However, she does accept that she did get things wrong.

Therefore, the panel considered it to be factually correct that Mrs Best received the score referred to in the charge.

The question that remained for the panel to answer was whether this score meant that Mrs Best had failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse. The panel heard consistent evidence from the NMC witnesses that a score of 3 or below meant that Mrs Best was not safe to practise without supervision as she did not meet the requisite standards to practise independently. The panel had sight of the grading scale for the scoring system that was used in the capability programme. Therefore, the panel adopted this methodology in considering whether Mrs Best had '*failed*' to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse. The panel had no doubt in this regard as a score of '0' was below the lowest possible score for Mrs Best to receive.

The panel found charge 5a proved.

Charge 5b

b. In week 2:
   i. Scored 1 out of 6 for record keeping activities.
   ii. Overstretched a Ktwo compression bandage.
   iii. Failed to draw up the correct amount of insulin.

These charges are found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

In respect of charges 5b(i), the panel had sight of Mrs Best's competency statement dated 25 February 2021. It noted that that this document had been signed by both Mrs Best and Colleague 7.

The panel noted that Mrs Best's competency statement dated 25 February 2021 showed that she had been given the score of '1' in the 'Mentor Rating Scale Outcome'. Colleague 7 attributed this score to Mrs Best's direct supervision during daily visits and record keeping. Therefore, the panel considered it to be factually correct that Mrs Best received the score referred to in charge 5b(i).

In taking account of its findings in charge 5a, the panel had no doubt that a score of '1' was indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

In respect of charge 5b(ii), the panel again noted from Mrs Best's competency statement dated 25 February 2021 that, under the 'Mentor Feedback' section, it is recorded:

> "*Discussion with Eleanor in relation to Ktwo compression bandages application she was over stretching this whilst applying. Examples of overstretching identified to Eleanor and explanation given on correcting this by undoing bandage and starting over*".

The panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted charge 5b(ii).

In respect of charge 5b(iii), Mrs Best says she has no recollection of this particular incident. However, the panel noted that Mrs Best's competency statement dated 25 February 2021 states under the 'Mentor Feedback' section that:

> "*Eleanor is competent at checking diabetics BM but whilst drawing up insulin she has when checking units been slightly above the correct dose. Discussion and teaching given to Eleanor in regards to drawing up and ensuring excess is expelled to correct dose by using the correct measurement level on syringe.*".

Mrs Best had also documented under the section 'Employee Feedback':

"*On the insulin syringes there are measurements on both sides of the syringe [Colleague 7] had made it clear to myself which side to use going forward.*".

As this document had been signed by both Mrs Best and Colleague 7, the panel accepted the more contemporaneous evidence from around the time of the events, as opposed to Mrs Best's current recollection.

Therefore, the panel found charges 5b(i), 5b(ii) and 5b(iii) proved.

Charge 5c

c. In week 2 and/or 3:
   i. Scored 2 out of 6 for record keeping activities.
   ii. Recorded two wounds on one careplan.
   iii. Documented a wound when the skin was not broken.
   iv. Did not complete a care plan for mood.
   v. Incorrectly graded a pressure ulcer.

These charges are found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 8, as well as the evidence provided by Mrs Best.

In respect of charge 5c(i), the panel had sight of Mrs Best's competency statement dated 9 March 2021. It noted that that this document had been signed by both Mrs Best and Colleague 7.

The panel noted that Mrs Best's competency statement dated 9 March 2021 showed that she had been given the score of '2' in the 'Mentor Rating Scale Outcome'. Colleague 7

attributed this score to Mrs Best's record keeping activities. Therefore, the panel considered it to be factually correct that Mrs Best received the score referred to in charge 5c(i).

In taking account of its findings in charge 5a, the panel was satisfied that a score of '2' was indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

In respect of charge 5c(ii), the panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge. The panel also noted from the document titled 'Meeting notes from 9/3/21 with EB and [Colleague 7]' it is recorded:

> "*Reviewed Minnie Mouse*
> *Needs to change careplans. EB has put both wounds onto one careplan*
> *These must be separated and have own careplan…*"[sic].

The panel was satisfied from the above that Mrs Best recorded two wounds on one care plan due to the contemporaneous evidence from around the time of the incident.

In respect of charge 5c(iii), the panel had regard to Mrs Best's CMF document, in which she states that the skin of this patient was broken. However, the panel noted that Mrs Best then appeared to deflect accountability for this on to Colleague 7.

The panel put Mrs Best's explanation to Colleague 7 in her oral evidence and it considered her response to be credible and reliable. Colleague 7 appeared to be shocked that Mrs Best would allege that other registered nurses, including Colleague 7 would attempt to cover up the fact that a wound had not been documented when it should have been. The panel had found Colleague 7 to be fair and balanced in her evidence; it did not consider her to have embellished her account or demonstrated any ill-will towards Mrs Best.

The panel preferred the evidence of Colleague 7 to that of Mrs Best in this particular circumstance. Colleague 7 was adamant that there was no broken skin.

In respect of charge 5c(iv), the panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge, albeit she has stated in her written representations that she does not recall this taking place.

The panel noted that Colleague 8 had attested that Mrs Best had not completed a care plan for mood. It also had regard to the document titled 'Meeting notes from 9/3/21 with EB and [Colleague 7]' where it is recorded:

> "*Reviewed Minnie Mouse…*
> *EB did not do a careplan for mood*"[sic].

Again, the panel was satisfied from the contemporaneous evidence that Mrs Best did not complete a care plan for the mood of the patient. It acknowledged that both Colleague 7 and Colleague 8's evidence corroborated each other in relation to this.

In respect of charge 5c(v), Colleague 8 had said in her oral evidence that grading a pressure ulcer was a basic skin care task that needed to be reviewed. The document titled 'Meeting notes from 9/3/21 with EB and [Colleague 7]' showed that:

> "*Reviewed Minnie Mouse…*
> *Wounds must be documented correctly and identified as Pressure ulcers and correct grade…*
> *Heel wound is hospital acquired PU and graded as 2 however EB documented slough present which would suggest PU 3…*
>
> *Learning needs*
> *EB to review PU pressure grading tool Pressure ulcer training on team 20/4/21.*"[sic].

Again, the panel was satisfied from the contemporaneous evidence that Mrs Best had incorrectly graded a pressure ulcer. Colleague 7 and Colleague 8's evidence corroborated each other in relation to this. In particular, Colleague 7 told the panel during her oral evidence that once Mrs Best had seen the wound, it really helped her understand the pressure ulcer grading system.

In taking account of all the above, the panel found charges 5c(i), 5c(ii), 5c(iii), 5c(iv) and 5c(v) proved.

Charge 5d

d. In week 4 received scores of 3 and 4 for diabetes management and/or medication administration.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4 and Colleague 7, as well as the evidence provided by Mrs Best.

In respect of this charge, the panel had sight of Mrs Best's competency statement dated 8 April 2021. It noted that that this document had been signed by both Mrs Best and Colleague 7.

The panel noted that Mrs Best's competency statement dated 8 April 2021 showed that she had been given the score of '3/4' in the 'Mentor Rating Scale Outcome'. However, the panel was unclear what this score related to as this was not specified in the competency statement. The panel had no documentary evidence before it to say that this score was awarded to Mrs Best in relation to diabetes management and/or medication administration. In addition, Colleague 7 said in her oral evidence that the '3/4' score was

the overall score but they were still working on wound care. The competency statement states that Mrs Best was conducting unsupervised injections and unsupervised visits for diabetic patients. It follows that the score of ‘3’ is more likely to be in respect of wound management, rather than diabetes management or medication administration.

Furthermore, the panel had regard to the stem of the charges, which alleges that Mrs Best failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse. The panel received evidence to suggest that a score of ‘3/4’ meant that a registered nurse was capable of working without supervision. Therefore, the panel determined that the NMC had not provided sufficient evidence to discharge its burden of proof in demonstrating that Mrs Best had failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse in respect of this charge. The evidence provided appeared to support the fact that Mrs Best had achieved an acceptable score for a band 5 registered nurse.

The panel found charge 5d not proved.

Charge 5e

e. In week 8:
   i. Received a score of 1 for wound assessment and management.
   ii. Received a score of 2 for record keeping.
   iii. Received a score of 0 for drug calculations.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 8, as well as the evidence provided by Mrs Best.

In respect of charges 5e(i), 5e(ii) and 5e(iii), the panel had sight of Mrs Best's competency statement dated 28 May 2021. It noted that that this document had been signed by both Mrs Best and Colleague 7.

The panel noted that Mrs Best's competency statement dated 28 May 2021 showed that she had been given the score of '1' for wound assessment and management, the score of '2' for record keeping and the score of '0' for drug calculations according to the 'Mentor Rating Scale Outcome'. Therefore, the panel considered it to be factually correct that Mrs Best received the scores referred to in charges 5e(i), 5e(ii) and 5e(iii).

In taking account of its findings in charge 5a, the panel had no doubt that scores of '0', '1' and '2' was indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

Therefore, the panel found charges 5e(i), 5e(ii) and 5e(iii) proved.

Charge 5f

f. In week 9:
   i. Received a score of 3 out of 6 for wound assessment and/or wound management and/or drug calculations and/or record keeping.
   ii. Missed an appointment with a diabetic patient.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 9, as well as the evidence provided by Mrs Best.

In respect of charge 5f(i), the panel had sight of Mrs Best's competency statement dated 7 June 2021.

The panel noted that Mrs Best's competency statement dated 7 June 2021 showed that she had been given the score of '3' for wound assessment and/or wound management and/or drug calculations and/or record keeping according to the 'Mentor Rating Scale Outcome'. Therefore, the panel considered it to be factually correct that Mrs Best received the score referred to in charge 5f(i).

In taking account of its findings in charge 5a, the panel was satisfied that a score of '3' was indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

In respect of charge 5f(ii), the panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted charge 5f(ii). This is also supported by Mrs Best's response in the notes from the investigatory meeting on 27 March 2019 and her written representations in her CMF document, as she states: "*I did miss this appointment however I am sure this visit was sent to me over What's App a messaging service used on mobile phones*"[sic].

However, in taking account of the contemporaneous evidence provided in the 'Mentor Feedback' section in Mrs Best's competency statement dated 7 June 2021, the panel noted that Colleague 7 stated that Mrs Best had missed a visit as:

> *"…It was discovered by myself whilst at home later that day at approximately 19.30. I phoned Eleanor once I discovered this visit was still on her schedule to ensure this had been completed by her this morning. Eleanor stated she hadn't visit this patient today. When questioning her she stated she didn't know why she would have missed this. I audited this visit and found this visit had been scheduled 2 days prior. Eleanor should have noticed thius visit whilst writing up her other visit…*"[sic].

The panel preferred the more contemporaneous evidence contained within Mrs Best's competency statement dated 7 June 2021. It had been signed by Colleague 7 the day after the incident took place, albeit this had not been signed by Mrs Best. Nonetheless, the panel was satisfied that Mrs Best had missed a visit with a diabetic patient.

Therefore, the panel found charges 5f(i) and 5f(ii) proved.

Charge 5g

g. In week 10:
   i. Received a score of 3 out of 6 for record keeping and/or wound management and/or diabetes management and/or medication administration.
   ii. Intended to draw up a dose of 10mgs of morphine sulphate when the correct dose was 2mgs.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

In respect of charges 5g(i) and 5g(ii), the panel had sight of Mrs Best's competency statement dated 28 November 2021. It noted that it had been signed by both Colleague 7 and Mrs Best.

The panel noted that Mrs Best's competency statement dated 28 November 2021 showed that she had been given the score of '3' for record keeping and/or wound management and/or diabetes management and/or medication administration according to the 'Mentor Rating Scale Outcome'. Therefore, the panel considered it to be factually correct that Mrs Best received the score referred to in charge 5g(i).

In taking account of its findings in charge 5a, the panel was satisfied that a score of '3' was indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

In addition to this, the panel noted that it is recorded by Colleague 7 in the 'Mentor Feedback' section that:

> "*…I approached the table and Eleanor was organising the breakthrough dose, she stated she was going to draw up 10mgs of morphine sulfate at this time I realised she had the palliative Kardex opened at the syringe driver prescription (regular medication section). I explained this to her and I opened the correct page for as required medication and the correct dose was 2mgs. I stated to her if I hadn't been there she would have given the wrong dose to which she stated she would have. Due to this near miss a Datix was completed…*"[sic].

The panel noted that in response to the above, Mrs Best has stated in the 'Employee Feedback' section:

> "*I agree with All Christine has said however I do wish my answer was different as to if I would have administered the medication however I never realised I was reading regular medications colum of the cardex but I did notice that the dose was the same as in the driver but thought I must be wrong and it was the correct dose. Christine pointed my error out to me and I was completely aware of where I went wrong I am familiar with the cardex and have taken some home to read over and refresh my memory. I applied my previous knowledge of the documentation and reflected on my errors and I have got syringe driver training booked but this is not until February. I plan to ask if I can assist with any other drivers to get more practice. My confidence has been knocked but I know what is required to rectify these issues.*"[sic].

Furthermore, this incident is also corroborated by the file note dated 1 December 2021. Therefore, the panel determined that Mrs Best had intended to draw up a dose of 10mgs of morphine sulphate when the correct dose was 2mgs.

The panel found charges 5g(i) and 5g(ii) proved.

Charge 5h

h. In week 11:
   i. Received a score of 3 out of 6 for record keeping and/or wound management.
   ii. Received a score of 1 out of 6 for medication administration and/or diabetes management.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

In respect of charges 5h(i) and 5h(ii), the panel had sight of Mrs Best's competency statement dated 5 December 2021. It noted that that this document had been signed by Colleague 7, albeit not by Mrs Best.

The panel noted that Mrs Best's competency statement dated 5 December 2021 showed that she had been given the score of '3' for record keeping and/or wound management, and a score of '1' for medication administration and/or diabetes management according to the 'Mentor Rating Scale Outcome'. Therefore, the panel considered it to be factually correct that Mrs Best received the scores referred to in charges 5h(i) and 5h(ii).

In taking account of its findings in charge 5a, the panel was satisfied that scores of ‘3’ and ‘1’ were indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

Therefore, the panel found charges 5h(i) and 5h(ii) proved.

Charge 5i

i. In week 12:
    i. Received a score of 3 out of 6 for record keeping and/or wound management.
    ii. Received a score of 1 out of 6 for diabetes management and/or diabetes management.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 7, as well as the evidence provided by Mrs Best.

In respect of charges 5i(i) and 5i(ii), the panel had sight of Mrs Best’s competency statement dated 12 December 2021. It noted that that this document had been signed by Colleague 7, albeit not by Mrs Best.

The panel noted that Mrs Best’s competency statement dated 12 December 2021 showed that she had been given the score of ‘3’ for record keeping and/or wound management, and a score of ‘1’ for diabetes management according to the ‘Mentor Rating Scale Outcome’. [The panel noted that ‘diabetes management’ was specified twice in charge 5i(ii) and determined to delete the second reference]. Therefore, the panel considered it to be factually correct that Mrs Best received the scores referred to in charges 5i(i) and 5i(ii).

In taking account of its findings in charge 5a, the panel was satisfied that scores of ‘3’ and ‘1’ were indicative of Mrs Best having failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 registered nurse.

Therefore, the panel found charges 5i(i) and 5i(ii) proved.

Charge 5j

j. Did not provide reflective pieces on a weekly basis.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 8, as well as the evidence provided by Mrs Best.

In having regard to the oral evidence received, the panel noted that the NMC witnesses gave varying accounts as to how many reflective pieces Mrs Best was asked to submit and whether or not this was on a weekly basis. The panel noted that Colleague 8 had stated in her oral evidence that Mrs Best was asked to submit a weekly reflective piece from the start of the capability programme. Colleague 4 told the panel in her oral evidence that she would have been expecting Mrs Best to provide as many as three reflective pieces each week. The panel noted that there did not appear to be any documentary evidence to indicate that Mrs Best was asked to provide reflective pieces on a weekly basis until the mid-point review of the capability programme.

At the mid-point review in April 2021, the panel did consider it to have been made clearer to Mrs Best as to what was being asked of her, and how often she was expected to provide a reflective piece. Colleague 8 told the panel during her oral evidence that Mrs

Best was given protected time each week for her to compile a reflective piece and to complete any outstanding reading.

The panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge. However, it had regard to Mrs Best's CMF document in which she stated:

> "*I did complete a reflection when asked or if I wanted to reflect on a visit. It was not agreed how many or when I was to complete these until our first meeting by that time I had completed 9 reflections. I was not told [Colleague 4] or [Colleague 8] wanted to see these as well as [Colleague 7]. I would have completed this…In the end I stopped completing reflections as they were always unsatisfactory.*"[sic].

From Mrs Best's own response, the panel could see that she was accepting that she had stopped completing the reflective pieces that were being expected of her. Mrs Best ended up submitting 13 reflective pieces in total over the 12-week capability programme period, but these did not appear to be forthcoming on a weekly basis. The panel considered it to have been important for Mrs Best to have provided these on a weekly basis once it became clear to her that this was required as her colleagues could have used the information within them to assess her progress and development.

Therefore, the panel found charge 5j proved.

Charge 5k

k. Did not provide reflective pieces that met the required standards.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 8, as well as the evidence provided by Mrs Best.

In her comments in the CMF document, Mrs Best stated:

> "*…I was advised to complete reflections using the NMC template for revalidation in the beginning which I did. I was told my reflections did not give enough insight. I then made my reflections longer, this too was an issue they were "too long" It was then decided would use GIBBS reflection model which I did but was again told they were too long...*".

The panel noted that Mrs Best was initially asked to provide reflective pieces using the NMC template. However, as this approach did not appear to be working for Mrs Best, the decision was made by colleagues at the Board for her to use the 'Gibbs' framework instead.

Colleague 7 told the panel in her oral evidence that Mrs Best's reflective pieces did improve after switching to the 'Gibbs' model, and that these did meet the required standard. She accepted that whilst there may still have been some errors with descriptions, the quality was much better and it allowed Mrs Best to demonstrate some critical thinking.

Having had sight of the 13 reflective pieces that had been provided by Mrs Best, the panel was of the view that whilst most of them demonstrated mixed qualities, it could be argued that some, if not all, were of an acceptable quality. The panel had no description before it of what Mrs Best would needed to have included for her to have achieved the required standard. It was not satisfied that there was clarity as to the standard that Mrs Best should have been reaching in respect of the reflective pieces she was submitting.

Therefore, the panel found charge 5k not proved.

Charge 5l

l. Did not ensure that you had the correct equipment for visits between 26 May 2021 and 9 June 2021.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, Colleague 7 and Colleague 8, as well as the evidence provided by Mrs Best.

In her CMF document, the panel noted that Mrs Best has stated:

> "*…I always carried equipment, I never had an oxygen saturation reader but this was not an essential as far as I was made aware of. Not all staff had one...*".

However, the panel had regard to an email dated 26 May 2021, which was sent by Colleague 8 to Mrs Best and Colleague 11. In this email, which outlined the notes of a meeting held on the same day, Colleague 8 stated:

> "*EB will contact [District Nurse] admin to request a thermometer, SAD2 meter and a replacement BP cuff as current one faulty*".

At this point, the panel considered Mrs Best to have been given a clear instruction to request the aforementioned equipment, with a follow up meeting to take place on 9 June 2021 to review this, along with other matters. On 9 June 2021, the panel noted that a further email with notes of the meeting held on the same day was sent by Colleague 8 to Mrs Best, with Colleague 7 and Colleague 4 copied into it stating:

> "*EB will collect sepsis equipment today (9/6/21) as has not done so since last meeting.*".

Colleague 8 told the panel that this equipment was readily available from the building where the meetings had taken place.

The panel considered the contemporaneous evidence to be indicative of the fact that Mrs Best did not ensure that she had the correct equipment for visits between 26 May 2021 and 9 June 2021. The panel considered it to be essential for a registered nurse who worked in the community to have all of the equipment required to be able to perform the role. It considered it to be Mrs Best's responsibility to ensure that she had all of the equipment needed. Mrs Best was attending some patients unsupervised by this point, and it determined that there would have been an expectation imposed on Mrs Best to be able to perform tasks within her scope of practice. In not having all of the appropriate equipment, patients' care could have been compromised.

Therefore, the panel found charge 5l proved.

Charge 5m

m. Did not provide any evidence of self-directed learning and/or complete a reading list.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4 and Colleague 8, as well as the evidence provided by Mrs Best.

In considering the semantics of this charge, the panel noted that the mischief identified is that Mrs Best 'did not provide any evidence' of her having done any self-directed learning and/or complete a reading list. However, Colleague 8 told the panel that there was no conclusive way of proving that Mrs Best had undertaken any self-directed learning and/or

completed a reading list. Colleague 8 said that staff at the Board just had to trust that Mrs Best had undertaken self-directed learning and/or completed the reading list when she signed and dated to say that she had done so. Both Colleague 7 and Colleague 8 attested to asking Mrs Best questions to test her knowledge around these areas, but that was about the extent of their checking. The panel noted that Colleague 8 was satisfied that Mrs Best had undertaken self-directed learning and completed the reading list from the answers she was given.

Therefore, whilst the panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge, it was nonetheless satisfied that Mrs Best had undertaken self-directed learning and completed the reading list. Mrs Best had also indicated that she was never asked to provide any evidence of her having done this, and the panel considered there to have been no requirement for her to have done so in the absence of any evidence to the contrary.

The panel was of the view that in completing reflective pieces and in signing the reading list to show she had completed it, there was some evidence of Mrs Best having undertaken self-directed learning and/or completed the reading list.

The panel found charge 5m not proved.

Charge 5n

n. Failed to visit Patient D on 15 December 2021.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

The panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge, although she stated in her written representations that she cannot recall this incident.

The panel had sight of Patient D's record from 15 December 2021 which stated that a visit had taken place on this day, and that it had been completed by Mrs Best.

However, in having regard to the supplementary NMC witness statement of Colleague 4, the panel noted that during a meeting between her and Mrs Best on 21 December 2021, Colleague 4 has stated:

> "*I informed the Registrant that she had documented that her visit was 30 minutes prior to the final capability meeting which she had had with me on 15 December, and thus she would not have had sufficient time to complete the care as recorded and be able to meet me. At this point, the Registrant became tearful and frustrated and stated that this was happening to her again…The Registrant was adamant that she had visited Patient D but the time that she recorded may have been wrong. The Registrant also advised that she did telephone Patient D to tell her about the problems with the IT systems but that she did provide care on 15 December 2021 as she had recorded…*".

Furthermore, Colleague 4 goes on to state:

> "*On 23 December 2021, the Registrant advised me via telephone that she had been attempting to contact her Union representative as she wanted to make a statement. The Registrant advised that she had not visited Patient (D) as she had recorded…*".

The panel also had sight of the letter dated 29 December 2021, which was sent by Colleague 4 to Mrs Best in response to her telephone resignation. The panel considered

this to be consistent with Colleague 4’s supplementary NMC witness statement as Colleague 4 has stated:

> “*…You subsequently advised me on Thursday 23th December 2021 you had in fact not delivered this care and that you had mislead me at our previous meeting. You could offer no satisfactory reason for falsely documenting care that you had not delivered…*”[sic].

Therefore, in taking account of all the above, the panel was satisfied that Mrs Best failed to visit Patient D on 15 December 2021. The panel was satisfied from the letter dated 29 December 2021 that Mrs Best had admitted that she had not visited Patient D on 15 December 2021, as she had initially indicated to Colleague 4. This letter was produced in response to Mrs Best’s resignation and was completed six days after her confession regarding Patient D. The panel noted that whilst the letter itself does not refer to Patient D by name or identification, the panel considered this to be implicit as Patient D was a topic of discussion at the previous meeting.

The panel found charge 5n proved.

Charge 5o

o. In relation to Patient F:
   i. Recorded in the notes that you had visited them at 12.10 on 15 December when you attended after 14:00.
   ii. Did not send the wound swab to the laboratory.
   iii. Did not document Patient F’s temperature or oxygen saturations.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4 and Colleague 12, as well as the evidence provided by Mrs Best.

The panel had sight of Patient F's record from 15 December 2021 which stated that a visit had taken place on this day, and that it had been completed by Mrs Best at 12:10 hours.

The panel had regard to Colleague 4's supplementary NMC witness statement, in which it was stated:

> "*…The Registrant advised me that she had visited Patient F at the time she documented at 12:10. I advised the Registrant that she had recorded another visit at 11:50 for 25 minutes so she would still have been in this patient's house at 12:10 when she supposedly visited Patient F. Again, the Registrant became flustered at this point and advised that her times may be wrong. The Registrant admitted that whilst she had spoken with the GP and had arranged for antibiotics to be prescribed for Patient F, the wound swab she had taken was still in her car. I asked the Registrant if she had undertaken any observations for Patient F and she advised that she had taken her temperature and oxygen saturation. Neither of these two things were documented…*".

The panel considered this to be corroborated by the internal statement provided by Colleague 12, who stated:

> "*…S.N. Best phoned me on 16/12/2021 to report her findings and to inform me she had requested an antibiotic. She informed me she had taken a swab, though had no time to deposit the swab at a Health centre for uplift to lab.*
>
> *On 17/12/2021, I spoke with the patient at her next visit. She reported, "the nurse visited well after 2pm", on 15/12/2021. However this visit is documented for 12:10pm…*".

The panel noted that whilst neither Colleague 12 or Patient F was called to give oral evidence on behalf of the NMC, this piece of documentary evidence corroborated the account provided by Colleague 4, that Mrs Best had visited Patient F at a later time than indicated in their record and in not having sent Patient F's wound swab to the laboratory.

The panel also noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted charges 5o(i), 5o(ii) and 5o(iii). Whilst Mrs Best had advised that she had taken Patient F's temperature and oxygen saturation levels, these were not documented in Patient F's records. The panel had no verifiable evidence before it to indicate that Mrs Best had undertaken these readings, other than her word that she had done so.

In taking account of the above, the panel was satisfied that Mrs Best had recorded in Patient F's record that she had visited them at 12.10 hours on 15 December, when she in fact attended after 14:00 hours, she did not send Patient F's wound swab to the laboratory, and she did not document Patient F's temperature or oxygen saturations.

Therefore, the panel found charges 5o(i), 5o(ii) and 5o(iii) proved.

Charge 6

That you, a registered nurse:

6. Recorded in the notes that you had visited Patient A on 18 December 2018 when you had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, Colleague 5 and Colleague 9, as well as the evidence provided by Mrs Best. It also had

regard to its findings in charge 1, where it determined that Mrs Best had not visited Patient A on 18 December 2018.

The panel noted within the paperwork that there was a retrospective entry created by Mrs Best on 20 December 2021, indicating that she had visited Patient A on 18 December 2021. In the 'Notes' section, the panel saw that Mrs Best had entered:

> "*Written in retrospective entry.*
>
> *Visited patient to assess wound however patient requested not to have intervention or assessment as she did not feel up to visit and that she would rather be in bed than sitting up in chair*".

Therefore, the panel was satisfied that Mrs Best had recorded in the notes that she had visited Patient A on 18 December 2018 when she had not.

The panel found charge 6 proved.

Charge 7

7. In a meeting on 20 December 2018 stated that you had visited Patient A when you had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1 and Colleague 5, as well as the evidence provided by Mrs Best. It also had regard to its findings in charge 1, where it determined that Mrs Best had not visited Patient A on 18 December 2018.

The panel noted that both Colleague 1 and Colleague 5 attested to Mrs Best stating in a meeting on 20 December 2018 that she had visited Patient A. This was supported by Colleague 5 stating in her oral evidence that she recalled Colleague 3 asking Mrs Best whether she had visited Patient A at this meeting, and Mrs Best had responded saying '*yes*'.

The panel noted that there were no meeting notes from 20 December 2018 within the paperwork before it. However, the panel was satisfied from the consistent and corroborative evidence from the NMC witnesses that Mrs Best had stated in a meeting on 20 December 2018 that she had visited Patient A when she had not.

Therefore, the panel found charge 7 proved.

Charge 8

8. Told Colleague 1 on 10 January 2019 that you had visited Patient A when you had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, as well as the evidence provided by Mrs Best. It also had regard to its findings in charge 1, where it determined that Mrs Best had not visited Patient A on 18 December 2018.

The panel noted in Colleague 1's NMC witness statement that she stated:

> "*…When I returned from my visit, I spoke to the Registrant about the incident in question. The Registrant stuck to the same story and stated that she had visited Patient A and that she must be lying. The Registrant at first appeared to be annoyed and was adamant that she had attended…*".

The panel noted that there were no meeting notes from 10 January 2019 within the paperwork before it. However, the panel considered Colleague 1’s evidence in this respect to be compelling. It was of the view that this evidence appeared to be consistent with other evidence provided by NMC witnesses. The panel noted that Mrs Best does not appear to have addressed this matter within her written representations contained in her CMF document.

In taking account of the above, the panel was satisfied that Mrs Best had told Colleague 1 on 10 January 2019 that she had visited Patient A when she had not.

The panel found charge 8 proved.

Charge 9

9. On 14 January 2019 told Colleague 2 that Colleague 1 had given you permission to print out the notes relating to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 1 and Colleague 2, as well as the evidence provided by Mrs Best.

The panel noted that Colleague 2 stated that a member of staff at the Board had approached her at around midday. They had found Patient A’s notes printed out and left at a communal printer. Colleague 2 told the panel that, as she was aware of an ongoing investigation into Mrs Best’s practice involving an incident with Patient A, she went to ask Mrs Best whether it was she who had printed these notes. Colleague 2 stated that Mrs Best confirmed that she had done so as her union representative has asked her for them, and that she had sought permission from Colleague 1 before doing so. Colleague 2 had told Mrs Best that she would be following this up with Colleague 1.

In Colleague 1’s oral evidence, she told the panel that she did not give permission for Patient A’s notes to be printed. She exhibited an email sent by Mrs Best with the time stamp on 14:11 hours on 14 January 2019, asking whether she could have a copy of any visit recordings with Patient A after 18 December 2018. Colleague 1 told the panel that she received a telephone call from Colleague 2 before she had finished reading the email from Mrs Best, asking whether she had indeed given Mrs Best permission to print Patient A's notes.

The panel preferred the evidence of Colleague 1 and Colleague 2 to that of Mrs Best in respect of this charge. Mrs Best merely states in her CMF document in relation to this incident “*This did not happen*”.

As the aforementioned email was not sent until 14:11 hours, the panel was satisfied that at the point of printing Patient A’s notes, Mrs Best had not asked permission from Colleague 1 to be able to do so. The evidence of Colleague 2 is consistent with that of Colleague 1, as Colleague 2 contacted Colleague 1 to ask whether Mrs Best had sought permission around the same time as Mrs Best asked for permission. Therefore, the panel was satisfied that Mrs Best had already printed Patient A’s notes, prior to asking Colleague 1 for permission.

The panel found charge 9 proved.

Charge 10a

10. At a disciplinary hearing on 12 November 2020 stated that:
    a. You had visited Patient A on 18 January 2018 when you had not.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 9, as well as the evidence provided by Mrs Best.

The panel identified that the date referred to in charge 10a appeared to be incorrect. Having raised the matter with Ms Marcelle-Brown, she confirmed that the date that this incident refers to is 18 December 2018, as specified in the other charges relating to Patient A. Having regard to the legal assessor's advice, the panel decided that it was appropriate to amend the charge to the correct date, noting as it did, that it could amend the charges any time prior to handing down on facts. The panel was satisfied that amending the charge to correct the date would more accurately reflect the evidence it had received throughout this case. It was of the view that this was a typographical error which did not impact upon the mischief alleged, so Mrs Best would not be prejudiced or disadvantaged in the making of this amendment.

The panel noted that in his NMC witness statement, Colleague 9 had stated:

> "*…In terms of the allegations, the Registrant continues to vehemently deny that she did not visit Patient A. the registrant maintained that she did visit Patient A but could not document the care…*".

However, the panel was not clear whether Mrs Best had repeated her denial at the disciplinary hearing. The panel considered there to be a lack of clarity from Colleague 9 as to the occasion to which he was referring when he stated that Mrs Best continued to deny that she did not visit Patient A. Whilst the panel had found that Mrs Best did not visit Patient A on 18 December 2018, it could not be satisfied that she had stated this at her disciplinary hearing on 12 November 2020. There were no minutes of the disciplinary hearing held on 12 November 2020 and Mrs Best's Statement of Case was written in May 2019, a year and a half prior to the disciplinary hearing.

Therefore, the panel found charge 10a not proved.

Charge 10b

b. You had discussed the discharge of Patient B with Colleague 3 when you had not.

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 9, as well as the evidence provided by Mrs Best. The panel noted that it had refused the NMC's application to admit Colleague 3's evidence as hearsay.

The panel considered there to be no cogent evidence to demonstrate that Mrs Best had stated that she had discussed the discharge of Patient B with Colleague 3 at the disciplinary hearing on 12 November 2020. The panel was aware that there were no minutes of the disciplinary hearing to confirm what was said and, in having regard to Colleague 9's NMC witness statement, it was not sufficiently clear that he was describing a discussion that took place on 12 November 2020.

Therefore, the panel found charge 10b not proved.

Charge 11

11. Recorded in the notes that you had a face to face appointment with Patient D on 15 December 2021 when you had not seen them.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

The panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge, although she had stated in her written representations that she cannot remember who or what this refers to.

The panel had sight of Patient D’s record from 15 December 2021 which stated that a visit had taken place on this day, and that it had been completed by Mrs Best. Mrs Best had indicated that she spent 20 minutes with Patient D at their home, at a face to face appointment and she had also documented a narrative of what she says took place at that visit.

The panel also had regard to its findings in charge 5n, where it determined that Mrs Best had failed to visit Patient D on 15 December 2021.

Therefore, the panel was satisfied that Mrs Best had recorded in the notes that she had a face-to-face appointment with Patient D on 15 December 2021 when she had not seen them.

The panel found charge 11 proved.

Charge 12

12. In a meeting with Colleague 4 on 21 December 2021 stated that you had visited Patient D on 15 December 2021 when you had not.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

Colleague 4 records in her witness statement that:

> "*During our meeting on 21 December 2021, the Registrant was very clear regarding the care that she had provided to Patient D. The Registrant was adamant that she had visited Patient D and had provided the care that she had recorded in Patient D's notes.*".

The panel noted that the meeting between Mrs Best and Colleague 4 was not a formally recorded meeting. Whilst Mrs Best states in her CMF document that this meeting did not take place as she believes she was on [PRIVATE] or annual leave, the panel accepted Colleague 4's evidence as it found her to be credible and reliable in this respect. Colleague 4 was able to provide a clear and detailed account of what was said in that meeting.

The panel also had regard to its findings in charge 5n, where it determined that Mrs Best had failed to visit Patient D on 15 December 2021.

Therefore, the panel was satisfied that Mrs Best stated in a meeting with Colleague 4 on 21 December 2021 that she had visited Patient D on 15 December when she had not.

The panel found charge 12 proved.

Charge 13

13. Recorded in the notes of Patient E that a referral had been made on 15 December 2021 to SPHERE when it had not been.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

The panel had sight of Patient E's record from 15 December 2021 which stated that a visit had taken place on this day, and that it had been completed by Mrs Best. In the 'Notes' section of the patient record, Mrs Best had also documented a narrative stating "*Continence referral made to sphere*". Colleague 4 told the panel that she had also contacted the SPHERE service who confirmed that no referral had been received.

The panel noted that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge. Mrs Best's account in her written representations appeared confused and contradictory, however, she seems to acknowledge that there were things outstanding for her to complete in respect of this referral.

The panel also received evidence to indicate that Mrs Best admitted that she had not made a referral to SPHERE for Patient E in a telephone call to Colleague 4 on 23 December 2021.

Therefore, the panel was satisfied that Mrs Best had recorded in the notes of Patient E that a referral had been made on 15 December 2021 to SPHERE when it had not been.

The panel found charge 13 proved.

Charge 14

14. Recorded in the notes of Patient G that a referral had been made on 16 December 2021 to SPHERE when it had not been.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

The panel had sight of Patient G's record from 16 December 2021 which stated that a visit had taken place on this day, and that it had been completed by Mrs Best. In the 'Notes' section of the patient record, Mrs Best had also documented a narrative stating "*Continence referral made and visits for pads to be collected scheduled to myself*". Whilst the panel noted that SPHERE is not specifically referred to in Patient G's records, the panel considered it to be implicit from Mrs Best's entry. Colleague 4 told the panel that she had also contacted the SPHERE service who confirmed that no referral had been received.

Furthermore, this was supported by the fact that Mrs Best had ticked the box in her CMF document to indicate that she admitted this charge. Mrs Best's account in her written representations did appear to be confused and contradictory, however, she seems to acknowledge that there were things outstanding for her to complete in respect of this referral.

The panel also received evidence to indicate that Mrs Best admitted that she had not made a referral to SPHERE for Patient G in a telephone call to Colleague 4 on 23 December 2021.

Therefore, the panel was satisfied that Mrs Best had recorded in the notes of Patient G that a referral had been made on 16 December 2021 to SPHERE when it had not been.

The panel found charge 14 proved.

Charge 15

15. Your actions at charge 6 and/or 7 and/or 8 and/or 10a and/or 11 and/or 12 were dishonest in that you intended to create the impression that you had seen a patient when you had not.

This charge is found proved in relation to charges 6, 7, 8, 11 and 12. This charge is found not proved in relation to charge 10a.

In reaching this decision, the panel took account of the evidence provided by Colleague 1, Colleague 2, Colleague 5, Colleague 6, and Colleague 9, as well as the evidence provided by Mrs Best.

It had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether Mrs Best had been dishonest in her actions, as outlined in charges in charges 6, 7, 8, 11 and 12. The panel noted that it had found charge 10a not proved, so it did not consider whether Mrs Best had been dishonest in this respect.

In particular, the panel noted in paragraph 74:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

The panel had regard to its earlier findings. It was satisfied that Mrs Best had intended to create the impression that she had seen Patient A and Patient D as alleged in charges 6, 7, 8 and 11 and 12 respectively, when she had not.

In relation to charges 6 and 11, the panel noted that Mrs Best had recorded entries in patient notes that were clearly untrue. In relation to charges 7, 8 and 12, the panel noted that it had found Mrs Best to have told other members of the Board that she had visited patients when she had not done so.

The panel was of the view that Mrs Best had sought to create a misleading impression from the entries/answers she had given. Mrs Best had repeatedly denied that she had not visited a number of patients, and it concluded that she sought to lend credence to her inaccurate statements and through her inaccurate documentation. Furthermore, the panel reminded itself that, in having regard to the incident involving Patient A, Mrs Best gave four differing accounts in trying to convince others that she had attended to Patient A as requested. Mrs Best had attempted to maintain her deception for a protracted period of time.

The panel noted that Mrs Best eventually conceded that she had not attended visits for three patients in a telephone call to Colleague 4 on 23 December 2021 when she resigned.

The panel reached the conclusion that ordinary, decent people would regard Mrs Best's conduct, as found proved in charges 6, 7 and 8, in respect of Patient A, and charges 11 and 12, in respect of Patient D, to be dishonest.

Therefore, in taking account of the above, the panel found charge 15 proved in relation to charges 6, 7, 8 and 11 and 12. It found charge 15 not proved in relation to charge 10a.

Charge 16

16. Your actions at charges 9 and 10b were dishonest in that you intended to create the impression you had permission to carry out a certain task when you did not.

This charge is found proved in relation to charge 9. This charge is found not proved in relation to charge 10b.

In reaching this decision, the panel took account of the evidence provided by Colleague 9, as well as the evidence provided by Mrs Best.

Again, the panel had regard to the case of *Ivey v Genting Casinos Ltd* in determining whether Mrs Best had been dishonest in her actions in respect of charge 9. The panel noted that it had found charge 10b not proved, so it did not consider whether Mrs Best had been dishonest in this respect.

The panel had regard to its earlier findings. It was satisfied that on 14 January 2019, Mrs Best had intended to create the impression by telling Colleague 2 that Colleague 1 had given her permission to print Patient A's notes when she had not.

The panel noted that at the time Mrs Best asked for Colleague 1's permission to print Patient A's notes, Colleague 2 had already confronted her about whether she had already obtained Colleague 1's permission to be able to do this. Colleague 1 had stated in her oral evidence that she recalls receiving a telephone call from Colleague 2 enquiring as to this five or ten minutes before receiving an email from Mrs Best requesting permission.

The panel was satisfied that the response Mrs Best gave to Colleague 2 at the time of her being confronted was untrue. It determined that Mrs Best had sought to create a misleading impression from the answer she had given. Mrs Best had not obtained permission from Colleague 1 at that point, and it was only after Colleague 2 had said that she would follow this up, that Mrs Best then contacted Colleague 1.

The panel considered there to have been no good reason for Mrs Best to have emailed Colleague 1 subsequent to Colleague 2 confronting her, if she had already received permission to print Patient A's notes. It was of the view that Mrs Best had sought to deflect

Colleague 2's attention away from what she was doing, as she knew that what she was doing was wrong.

The panel reached the conclusion that ordinary, decent people would regard Mrs Best's conduct, as found proved in charge 9, to be dishonest.

Therefore, in taking account of the above, the panel found charge 16 proved in relation to charge 9. It found charge 16 not proved in relation to charge 10b.

Charge 17

17. Your actions at charges 13 and/or 14 were dishonest in that you intended to create the impression that a referral had been made when it had not been.

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Colleague 4, as well as the evidence provided by Mrs Best.

Again, the panel had regard to the case of *Ivey v Genting Casinos Ltd* in determining whether Mrs Best had been dishonest in her actions in respect of charges 13 and/or 14.

The panel had regard to its earlier findings and it was satisfied that Mrs Best intended to create the impression that referrals had been made to SPHERE in respect of Patient E and Patient G, as found proved in charges 13 and 14, when they had not been.

The panel noted that when Mrs Best was asked to provide evidence of her SPHERE referrals for Patient E and Patient G to Colleague 4, she stated in an email dated 21 December 2021 that:

"*…I don't keep my emails unless it's important. my folders are always empty, I keep most of my referrals though in case I need to resend or its wrong…*"[sic].

The panel could think of no rational explanation as to why Mrs Best would have recorded the information regarding the SPHERE referrals in two patients' notes, other than that she was seeking to create a misleading impression from the entries she had made. The panel was satisfied that Mrs Best had wanted to manipulate the position so that other members of the Board would believe that she had provided additional care to patients when she knew that she had not done so.

The panel reached the conclusion that ordinary, decent people would regard Mrs Best's conduct, as found proved in charges 13 and 14, in respect of Patient E and Patient G respectively, to be dishonest.

Therefore, the panel found charge 17 proved.

Fitness to practise

You were in attendance for this part of the hearing but not represented.

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/or lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result.

Submissions on misconduct and lack of competence

Ms Saran invited the panel to have 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.'*

Ms Saran further invited the panel to take the view that the facts found proved amount to misconduct. She identified the specific, relevant standards where your actions amounted to misconduct. She submitted that a number of paragraphs from the 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) were breached. Specifically:

> ***'10 Keep clear and accurate records relevant to your practice***
> *This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.*
>
> > *To achieve this, you must:*
> > *10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements,*
>
> ***20 Uphold the reputation of your profession at all times***
>
> > *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

Ms Saran submitted that in the proceedings held in March 2023, the panel had determined that there were a number of misconduct charges found proved, including findings of dishonesty. These actions encompassed the following aspects: firstly, falsely indicating that you had attended to patients when, in fact, you had not; secondly, falsely asserting that you possessed authorisation to execute certain tasks, despite lacking such permissions; and thirdly, falsely representing that you had made patient referrals to various services, which was not the case.

Moreover, it is noteworthy that the panel gave substantial attention to the patient records for Patient A. Within this context, it was established that you had documented entries that were subsequently proven to be inaccurate. Additionally, your persistent denial of the allegation that you failed to visit Patient A, coupled with the provision of four different accounts regarding that patient visit as identified through the local and NMC investigations, were noted by the panel. In light of these findings, the panel determined that your actions amounted to an attempt to maintain your deception over a prolonged period of time.

Ms Saran then moved onto the issue of lack of competence. She stated that the NMC has defined a lack of competence as something that:

> *'would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk.'*

Ms Saran submitted that in relation to lack of competence you breached the following paragraphs of The Code:

> ***'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

3 Make sure that people's 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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 complete all 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

10.5 take all steps to make sure that all records are kept securely, and

10.6 collect, treat and store all data and research findings appropriately.'

Ms Saran submitted that the panel has already found that you have failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 5 nurse. The failures relate to a variety of issues such as missing patient visits, handling records, calculating, drawing up and administering drugs, record keeping, wound assessment and management and diabetes management.

Ms Saran invited the panel to find that these are basic nursing skills, which an experienced nurse such as yourself, should have been well aware of and put into practice. However, the panel had seen that your standard of work over a prolonged period of time, involved numerous incidents while you were under supervision and this demonstrates that your performance was at an unacceptably low standard which put patients at risk of harm.

Ms Saran submitted that there were repeated issues of administering wrong medication dosage which could have harmed the patients and the same concern relates to missing diabetic patient appointments. She said that missed visits to a patient could have resulted in the patient deteriorating in health. She therefore submitted that all these amounted to lack of competence.

You gave evidence under oath… [PRIVATE]

You stated that you started to struggle with your workload but never spoke up as you did not want to be talked about or to be "*marked*" so you continued on without requesting support. You know in hindsight this was a breach of The Code as it was your responsibility to [PRIVATE]. You submitted that mistakes were made and this was when you were first provided with support, and this support has followed you from base to base as you were moved around a lot by management. The support was never consistent and sometimes you would practice alone due to staff shortages, and on other shifts you would have a Band 6 nurse with you. You would just continue on, and sometimes unaware of any wrongdoing until someone pointed this out to you. You said that this started to affect your confidence and you continued to make minor errors. However, you were afraid to ask for help in fear of losing your job.

You stated that you were placed onto a capability stage one process where you would be supported through any training required. However, you never finished this as [PRIVATE].

You said [PRIVATE] you were to continue on supported visits and this is when you began to make more mistakes relating to the administration of insulin and record keeping. You

were then *“marked as a failure”* and everything you did was scrutinised. You said it became unbearable to work and you were being accused of things that you did not recall had occurred. [PRIVATE]

You told the panel [PRIVATE] you asked to be moved to a more stable environment with consistent support. However, this was denied and you were told that you would lose your NMC registration if you did not complete the capability process. You were advised to complete the process but were constantly brought down by your mentor. You said you were too afraid to speak out as you were already marked.

You stated that on reflection you see how this all affected your role as a nurse and your ability to practice safely and effectively. You said you have buried your head in the sand up until now. You lost your Union representation due to resigning from your previous post. You have tried to navigate your way through this hearing process by yourself…[PRIVATE]

You had been successful in obtaining a Band 5 nursing role at Queen Elizabeth University Hospital in Glasgow, despite being subject to an interim conditions of practice order by the NMC. You told the panel that you were commended on your honesty and transparency when you gained this employment. You were eventually advised that you would be more suited to work on a more general ward, which would be less pressured.

You stated that you can be a good nurse again and wish to be one. It was hard to obtain your degree and a position in District Nursing. Due to your inability to speak up and admit to struggling you put patients at risk of harm, and this was furthest from your intentions.

You said you are deeply sorry for the harm you could have caused and wish in the future to rectify any wrongdoings and increase your learning in any way possible. You said you want to continue to hold onto your registration and that you are willing to do any necessary training or further education required.

You told the panel that you are currently not safe to practise without restrictions due to all the errors you made which has affected your confidence. You said you could work in a less pressured environment with conditions attached to your registration.

You stated that you understand how your conduct would be seen as dishonest. You said that you recognise that nurses have to be honest, transparent and trustworthy. Further, you said that you did not set out to, nor was it your intention to deceive anyone.

Submissions on impairment

Ms Saran 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).

Ms Saran submitted that your fitness to practise is impaired, which you accept is due to instances of misconduct and a lack of competence. In referring the panel to the judgment in *Grant*, Ms Saran referred to paragraph 74, in which Mrs Justice Cox 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.'

Ms Saran submitted that you put patients at risk of harm and breached fundamental tenets of the nursing profession which brought the profession into disrepute. You have also acted dishonestly and all four limbs of Dame Janet Smith's "test" are engaged and there remains a significant risk of repetition.

Ms Saran stated that the panel reviewed evidence pertaining to your capability plan. Notably, it was observed that you had not completed the initial phase, proceeding instead to the next stage, which was subsequently disrupted by your voluntary resignation. As a consequence, you did not complete the capability plan.

Throughout the capability plan, you were afforded opportunities to address the concerns identified through remediation measures. Unfortunately, these opportunities were met with an inadequate response, as you failed to meet the required standards. Furthermore, once

you secured employment as a Band 5 in A&E, you breached one of the conditions of the NMC's interim conditions of practice order, when you administered intravenous saline without the required supervision. This occurred shortly after you started your employment.

Ms Saran submitted that, the Learn Pro User training certificates that you provided the panel do not demonstrate successful remediation in relation to the concerns pertinent to this case, with specific emphasis on aspects such as medication management and record-keeping practices. She said that there is a high risk of repetition of these issues, particularly in light of your limited insight into your own actions and your persistent denial of the majority of charges brought against you. She said that it is notable that during this process, you acknowledged the inappropriateness of your dishonesty. However, Ms Saran stated that in your response, there is a discernible inclination to attribute responsibility to others for your own professional shortcomings.

In conclusion, Ms Saran submitted that you have failed to adequately display remorse for your actions. This includes both the substantial risks to which patients were subjected and the broader implications of your behaviour on the reputation of the nursing profession as a whole. The totality of these circumstances highlights a significant challenge to your capacity to continue to practice as a nurse in a manner that upholds the requisite standards and competence expected of a registered nurse.

In making limited submissions at the impairment stage, you stated that you did not intentionally cause harm to anyone and that you never wanted any of this to happen. Further, you said that it is very difficult for you to know that your actions could have harmed patients. You said that you are very sorry for what had happened. At the conclusion of giving your evidence, you agreed that your fitness to practise is impaired and that you should not practise without restrictions.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Rylands v General Medical Council.* [1999] Lloyd's Rep Med 139, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Grant.*

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 considered each of the misconduct charges (6, 7, 8, 9, 11, 12, 13, 14, 15 in part, 16 in part, and 17) both individually and collectively.

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

In relation to charges 6, 11, 13 and 14:

'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

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

In relation to charges 7, 8, 9 12:

‘20 Uphold the reputation of your profession at all times

> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment and*
>
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people’*

In relation to charges 15 in part, 16 in part and 17:

‘20 Uphold the reputation of your profession at all times

> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.’*

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 your actions were a serious departure from the standards expected of a registered nurse.

The panel has concluded that your actions constituted serious professional misconduct. This misconduct occurred over an extended duration, further amplifying its significance, and was further compounded by the presence of dishonesty.

Decision and reasons on lack of competence

When determining whether the facts found proved in charges 1-5 amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

The panel considered the lack of competence charges 1, 3, 4, 5a, 5b, 5c, 5e, 5f, 5g, 5h, 5i, 5j, 5l, 5n, 5o both individually and collectively. It determined that all the charges, apart from 5j, amounted to a lack of competence.

In relation to charges 1, 2, 3, 4, and 5 ,apart from 5j:

'*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

3 Make sure that people's 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'

In relation to charges involving record keeping:

'*10 Keep clear and accurate records relevant to your practice*

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

To achieve this, you must:

10.1 complete all 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'

In relation to charge 3:

'10 Keep clear and accurate records relevant to your practice

10.5 take all steps to make sure that all records are kept securely, and

10.6 collect, treat and store all data and research findings appropriately.'

In relation to charge 5j:

'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.'

The panel considered that charge 5j was a breach of the Code but did not deem it serious enough to amount to lack of competence.

The panel bore in mind, when reaching its decision, that you should be judged by the standards of an average Band 5 registered nurse. Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was of an unacceptably low standard of performance. This was judged on a fair sample of your work over a number of years and highlighted competence issues in areas such as: failure to visit a number of patients; not following procedures; issues with medicine management, record keeping, care planning, wound and skin care and care of diabetic patients. All of this had the potential to put patients at risk of harm.

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

Decision and reasons on impairment by misconduct and/or by lack of competence

The panel next went on to decide if as a result of the misconduct and/or lack of competence, your 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 limbs a-d are engaged. Patients were put at risk of harm as a result of your misconduct and lack of competence and that you had breached the fundamental tenets of the nursing profession. Therefore, you brought the reputation of the nursing profession into disrepute.

The panel already had determined that you have acted dishonestly due to your intention to mislead others. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not regard charges relating to dishonesty as extremely serious.

The panel had regard to the case of *Cohen* and considered whether the misconduct identified is capable of remediation, whether it has been remedied and whether there is a risk of repetition.

The panel noted that you stated you are currently not safe to practise without restrictions. It considered that the lack of competence issues are capable of being addressed but there is no evidence before the panel which demonstrates you had remedied the concerns identified or that you have taken steps to strengthen your practice.

The panel had sight of your Learn Pro training certificates and determined that these were not relevant to the issues raised by the charges and have not remedied the concerns. The panel has also received and noted a positive testimonial from your current Line Manager, concerning your performance in a Band 2 role.

The panel noted that your insight into the misconduct is limited as you partially admit your shortcomings but still tend to blame others at times for your failures. Moreover, given the absence of sufficient insight into your misconduct and lack of competence, the panel is of the view that you are liable, in future, to put patients at unwarranted risk of harm, breach fundamental tenets of the profession, bring the profession into disrepute and act dishonestly.

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

The panel therefore found that your fitness to practise is currently impaired on the grounds of public protection. In addition, it determined that public confidence in the nursing profession and in the NMC as the regulator would be undermined if a finding of impairment were not made.

Having regard to all the above, the panel was satisfied that your fitness to practise is currently impaired on the grounds of both public protection and also in the wider public interest in relation to your misconduct and lack of competence.

Sanction

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

Ms Saran informed the panel that, in the Notice of Hearing, dated 19 January 2023, the NMC advised you that it would seek the imposition of a striking-off order if the panel found your fitness to practise is currently impaired.

Ms Saran submitted that the NMC is seeking a striking-off order because your conduct fell so seriously below the standard expected of a registered nurse, that it is fundamentally incompatible with remaining on the NMC register.

Ms Saran apprised the panel of earlier incidents in 2015, wherein you were the subject of a local investigation for concerns of a similar nature to those currently under the panel's consideration. She noted that during this episode, you did not visit two patients and inaccurately documented the notes of another patient. An explanation for these incidents was not provided by you, resulting in a first and final written warning for a duration of 12 months. Ms Saran submitted that these instances from 2015, together with your recent dishonesty, shows it was not an isolated incident but revealed deep-seated attitudinal issues and demonstrated a pattern of behaviour.

Ms Saran submitted that your misconduct was further compounded by instances of serious dishonesty by deliberately covering up clinical failings. These encompassed situations where you had not visited patients as required, printed-off patient notes without proper authorisation, and documented you had directed patients to other services when you had not. She stressed that you had attempted to attribute your failures to colleagues and patients, specifically noting your efforts to mislead colleagues in relation to your care of Patient A, over a prolonged period of time.

Addressing the topic of remediation, Ms Saran pointed out the absence of any evidence in this regard. You provided only one testimonial from your current line manager, which failed to address the concerns relating to dishonesty and trustworthiness.

Ms Saran submitted that your misconduct and lack of competence had exposed patients to risk of significant harm. She stated that a conditions of practice order would fall short of safeguarding the public and addressing the public interest. She further submitted that such an order would not be sufficient to maintain public confidence in the profession. She said that your recent behaviour in relation to capability programmes and the breach of the

interim conditions of practice order, indicated a lack of willingness to adhere to or comply with conditions, rendering them unworkable and inappropriate.

Ms Saran concluded that a suspension order would not adequately address the seriousness of the proven misconduct and lack of competence. She noted the extensive and wide range of clinical failings, further exacerbated by a prolonged period of deliberate dishonesty aimed at misleading colleagues, which in turn posed a significant risk to several patients. Ms Saran submitted that there is evidence to demonstrate a pattern of dishonest behaviour and deep-seated attitudinal issues.

Ms Saran further submitted that the most suitable course of action would be to impose a striking-off order, to mark the severity of your misconduct. She therefore invited the panel to consider imposing a striking-off order.

In your address to the panel, you shared that your life had undergone considerable upheaval since 2015. You acknowledged your responsibility for the mistakes you had made while maintaining your innocence on certain matters. You described being bullied by colleagues and facing difficulties in your personal life since 2015. You expressed remorse for your actions, and stated your willingness to accept any sanctions deemed appropriate by the panel.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Previous disciplinary findings in 2015 which are of a similar nature to the current practice concerns being considered by the panel.
- Lack of insight into your failings.
- A discernible pattern of misconduct over a prolonged period of time, spanning from December 2018 to December 2021.
- Your misconduct placed patients at risk of significant harm which was exacerbated by consistent dishonesty.

The panel also took into account the following mitigating features:

- A difficult and challenging working environment in which support provided was, at times, variable.
- [PRIVATE]
- Personal hardship in your family life spanning from 2015 up until present day.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of its findings on facts and impairment. 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 its findings on facts and impairment, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where:

> *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that your misconduct and lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of its findings on facts and impairment. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case. The misconduct identified in this case was not something that can be addressed through retraining as dishonesty is difficult to address via the imposition of conditions. Moreover, the panel noted that your variable level of compliance with capability programmes, as well as your recent breach of the interim conditions of practise order, demonstrates your inability to comply with such an order. Furthermore, the panel concluded that the placing of conditions on your 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 a 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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

Your conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the incidents were not isolated given that these were numerous, took place over a prolonged period of time and had the potential to put patients at significant risk of harm. The panel also determined that there are attitudinal issues. The panel determined that in the absence of sufficient insight or strengthened practice, it was not satisfied that the facts found proved will not be repeated.

For these reasons, the panel determined that a suspension order would not be a sufficient, appropriate, or proportionate sanction.

Finally, in considering 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 also took account of the NMC guidance: 'How we determine seriousness' and the three broad categories of factors which may indicate the seriousness of a case as follows:

- *'Serious concerns which are more difficult to put right*
- *Serious concerns which could result in harm to patients if not put right*

- *Serious concerns based on the need to promote public confidence in nurses, midwives, and nursing associates'*

Your misconduct consisted of significant departures from the standards expected of a registered nurse and is fundamentally incompatible with you remaining on the NMC register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and are difficult to put right and to allow you to continue practising would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

The panel determined that your conduct raises fundamental questions about your nursing abilities, professionalism, honesty, and integrity. The regulatory concerns are multiple, wide ranging and occurred over a prolonged period of time. Having regard to the guidance reproduced above, the misconduct is serious and created real risk of harm to the patients involved.

Having regard to your misconduct including the dishonesty elements, the panel was of the view that you presented a risk to the public should you continue practising at this time. In addition, because of your failings and dishonesty, a more serious sanction is justified in this case in order to declare and uphold proper standards and maintain public trust and confidence in nurses, midwives, and nursing associates.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

The panel considered that this order is 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 decision will be confirmed to you 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 is in your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Saran. She submitted that an interim suspension order is necessary to cover the period until the striking-off order comes into effect having regard to the panel's findings. Ms Saran submitted that if you appeal the decision of the panel, then you would be able to practice without restrictions until the appeal process is finished.

Decision and reasons on interim order

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

The panel concluded that 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.

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

That concludes this determination.