Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday, 10 November 2023

Virtual Hearing

Name of Registrant:	**Grace Bempong**
NMC PIN	03H0424O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 7 August 2003
Relevant Location:	Glasgow
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Marcia Levene Smikle (Registrant member) Adrian Blomefield (Lay member)
Legal Assessor:	Michael Levy
Hearings Coordinator:	Margia Patwary
Nursing and Midwifery Council:	Represented by Bianca Huggins, Case Presenter
Miss Bempong:	Not present and represented at the hearing by Tracey Lambert, instructed by UNISON
Consensual Panel Determination:	Accepted
Facts proved by admission:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 2a, 2bai, 2baii, 2baiii, 3a, 3b, 3ci, 3cii, 4ai, 4aii, 4aiii, 4b
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, on 31 October 2018:

1) In respect of Patient A
   a) Failed to properly complete the NEWs chart by tallying the NEWs score;
   b) Did not sign the NEWs chart;
   c) Left the completion of the NEWs chart to a newly qualified nurse who had sought your assistance;
   d) Failed to verbally inform the newly qualified nurse of the oxygen saturation level;
   e) Failed to escalate Patient A's deterioration to a medical team in accordance with the NEWs local escalation policy;
   f) Failed to carry out and/or instruct others to carry out hourly observations on Patient A after the observations at 13.25.

2) Did not hand over Patient A's condition to the night shift:
   a) Verbally;
   b) When making the 5pm entry in Patient A's clinical notes, by making any reference to:
   i) Patient A's condition;
   ii) Patient A's NEWs score;
   iii) Patient A's oxygen saturations.

3) In respect of Patient B:
   a) Failed to follow medical instructions to take a urine sample before administering Gentamicin;
   b) Failed to replace Patient B's catheter after administering Gentamicin;
   c) Failed to verbally inform the night shift that Patient B required:
   i) A urine sample to be taken;
   ii) The existing catheter to be replaced.

4) In respect of Patient B:

a) Failed to record on the Gentamicin chart;

i) Your signature;

ii) The date the Gentamicin was administered;

iii) The time the Gentamicin was administered;

b) Failed to ensure that a second person/checker signed the Kardex for the administration of Gentamicin.

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

Consensual Panel Determination

At the outset of this hearing, Ms Huggins, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Miss Bempong.

Ms Huggins summarised the agreed CPD and referred the panel to the NMC guidance on considering consensual panel determinations, reference DMA-2. She submitted it is a matter for the panel to agree the CPD before it.

Ms Lambert, on behalf of Miss Bempong informed the panel that she remains to be employed by her employer, who had initially referred her to the NMC. Miss Bempong is currently employed as a Band 3 Healthcare Assistant and her employer is willing to work with her on a development programme to assist her to working as a registered nurse. Ms Lambert asked the panel to consider recommendations that a future reviewing panel would be assisted by.

Ms Lambert invited the panel to accept the CPD as this would allow Miss Bempong to comply with the recommendations.

The agreement, which was put before the panel, sets out Miss Bempong's full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a suspension order for a period of 12 months with a review.

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

That provisional CPD agreement reads as follows:

The Nursing & Midwifery Council ("the NMC") and Miss Grace Bempong ("Ms Bempong"), PIN 03H0424O ("the Parties") agree as follows:

1. *Ms Bempong is aware of the CPD hearing. Ms Bempong does not intend on attending the hearing and is content for it to proceed in her and her representative's absence. Ms Bempong and/or her representative will endeavour to be available by telephone should clarification on any point be required, or should the panel wish to make other amendments to the provisional agreement.*

The charge

2. *Ms Bempong admits the following charges:*

"That you, a registered nurse, on 31 October 2018:

1) In respect of Patient A

a) Failed to properly complete the NEWs chart by tallying the NEWs score;
b) Did not sign the NEWs chart;
c) Left the completion of the NEWs chart to a newly qualified nurse who had sought your assistance;
d) Failed to verbally inform the newly qualified nurse of the oxygen saturation level;
e) Failed to escalate Patient A's deterioration to a medical team in accordance with the NEWs local escalation policy;
f) Failed to carry out and/or instruct others to carry out hourly observations on Patient A after the observations at 13.25.

2) Did not hand over Patient A's condition to the night shift:
a) Verbally;

b) When making the 5pm entry in Patient A's clinical notes, by making any reference to:

i) Patient A's condition;

ii) Patient A's NEWs score;

iii) Patient A's oxygen saturations.

3) In respect of Patient B:

a) Failed to follow medical instructions to take a urine sample before administering Gentamicin;

b) Failed to replace Patient B's catheter after administering Gentamicin;

c) Failed to verbally inform the night shift that Patient B required:

i) A urine sample to be taken;

ii) The existing catheter to be replaced.

4) In respect of Patient B:

a) Failed to record on the Gentamicin chart;

i) Your signature;

ii) The date the Gentamicin was administered;

iii) The time the Gentamicin was administered;

b) Failed to ensure that a second person/checker signed the Kardex for the administration of Gentamicin.

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

Background

3. *Ms Bempong appears on the register of nurses, midwives and nursing associates maintained by the NMC as an Adult Registered Nurse (RN1) and has been on the NMC register since 2003.*

4. *In 2004, Ms Bempong began working as a nurse at Queen Elizabeth University Hospital ("the Hospital"), NHS Greater Glasgow and Clyde ("the Trust").*

5. *On 27 August 2015 following internal disciplinary proceedings, Ms Bempong was issued with a first and final warning for 18 months by the Trust, for failing to provide appropriate care to a patient who fell and hit his head during Ms Bempong's shift on 16 January 2015 and subsequently died. Ms Bempong did not escalate the patient to a doctor, did not take observations, failed to complete care round records and did not complete the documentation around falls. Ms Bempong was placed on a competency plan which she completed successfully on 17 May 2016. As part of the competency plan, Ms Bempong undertook a course on escalating deteriorating patients in February 2016.*

6. *On 10 November 2017, following local disciplinary proceedings, Ms Bempong was issued with a further first and final warning for 12 months for a lack of patient care in respect of 4 patients on a nightshift of 7 – 8 June 2017. Ms Bempong made a number of errors which included failing to administer antibiotics as prescribed, not escalating a deteriorating patient, not taking observations as required, making inaccurate and inadequate clinical records and not carrying out active care as required.*

7. *On 4 September 2017, Ms Bempong attended a second workshop on the recognition of deteriorating patients.*

8. *Both the two previous incidents outlined above, involved poor patient care including Ms Bempong's failure to escalate deteriorating patients, to conduct observations and inaccurate/inadequate record keeping. The parties agree that these previous matters are relevant to the current concerns raised against Ms Bempong as the regulatory charges faced by Ms Bempong are for similar matters. Ms Bempong does not face regulatory charges for these matters as they were suitably dealt with a local level in 2015 and 2017.*

9. *Ms Bempong was referred to the NMC on 14 August 2019 by AC, Assistant Chief Nurse/Midwife, Professional Governance and Regulation Team, the Trust.*

10. *The referral relates to Ms Bempong's care of Patients A and B on 31 October 2018. At that time, as set out above, Ms Bempong was subject to a live disciplinary warning in respect of like conduct.*

11. *The matters which form the basis of the referral, were investigated at a local level. At a disciplinary hearing held on 30 May 2019, Ms Bempong was down-graded to a Band 2 Health Care Support Worker. Ms Bempong appealed this decision but her appeal was unsuccessful.*

12. *Ms Bempong remains employed by the Trust as a Health Care Support Worker and is now a Band 3 Health Care Support Worker.*

The facts relating to Charges 1 and 2 (Patient A)

13. *On 31 October 2018, Ms Bempong was working a day shift (07:15-19:30) on Ward 55 at the Hospital. Ward 55 is an elderly care ward and caters for about 30 patients. Patient A had been admitted to the Hospital on 30 October 2018 with dyspnoea (shortness of breath) and general decline. Patient A had a medical history of heart failure and pulmonary oedema (a condition in which too much fluid accumulates in the lungs, interfering with a person's ability to breathe normally) and was receiving oxygen via a nasal cannula.*

14. *Ms Bempong failed to provide appropriate care to Patient A whose oxygen saturation levels had declined from 96% when checked at 08:20, to 84% when checked at 13:25. Ms Bempong did not tally the NEWs score nor sign the NEWs chart which she left to a newly qualified nurse who had sought her assistance. The decline in saturation levels apparent at 13.25 should have triggered hourly observations and an escalation to a doctor for review, however no further observations were conducted by Ms Bempong and she did not instruct others to carry out observations. Further Ms Bempong did not escalate this deterioration to a doctor who should have been informed of the low oxygen saturation and high respiratory rate.*

15. *Further, Ms Bempong failed to hand over Patient A's condition to the night shift nor did she make make any reference on Patient A's clinical notes in the 5pm entry, of Patient A's condition, the NEWs score or oxygen saturation levels. Patient A subsequently deteriorated further and unfortunately passed away. The NMC have not obtained any evidence to suggest that Ms Bempong's actions resulted in or caused the death of Patient A.*

The facts relating to Charges 3 and 4 (Patient B)

16. *During the same shift, Ms Bempong was instructed to undertake the following actions in respect of Patient B who had signs of a possible infection: take a specimen of urine, change the catheter and administer a dose of Gentamicin (intravenous antibiotic) in that specific order. Ms Bempong administered the gentamicin but did not obtain a counter signature as per the protocol for all IV medications or record the time this medication was administered. In addition, Ms Bempong did not take a urine sample prior to administering the gentamicin and the existing catheter was not replaced. Nor did Ms Bempong verbally inform the night shift that a urine sample was required from Patient B and the existing catheter required replacement.*

17. *In the Case Management Form dated 25 July 2023, Ms Bempong admits the charges and current impairment.*

Misconduct

18. *Ms Bempong has admitted the regulatory charges and accepted that her fitness to practice is impaired by reason of her misconduct.*

19. *The comments of* ***Lord Clyde in Roylance v General Medical Council [1999] UKPC 16*** *may provide some assistance when considering what could amount to misconduct:*

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

20. *Further assistance may be found in the comments of* ***Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin)*** *and* ***Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin)****:*

    "[Misconduct] connotes a serious breach which indicates that the [nurse's] fitness to practise is impaired"
    and
    "The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners".

21. *The Parties agree that Ms Bempong's misconduct is serious and falls far short of what is expected of a registered nurse. The misconduct is a serious departure from expected standards and risks causing harm to the public and bringing the*

nursing profession into disrepute. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional.

22. *At the relevant time, Ms Bempong was subject to the provisions of* ***The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*** *("the Code"). The Parties agree that the following provisions of the Code have been breached in this case;*

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*

8. Work co-operatively

To achieve this, you must:

8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

8.2 *maintain effective communication with colleagues*

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

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

8.6 *share information to identify and reduce risk*

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

To achieve this, you must:

9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

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

To achieve this, you must:

11.1 *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

23. *Ms Bempong did not escalate Patient A's deterioration to a medical team in accordance with the NEWs local escalation policy and did not carry out and/or instruct others to carry out hourly observations on Patient A after the observations at 13.25. Furthermore, Ms Bempong did not properly complete the NEWs chart in that she did not record the NEWs score for Patient A and did not sign the NEWs chart. Ms Bempong left the completion of the NEWs chart to a newly qualified nurse who had sought Ms Bempong's assistance and she did not inform the newly qualified nurse of Patient A's oxygen saturation level. Ms Bempong failed to handover , Patient A's deteriorated condition to the night shift either verbally or by recording it in patient's notes along with Patient A's NEWs score and oxygen saturation. All of these actions of Ms Bempong could have caused serious harm to Patient A.*

24. *The parties agree that these failures in care fell far below the standards set out in the Code of Conduct identified above.*

25. *Ms Bempong did not follow medical instructions to take a urine sample from Patient B before administering Gentamicin to that patient. After administering Gentamicin to Patient B, Ms Bempong did not replace Patient B's catheter. Furthermore, Ms Bempong did not verbally inform the night shift colleagues that a urine sample was required from Patient B and that this patient's catheter had to be replaced. Ms Bempong did not record on Patient B's Gentamicin chart any of the following information: her signature, the date the Gentamicin was administered to Patient B and the time the Gentamicin was administered to that patient. Ms Bempong also did not ensure that a second person/checker signed the Kardex for the administration of Gentamicin to Patient B. All of this could have caused serious harm to Patient B.*

26. *The parties agree that these failures, too, fell far below the standards expected of a registered nurse and breach those parts of the Code of Conduct identified above. The parties agree that Mrs Bempong's actions, individually and collectively, amount to serious professional misconduct.*

Impairment

27. *Ms Bempong accepts and the Parties agree that her fitness to practise is currently impaired by reason of her misconduct.*

28. *Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. It is therefore imperative that nurses make sure that their conduct at all times justifies both their patients' and the public's trust in them and in their profession.*

29. *In addressing impairment, the Parties have considered the factors* ***outlined by Dame Janet Smith in the Fifth Shipman Report and approved by Cox J in the case of CHRE v Grant & NMC [2011] EWHC 927 (Admin)*** *("Grant"). A summary is set out in the case at paragraph 76 in the following terms:*

"Do our findings of fact in respect of the [nurse'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 [nursing] 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 [nursing] profession; and/or*
d. *has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

30. *The panel should also consider the comments of Cox J in Grant at paragraph 101:*

"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."

31. *The Parties agree that limbs a), b) and c) as identified in the above case, are engaged. Dealing with each limb in turn:*

Public Protection

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

32. *In accordance with* ***Article 3(4) of the Nursing and Midwifery Order 2001*** *("the Order") the overarching objective of the NMC is the protection of the public.*
33. *The Order states:*

The pursuit by the Council of its overarching objective involves the pursuit of the following objectives-

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

34. *The case of Grant makes it clear that the public protection must be considered paramount and Cox J stated at para 71:*

"It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public .."

35. *Whilst there is no evidence that Ms Bempong's actions actually caused harm to the patients in question, the course of conduct in respect of all the regulatory charges put both Patients A and B at unwarranted risk of harm.*

36. *Further, Ms Bempong's actions on 31 October 2018, are to be viewed within the context of Ms Bempong having previously undergone local disciplinary proceedings for providing similar poor patient care in both 2015 and 2017. This is relevant because Mrs Bempong knew the standard of care that was expected of her towards patients in a similar situation but did not act accordingly.*

Public Interest

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

37. *Registered professionals occupy a position of trust in society to be responsible for the care of residents or patients. Ms Bempong repeatedly failed to provide adequate patient care despite two previous formal warnings for concerns of a similar nature and despite previously successfully completing a competency plan and relevant training. At the time of the concerns about Ms Bempong's provision of clinical care to Patients A & B, she was still subject to a 12 month disciplinary warning following one of the previous disciplinary matters mentioned above. This directly constitutes a breach of the trust placed in Ms Bempong as a registered professional.*

38. *The Parties agree that such behaviour not only brought Ms Bempong's reputation into disrepute, but also that of the wider profession. This in turn undermined the public's confidence in the profession as a whole.*

Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession

39. *The Code divides its guidance for nurses into four categories which can be considered as representative of the fundamental principles of nursing care. These are:*
    a) *Prioritise people;*
    b) *Practise effectively;*
    c) *Preserve safety and*
    d) *Promote professionalism and trust*

40. *The Parties have set out above, how, by identifying the relevant sections of the Code, Ms Bempong has breached fundamental tenets of the profession. These sections of the Code define, in particular, the responsibility to promote professionalism and trust.*

Remediation, reflection, training, insight, remorse

41. *NMC guidance adopts the approach of* ***Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin)*** *by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

42. *The Parties have also considered the NMC's guidance entitled* ***'Insight and strengthened practice' (FTP-13****) states, "Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their*

practice will usually be central to deciding whether their fitness to practise is currently impaired".

43. *In her response to the Case Examiners, Ms Bempong provided a reflective statement received by the NMC on 4 February 2022 in which she set out the circumstances that led to inadequate care provided to Patient A. In this statement, Ms Bempong admitted to her failures and put forward some mitigation. She stated:*

"On that day in question l was working with LS but the ward manager KC moved her to the Victoria ACH upon the instructions of the Lead nurse. Before she left she made me aware that the patient in room 5 (side room) was unwell and the doctor was with her and l have to monitor her. The doctor prescribed intravenous antibiotic for her which was administered. And l was constantly monitoring her leaving the six patients in the six bedded room, of whom one was re -admitted with recurrent falls and head injury who needed one on one care which was not provided.

There was also a patient in room 9 bed 4 who was for discharge home on that day and was sitting beside her bed. Whilst l was organising her discharge LB declared the bed empty without my knowledge because she was in charge that day.

Another patient was brought in with head injury her and her husband was with her so l questioned LB about that as to why two patients be admitted for one bed and she said l should move the patient for discharge to the table to watch television but the patient refused to move so there was restriction to the entrance to the toilet. I had no choice than to continue to organise an ambulance, home help medication and all the discharge plans.

But before LS was moved LB moved her to her side to help her to move an unwell patient to one of the side rooms, so l was struggling on my own. K.C when going home told me that she will send somebody to come and help me but nobody (sic). She also told me to ask DB to come and help me but l asked him and he refused to come and help me claiming he can't be everywhere.

I was overwhelmed as l was constantly going back to make sure the patient in room 9 bed 1 was safe as she was wandering around. The patient who was in room 9 bed 5 was unwell and was seen by the doctor and was on intravenous potassium.

L S was doing the observation and was struggling with it so she called me to help which l did but did not complete the news chart as l thought LS would continue it because l was in the middle of doing the medication rounds.".

44. Ms Bempong further stated:

"In addition to my reflection, l sincerely regret my actions on that day and sincerely apologise and will not repeat it given the opportunity to practise.

In future what l would do differently to avoid repetition is to flag with my superior immediately if there is an unsafe level of staff."

45. Ms Bempong's representative provided the following response to the NMC on 8 October 2019:

"Grace wished to apologise to the patients, the employer and the NMC for any failures or omissions.
Grace can demonstrate insight into the events that took place. In future Grace will make sure the staffing levels are safe and if any of her team are moved she will challenge if required and complete a datix.

Grace is aware of the importance of completing all documentation.

Grace is in the process of updating her Learn Pro Modules.

The employer has sent Grace on an Adult Life Support Training. Grace will continue to fully engage with the NMC at every level."

46. Ms Bempong has provided evidence of Continuous Professional Development in terms of training between 2015 and 2023. Of relevance is that Ms Bempong completed training in Urinary Catheterisation, Catheter Care Management and Collecting a Urine Sample on 12 July 2018, approximately 3 months prior to her failure to take a specimen of urine from Patient B or change the catheter on 31 October 2018.

47. In respect of training subsequent to 31 October 2018 and Ms Bempong becoming a Health Care Support Worker in May 2019, Ms Bempong has completed the following Continuous Professional Development courses:

- *Health Care Support Worker Code of Conduct on 22 February 2021*
- *Outbreaks in Healthcare Settings on 31 August 2023*
- *Prevention of Pressure Ulcers on 10 February 2023*
- *Food Hygiene on 7 July 2023*
- *Segregation of Waste and Linen on 21 February 2023*
- *Discharge on 21 February 2023*
- *Breaking the Chain of Infection on 14 September 2023*
- *Why Infection Prevention and Control Matters on 11 September 2023*
- *Quality Improvement Fundamentals on 21 February 2021.*

48. Ms Bempong has completed the following role specific mandatory modules since becoming a Health Care Support Worker in May 2019:

- *Management of Needlestick and Similar Injuries on 21 February 2023*
- *An Introduction to Falls on 1 February 2023*

- *The Falls Bundle of Care on 8 February 2023*
- *Risk Factors for Falls (Part 1) on 8 February 2023*
- *Risk Factors for Falls (Part 2) on 1 February 2023*
- *What to do when your patient falls on 1 February 2023*
- *Bedrails on 21 February 2023*
- *NEWS2 on 15 August 2020*

49. Ms Bempong has completed the following statutory/mandatory courses:

- *Fire Safety on 23 May 2023*
- *Health and Safety, an Introduction on 19 August 2021*
- *Reducing Risks of Violence and Aggression on 20 August 2021*
- *Equality and Human Rights on 21 August 2021*
- *Manual Handling Theory on 12 August 2021*
- *Public Protection (Adult & Child) on 19 August 2021*
- *Standard Infection Control Precautions on 23 November 2020*
- *Security and Threat on 19 August 2021*
- *Safe Information Handling on 21 February 2021*

50. On 18 October 2023 the NMC received a further reflection by Ms Bempong in which she states:

"Background

Until 30th May 2019 I was employed by Greater Glasgow and Clyde NHS Trust as a Registered Nurse , following two disciplinary hearings I was demoted to the post of a Health Care Assistant Band 3 . I remain employed by the Trust in this position .

I fully accept the regulatory concerns and that my practise fell short of what is expected of a Registered Nurse , I accept what went wrong and that my current fitness to practise is impaired .

What have I learnt

Following the disciplinary hearings and the NMC investigation I have reviewed my practise , through reviewing the concerns , research , training and reading .

I have learnt that the NMC code confirms to registrants the requirements of a registrant in maintaining patient records .

What does the NMC code say about record keeping?

You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice. This applies to the records that are relevant to your scope of practice.29 Jan 2015

In addition, from reviewing and reading the NMC Guidelines for Good Record Keeping (2009)I have learnt that without clear and accurate records my actions have an effect on not only my patients but my colleagues working with me in the multi-disciplinary team . The NMC guidelines state that all records must be recorded in a timely manner and must be clearly written and permanent. They must also be factual, consistent, and clear . Every entry into the patients notes regardless of which member of the multidisciplinary team has written it must all be dated, timed, and signed with printed name and designation. If the individual has made an error, they should never use correction fluid it should be singly scored, dated, timed and signed .

The Nursing and Midwifery Council believes the record keeping is an integral and fundamental part of the nursing career. (NMC,2010) Record keeping is a multidisciplinary approach and a professional tool which helps to assist in the caring process. Diamond States that all records must be kept but principle as part of the duty of care owed to the patient not for the protection of members of the multidisciplinary team. (Diamond, B, 2005)

I accept that my actions and record keeping at the time of the regulatory concerns could be seen as me not being sufficiently patient focussed . On reflection , I acknowledge that good patient records promote good patient care, and I am striving to achieve this through my current role . Good record keeping promotes a high standard for care as it suggests that the nurse is a safe and skilled practitioner with good communication who involves the patient in the discussions with other healthcare professionals. It is an integral and important part of my role as a nurse. Good record keeping also provides an accurate account of care planning and delivery of care for each patient and may also provide a means of detecting a change in the patient's condition early.

I fully understand and accept that my role as a RN and as a HCA requires this approach to record and maintain accurate patient records.

It is my responsibility to do so and by complying with these requirements my standard of care and that of the wider team will improve and provide the best care for our patients .

ACTION PLAN

My plan is based on the following four action points.

1. Individuals should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing care, including any details of information given about care or treatment.

2. Records should be accurate and recorded in such a way that the meaning is clear.

3. Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.

4. Individuals have a duty to communicate fully and effectively with colleagues, ensuring that they have all information they need about the people in their care.

I will work towards meeting these goals through further training , reviewing, and improving my current practise. Working as a collaborative team member with my colleagues .

Grace Bempong

October 2023"

51. *The parties agree that Mrs Bempong has demonstrated remorse for her conduct. Whilst there is evidence of some insight from Ms Bempong, the Parties agree that this insight is limited as her reflection does not fully address the impact of her actions on patient safety more widely than accurate recordkeeping, nor does it address the importance of patient safety or deal with the necessity of escalating deteriorating patients.*
52. *Whilst Ms Bempong has provided a list of the Continuous Professional Development activities and training completed as set out above, in terms of training relevant to the areas of misconduct, Ms Bempong completed a course on NEWS2 on 15 August 2020. This was role specific and therefore, whilst relevant, was based on the role of a Health Care Support Worker rather than that of a registered nurse.*

53. *The Parties agree that Ms Bempong's insight requires further and fuller development and that further training should be undertaken to remediate the concerns and demonstrate safe practice. The Parties therefore agree that the concerns in this case have not been remedied and as such it cannot be said that it is highly unlikely that the conduct will be repeated. Therefore in light of these factors and previous disciplinary warnings for Ms Bempong's failings of a similar nature, her practice currently poses a risk to health, safety and wellbeing of patients.*

Public protection impairment

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

Public interest impairment

55. A finding of impairment is also necessary on public interest grounds.

56. In ***CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin****) Cox J commented as follows:*

"71. It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations… namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession …
74. In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

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

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

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

59. The Parties agree Ms Bempong's fitness to practise is impaired on public protection and public interest grounds.

Sanction

60. In accordance with the Order, the overarching objective of the NMC is the protection of the public.

61. Whilst sanction is a matter for the panel's independent professional judgement, the Parties agree that a 12 months' suspension order with a review is the most appropriate and proportionate sanction.

62. In reaching this agreement, the Parties considered the ***NMC's Sanctions Guidance****, bearing in mind that it provides guidance and not firm rules. The panel will be aware that the purpose of sanctions is not to be punitive but to protect the public and satisfy public interest. The panel should take into account the principle of proportionality and it is submitted that the proposed sanction is a*

proportionate one that balances the risk to public protection and the public interest with Ms Bempong's interests.

63. *The aggravating features of this case have been identified as follows:*

a) *Previous disciplinary findings at Trust level in respect of similar concerns.*
b) *Being subject to a disciplinary written warning in respect of similar concerns at time of later incident.*
c) *Conduct which put patients at risk of suffering harm.*

64. *The mitigating features of this case have been identified as follows:*
    a) *Some insight.*
    b) *Early admissions and has expressed remorse*

65. *Considering each sanction in turn, starting with the least restrictive:*

66. ***Taking no action or a caution order*** *- The NMC's guidance (SAN-3a and SAN-2b) states that it will be rare to take no action where there is a finding of current impairment and this is not one of those rare cases. The seriousness of the misconduct means that taking no action would not be appropriate. There is a pattern of poor patient care given the 2015 and 2017 disciplinary written warnings in relation to similar concerns. Therefore there is evidence of repetition.*

67. *For the reasons stated above a caution order would also not be in the public interest nor mark the seriousness and would be insufficient to maintain high standards within the profession or the trust the public place in the profession.*

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

- *no evidence of harmful deep-seated personality or attitudinal problems*
- *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
- *no evidence of general incompetence*
- *potential and willingness to respond positively to retraining*
- *the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
- *patients will not be put in danger either directly or indirectly as a result of the conditions*
- *the conditions will protect patients during the period they are in force*
- *conditions can be created that can be monitored and assessed.*

69. *There is no evidence of Ms Bempong displaying any harmful, deep-seated, personality or attitudinal concerns or general incompetence behind the misconduct. However, the Parties agree that the circumstances in which the misconduct occurred took place against a background of Ms Bempong have previously received two disciplinary written warnings regarding previous concerns of similar nature. The fact that the more recent misconduct appears to be a repetition of the previous failures seriously aggravates the position. A conditions of practice order focussed on record-keeping, assessment / observation and escalation may ordinarily have been appropriate were this conduct to have occurred on one isolated shift in October 2018 only; however this is the third occasion upon which Ms Bempong has provided poor patient care and failed to escalate a deteriorating patient and as detailed above, Ms Bempong was still subject to a written warning in October 2018 for similar matters involving poor patient care.*

70. Furthermore, Ms Bempong had previously undertaken further training upon recognition and escalation of deteriorating patients in February 2016 and September 2017. One of the outcomes of the competency plan imposed in 2015 was to demonstrate competency in patient need and rapidly establishing deterioration in a patient's condition and responding appropriately. The action plan was successfully completed in May 2016. However despite that, Ms Bempong went on to make further errors on 7-8 June 2017 and then on 31 October 2018

71. In respect of record keeping, there were errors of this nature in 2015. Part of the competency plan then was to demonstrate high standards of record keeping. However, Ms Bempong repeated record keeping errors in the above shift in June 2017 in respect of four patients and on 31 October 2018.

72. Therefore, a conditions of practice order would not reflect the seriousness of the concerns raised, address the pattern of errors or maintain public confidence.

*73. **Suspension Order** – The Parties consider that a suspension order is appropriate and proportionate. The NMC's guidance (SAN-3d) states that a suspension order may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):*

- *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, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

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

74. *As stated above there is no evidence of Ms Bempong having any harmful, deep-seated, personality or attitudinal concerns or general incompetence behind the misconduct. However whilst the misconduct related to two patients on a single shift on 31 October 2018, there is evidence of a pattern of similar concerns given the concerns that resulted in the written warnings in 2015 and 2017.*

75. *There are no previous regulatory or disciplinary findings or evidence of prior concerns from 2003 until 2015 and 2017.*

76. *The above guidance further states:*

> *"When considering seriousness, the Fitness to Practise Committee will look at how far the nurse, midwife or nursing associate fell short of the standards expected of them. It will consider the risks to patients and to the other factors above, and any other particular factors it considers relevant on each case.*
>
> *When making a suspension order the Fitness to Practise Committee may wish to explain clearly what expectations it has, or what actions the nurse, midwife or nursing associate could take that would help a future Committee reviewing the order before it expires."*

77. Ms Bempong fell far short of the standards expected of her due to the two previous disciplinary written warnings in 2015 and 2017 for like concerns, and the fact that one of the warnings was live at the time of the most recent misconduct in October 2018. However there have been no previous regulatory findings.

78. Ms Bempong has fully engaged with the NMC process. She admitted the allegations at an early stage. She has produced a reflective statement, has acknowledged her actions were wrong and expressed remorse.

79. Both a suspension order and a striking-off order require the misconduct to be so serious that a removal from the register is justified. The difference is whether that removal is temporary or permanent. There is no doubt that the serious nature of the misconduct, which includes repetition means that a removal from the register is the only sanction sufficient to mark the seriousness.

80. The Guidance reflects that the main difference between the appropriateness of a suspension order and a striking-off order involves an assessment of whether Ms Bempong's misconduct is fundamentally incompatible with her continued presence on the register. Her conduct did not involve a deliberate breach of her duties and responsibilities, although it was longstanding as there were two instances following previous disciplinary written warnings for similar concerns. While there was a risk to patients, no patient harm was caused. Further, had Ms Bempong not engaged with the NMC and not demonstrated any insight, it may have been that her permanent removal was warranted. However it is acknowledged that the approach to sanction should always be proportionate and the least restrictive sanction that meets the objective of public protection ought to be taken.

81. The Parties agree that in this case a suspension for a period of 12 months will be sufficient to meet the objectives by providing a time period for Ms Bempong

to further reflect on her misconduct with a particular focus on her patient care, record keeping, the impact of her actions more widely and focus on associated risks.

82. The period of suspension will also make a declaratory statement that Ms Bempong's misconduct was unacceptable and that the regulator of the profession will impose severe penalties when such behaviour is brought to its attention.

83. The Parties agree that there should be a review of the order before its expiry in order to assess: whether Ms Bempong has remedied her misconduct, whether the risk of repetition has decreased and whether she has addressed other matters outlined as unresolved in this document.

*84. **Striking-Off Order** - This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. The Parties agree that a striking-off order would not be appropriate or proportionate for the reasons set out above.*

Interim order

85. An interim order is required in this case. The interim order is necessary for the protection of the public and otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event panel's decision is appealed. The interim order should take the form of an interim suspension order.

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

panel that is determining the allegation, provided that it would be relevant and fair to do so.

Here ends the provisional CPD agreement between the NMC and Miss Bempong. The provisional CPD agreement was signed by Ms Lambert on behalf of Miss Bempong's on 31 October 2023 and the NMC on 6 November 2023.

Decision and reasons on the CPD

The panel decided to accept the CPD.

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

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

Decision and reasons on impairment

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

In this respect, the panel endorsed paragraphs 18 to 26 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Miss Bempong's fitness to practise is currently impaired by reason of misconduct.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

The panel determined that Miss Bempong's fitness to practise is currently impaired in relation to both public protection and public interest. In this respect the panel endorsed paragraphs 27 to 59 of the provisional CPD agreement.

Decision and reasons on sanction

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

The panel took into account the following aggravating features agreed by both parties. However, the panel had concerns in relation to Miss Bempong's reflective piece and were of the opinion that her insight was limited and did not address her failings. Therefore the panel felt it was more of an aggravating factor than a mitigating factor.

Ms Huggins and Ms Lambert on behalf of Miss Bempong agreed to this amendment.

The panel took into account the amended following aggravating factors:

- Previous disciplinary findings at Trust level in respect of similar concerns;
- Being subject to a disciplinary written warning in respect of similar concerns at time of later incident;
- Conduct which put patients at risk of suffering harm; and
- Limited insight

The panel also took into account the following mitigating factor:

- Early admissions and has expressed remorse

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Bempong's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Bempong's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Bempong's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. However, the panel is of the view that there are no practical or workable conditions that could be formulated, in relation to the charges admitted in this case. Further, the panel concluded that the placing of conditions on Miss Bempong's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into consideration that the admitted misconduct in this case relates to clinical concerns and that there is evidence of a pattern of similar concerns that resulted in Miss Bempong being issued written warnings in 2015 and 2017 by her employer. It noted that the clinical concerns are wide ranging. It noted that Miss Bempong's conduct had the potential to put patients at risk of harm. The panel was of the view that this misconduct is serious and should properly be marked.

The panel bore in mind Miss Bempong's admissions, limited insight and initial steps to strengthen her professional practice. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Miss Bempong's case to impose a striking-off order.

Balancing all of these factors the panel agreed with the CPD that a suspension order for a period of 12 months with a review would be the appropriate and proportionate sanction.

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.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective piece on your failings which uses NMC Code as a framework to demonstrate how you intend to return to safe nursing practice;
- Copies of a personal development plan (PDP) to include reviews with your supervisor demonstrating the outcomes and providing evidence which addresses the following areas of practice:
    - Record keeping
    - Drug management and administration
    - Assessment and evaluation of and where appropriate escalation of the deterioration of patients
    - Collaborative team working
- Testimonial from your employer being very specific in respect of the areas identified in your PDP.

This will be confirmed to Miss Bempong in writing.

Decision and reasons on interim order

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

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

The panel agreed with the CPD that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential period of appeal.

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

That concludes this determination.