# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**19 – 25 and 28 - 29 April 2022,**
**6 - 15 March 2023,**
**17 - 19 October 2023**

Virtual Hearing

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| **Name of registrant:** | Reson Kuttikkat Cherunny |
| **NMC PIN:** | 18E0212O |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>RN1: Adult Nurse – 16 May 2018 |
| **Relevant Location:** | Wiltshire |
| **Type of case:** | Misconduct/Lack of competence |
| **Panel members:** | Penny Titterington (Chair, Lay member)<br>Dr Sally Underwood (Registrant member)<br>Alison Hayle (Lay member) |
| **Legal Assessor:** | Alain Gogarty |
| **Panel Secretary:** | Teige Gardner - April 2022<br>Catherine Acevedo - March and October 2023 |
| **Nursing and Midwifery Council:** | Represented by Alys Williams, Case Presenter |
| **Mr Cherunny:** | Present but unrepresented |
| **Facts proved:** | Charges 1, 2, 3a, 3b, 4b, 4c, 9a, 9b, 9c, 11, 12, 13, 14 |
| **Facts not proved:** | Charges 4a, 5, 6, 7, 8, 9d, 10 |
| **Fitness to practise:** | Impaired |
| **Sanction:** | Striking-off order |
| **Interim order:** | Interim suspension order (18 months) |

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Williams, on behalf of the Nursing and Midwifery Council (NMC), to move the preface sentence of charges 1 to 7 to just before charge 5.

It was submitted by Ms Williams that the proposed amendment would provide clarity and more accurately reflect the evidence, as she informed the panel that the SMART objectives were not in place until 11 October 2018. She told the panel that charges 1 to 4 allegedly occurred before this date.

~~*"Whilst subject to SMART objectives*~~

1) *During the week commencing 16 August 2018 took 50 minutes to complete a medication round for three patients.*

2) *During the week commencing 20 August 2018 needed prompting to complete fluid charts contemporaneously.*

3) *During the week commencing 3 September 2018;*
    a) *Were unable to provide a full handover to staff on the next shift.*
    b) *Did not escalate one or more deteriorating patients until prompted to do so.*

4) *On 26 September 2018 discharged Patient A without;*
    a) *Completing the discharge paperwork.*
    b) *Checking the medication against the electronic discharge sheet ("EDS").*
    c) *Giving them a copy of their EDS.*

*Whilst subject to SMART objectives*

5) *On a date on or around 18 October 2018 did not escalate a patient who had not had a drink or passed urine all day.*

6) *On 3 November 2018 did not prioritise Patient B who presented with a respiratory rate of five breaths per minute."*

The panel heard from submissions from you. You submitted that you agreed with the application.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Following the oral evidence from Witness 1, Ms Williams made an application to amend charge 9. She requested that the date in charge 9 be changed to include 4 January 2019.

It was submitted by Ms Williams that the proposed amendment would provide clarity and more accurately reflect the oral evidence given by Witness 1, as she informed the panel that the oral drug competency assessment took place on 4 January 2019. She submitted that, in light of this, there could be an error in the date of charge 9. She submitted that 4 January 2019 should be added to the charge to ensure there is consistency between Witness 1's oral evidence and the charge. She submitted that there would be no injustice against you if this amendment is made as you deny the charge regardless of the date.

"…

9) *On 1 January 2019 or 4 January 2019 failed an oral drug competency assessment, in that you;*
    a) *Intended to administer oral medication to Patient C who was "nil by mouth".*
    b) *Signed for the administration of suppositories to Patient D but did not administer them.*
    c) *Left the drug trolley unattended on one or more occasions.*
    d) *Were unable to explain why Allopurinol was prescribed for Patient E."*

You told the panel that you did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity, accuracy and consistency with Witness 1's oral evidence.

**Details of charge as amended**

*"That you, between 11 July 2018 and 3 January 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:*

1) *In or around August 2018 took 50 minutes to complete a medication round for three patients.*

2) *During the week commencing 20 August 2018 needed prompting to complete fluid charts contemporaneously.*

3) *During the week commencing 3 September 2018;*

a) *Were unable to provide a full handover to staff on the next shift.*
b) *Did not escalate one or more deteriorating patients until prompted to do so.*

4) *On 26 September 2018 discharged Patient A without;*
   a) *Completing the discharge paperwork.*
   b) *Checking the medication against the electronic discharge sheet ("EDS").*
   c) *Giving them a copy of their EDS.*

*Whilst subject to SMART objectives*

5) *On a date on or around 18 October 2018 did not escalate a patient who had not had a drink or passed urine all day.*

6) *On 3 November 2018 did not prioritise Patient B who presented with a respiratory rate of five breaths per minute.*

*Whilst subject to stage 1 of a performance management policy*

7) *On 10 December 2018 did not communicate effectively with a Band 2 nursing assistant about whether the 18:00 skin bundles for your patients had been completed.*
8) *On 31 December 2018 recorded that Patient F had remained continent when in fact you had not checked whether they had been continent or not.*

9) *On 4 January 2019 failed an oral drug competency assessment, in that you;*
   a) *Intended to administer oral medication to Patient C who was "nil by mouth".*
   b) *Signed for the administration of suppositories to Patient D but did not administer them.*
   c) *Left the drug trolley unattended on one or more occasions.*
   d) *Were unable to explain why Allopurinol was prescribed for Patient E.*

*10) On 8 January 2019 did not prioritise your workload.*

*11) On an unknown date did not treat a dementia patient with dignity and respect in that you left them naked on the floor.*

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

*That you, a registered nurse:*

*12) Between 3 April 2019 and 15 January 2020 knowingly worked as a nurse in breach of an interim suspension order on approximately 158 shifts.*

*13) Between 3 April 2019 and 15 January 2020 failed in your professional duty to inform your employer that you were subject to an interim suspension order.*

*14) Your conduct in Charge 13, above, was dishonest in that you knowingly concealed from your employer that you were no longer entitled to practise as a nurse so that you could continue to work as a nurse.*

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

**Application for adjournment**

When the charges were initially read out you disputed charges 1 – 11 but admitted 12, 13 and 14.

After hearing live evidence, the panel heard submissions from Ms Williams, on behalf of the Nursing and Midwifery Council (NMC). She submitted that at the end of the NMC's evidence and whilst giving your evidence you stated that you no longer admit to charges

12, 13 and 14. The panel considered your application to vacate your admissions to these charges and, having heard the advice of the legal assessor, decided in the interest of fairness to grant your application. Therefore, Ms Williams would need to call further witnesses, whose written statements had already been admitted into evidence, to give live evidence. The panel was able to hear from one NMC witness relating to these newly disputed charges, however Ms Williams informed the panel that two further witnesses are required to give live evidence. She informed the panel that these two NMC witnesses would not be able to attend this hearing to give evidence, due to the short notice. She submitted that the witnesses are willing to attend, but are unavailable this week. Ms Williams requested that the panel adjourn proceedings, as the NMC's case can go no further in the absence of these witnesses.

You did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel considered the application carefully, and determined to adjourn these proceedings to a future date in the interest of fairness to all parties. The panel took into consideration the cost and delay of adjourning proceedings, however was of the view that, in these circumstances, adjourning this hearing is the only appropriate decision.

This decision will be sent to you in writing.

**Hearing resumed on 6 March 2023**

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Williams, on behalf of the NMC, to amend the wording of charge 1.

The proposed amendment was to remove the words “During the week commencing 16” and replace with “in or around”. It was submitted by Ms Williams that the proposed amendment would provide clarity and more accurately reflect the evidence.

1) *~~During the week commencing 16~~* ***In or around*** *August 2018 took 50 minutes to complete a medication round for three patients.*

You told the panel that you were unsure if this incident happened in August.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

**Background**

The NMC received a referral concerning your fitness to practice on 8 February 2019 from Salisbury NHS Foundation Trust (‘the Trust’) relating to your time working as a registered nurse on the Whiteparish Ward (‘the Ward’). Salisbury District Hospital (‘the Hospital’).

The Ward is an endocrine and general medicine ward housing up to 23 beds for both male and female patients, generally aged 18 and above. The Ward is generally fully occupied and deals with several discharges and admissions on most days. You joined the Ward on 11 July 2018, having been working for the Trust since 22 November 2017 on the Acute Medical Unit (‘the AMU’).

You first obtained your nursing licence in India in 2008. Your role at the AMU was your first nursing role in the UK, and you obtained your UK nursing PIN whilst working there, in May 2018. You appeared not to be able to cope with the pace of the AMU and so your transfer to the Ward was arranged, initially for an eight week period, to facilitate an improvement in your clinical skills.

You were supervised during your time on the Ward by Sister, Ms 1, who carried out the majority of your supervision on shift. Senior Sister Ms 2 oversaw your progress. Broadly, it is the evidence of those witnesses on behalf of the NMC that notwithstanding the support and supervision put in place, your clinical competency did not improve. Whilst your progress was initially dealt with using the informal stage of the Trust's Performance Policy, the matter was formally escalated to Stage 1 of the formal stage on 27 November 2018, and Stage 2 on 4 January 2019. You resigned from your role at the Trust on 3 February 2019.

The regulatory concerns identified as arising from the allegations and investigated by the NMC are concerns regarding your capability in respect of medication administration, time management, record keeping, communication with colleagues and patients, and escalation of patients.

Following the Trust's referral, the NMC referred the case to the Investigation Committee for an Interim Order Hearing. On 25 March 2019 a panel of the investigation committee imposed an interim suspension order for 18 months. You were not present and were not represented at that hearing, but called the screening case officer on 3 April 2019 to say that you had received the panel's determination at your address in India.

On 16 January 2020, your employer Caring Homes Group carried out an immigration audit and noted that your PIN was subject to an interim suspension order. The NMC was informed. You had been working as a registered nurse at Laverstock Care Centre on a permanent contract of 48 hours per week since 13 February 2019. You had not informed your employers of the interim suspension order.

**Decision and reasons on facts**

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Williams on behalf of the NMC and by you.

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

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Ms 1: Sister in Adult Nursing at the Hospital;
- Ms 2: Senior Sister/Line manager at the Hospital.
- Mr 3 Senior Investigator at the NMC;
- Ms 4: Home Manager at Laverstock Care Centre;
- Ms 5: Peripatetic Manager at Laverstock Care Centre;

The panel also heard evidence from you under affirmation.

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 disputed charges and made the following findings.

**Charge 1**

> *In or around August 2018 took 50 minutes to complete a medication round for three patients.*

**This charge is found proved.**

In reaching this decision the panel took into account Ms 1's evidence and your evidence.

Ms 1 made supervisory notes of the incident which stated *"Week commencing 16th of August me and Resin spoke about his time management skills, he took 50mins to do 3 patients drugs. I made it clear to him that it is important to have all aspects of the drug round completed and get the job done well but he needs to remember that he has at least 7 patients to look after. Resin showed he understood and will try and speed up".*

The panel had regard to the employee performance management plan 'SMART' targets that were to be achieved by 31 October 2018. Target 1 'Drug administration' required you to complete the drug competencies document and to be supervised during drug rounds until all competencies were signed off. Target 2 'Time management' to complete all aspect of drug round within 1.5 hours… and be able to cover 8 patients on a morning round by 31 October 2018, indicating that this was an issue previously raised with you.

You said during your oral evidence that you took about 40 minutes to complete the medication round for three patients. You said it took this long because there were medicines which were missing from the drug trolley. You said you had to ask the pharmacist to order these medications which took some time.

The panel noted that you appear to accept that it took you longer than expected to complete a medication round for three patients. The panel preferred the evidence of Ms 1 in relation to the time it took you, as she was supervising you and had reason to note the time and record it. The panel therefore determined, on the balance of probabilities that in or about August 2018 you took 50 minutes to complete a medication round for three patients. It therefore found charge 1 proved.

**Charge 2**

> *During the week commencing 20 August 2018 needed prompting to complete fluid charts contemporaneously.*

**This charge is found proved.**

In reaching this decision the panel took into account Ms 1's evidence and your evidence.

Ms 1 said in her witness statement *"On the week commencing 20 August 2018, I spoke to Reason about his organisation skills. Reason was taking a long time to complete tasks with prompts from me. I had to ask Reason to complete paperwork as he goes along after doing spot checks and seeing he was not completing paperwork on time. I had asked Reson to prioritise his paperwork as accurate information will help protect his patients. I was having to intervene a lot to ensure to keep patients safe".*

Ms 1 also made supervisory notes of the incident nearer to the time which stated *"Week commencing 20th of August me and Reson had a conversation about his organisation skills and him needing to prioritise better as he was only taking 3 patients who did not have many things going on and still he needed me to prompt him to complete tasks, including filling out paperwork ie fluid charts as he goes along".*

You denied this charge. You said during your evidence that fluid charts are usually

handled by the carers and whoever gives the fluids records it in the notes. You said that when you give any fluid you complete the fluid chart straight away so you did not need to be prompted. You said that the carers give the fluid and they write it on a piece of paper and fill out records later in the afternoon or the end of the shift. You said that Ms 1 saw this fluid chart and blamed you but you had not been the one to give the fluid at this particular time, it was the carers who had given and not filled the fluid chart.

The panel also saw SMART objective number 4 dated 27 November 2018 which had *'keeping charts up to date… at a minimum of every drug round'* as one of the objectives indicating that this was an issue previously raised with you.

The panel found Ms 1 to be a generally reliable witness with no reason to fabricate her evidence. She does not give a specific incident but does state that generally she had to prompt you to complete paperwork, including the fluid charts, after she had done spot checks. The panel considered that Ms 1 made a note of the issue close to the time. The panel therefore accepted her evidence.

The panel determined, on the balance of probabilities, that during the week commencing 20 August 2018, you needed prompting to complete fluid charts contemporaneously. The panel therefore found charge 2 proved.

**Charge 3a**

> *During the week commencing 3 September 2018;*
> *a) Were unable to provide a full handover to staff on the next shift.*

**This charge is found proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 said her witness statement *“On the week commencing 3 September… is not handing over fully to the night staff on the next shift and I’m having to intervene”.*

Ms 1 said in her supervisory notes *“Week commencing 3rd September I re spoke to Resin about prioritising his work load and knowing what is going on with his set of patients, their has still been times when he can not answer me, and is not handing over fully to the night staff on the nest shift and I’m having to intervene[sic]”.* Ms 1 supported this note in her witness statement and oral evidence.

You said in your oral evidence that you did provide a full handover to the next shift about your patients but that you left out the patient’s likes and dislikes regarding food and this is what Ms 1 meant about you not providing a full handover. You said it was a one-time incident and you have learnt from that mistake and have not repeated it.

The panel also had sight of the SMART objective number 5 dated 27 November 2018 which had *‘communication’* as one of the objectives in particular *“Ensuring clear and effective communication with all members of the multidisciplinary team. Communicate clearly with the Nursing assistant who you are working with. Inc making a plan for the day*”.

The panel noted that you do not appear to dispute that you did not provide a full handover and this had been discussed at the time, the only issue was the details of what had been omitted. The panel notes that Ms 1 said in her oral evidence that food likes and dislikes were not relevant and she had raised concerns because there had been a patient who was unwell during the day that you did not handover to the night staff.

The panel considered that Ms 1 would not have raised an issue regarding your ability to provide handover if it had only been about food likes and dislikes.

Having already found Ms 1 to be generally reliable witness the panel preferred her evidence. The panel determined, on the balance of probabilities, that you were unable to

provide a full handover to staff on the next shift during the week commencing 3 September 2018. It therefore found charge 3a proved.

**Charge 3b**

*Did not escalate one or more deteriorating patients until prompted to do so.*

**This charge is found proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 said in her witness statement *"On the week commencing 3 September 2018, I spoke to Reason about prioritising his workload. Reason did not fully understand his patients and did not escalate some of his patients until I prompted him. This was a concern as if Reason doesn't understand his patients, could he provide the right level of care and could he handover the correct information. No patient harm was caused however if there was no escalation there was potential for patient harm".*

Ms 1 said in her supervisory notes *"Reson has had patients who have become unwell and he does not act on things quickly, he has not escalated the patient until prompted by me".*

Your evidence was that you disagree with this allegation because if you knew that a patient was deteriorating, you would immediately go and check their National Early Warning Score (NEWS), inform the doctors and do whatever else is required.

The panel also had sight of the SMART objective number 6 dated 27 November 2018 which was *'Escalation of patients'*, indicating that this was an issue previously discussed with you.

Having already found Ms 1 to be a generally reliable witness the panel accepted her evidence. The panel determined, on the balance of probabilities, that you did not escalate one or more deteriorating patients until prompted to do so during the week commencing 3 September 2018. It therefore found charge 3b proved.

**Charge 4a**

> *On 26 September 2018 discharged Patient A without;*
> *a) Completing the discharge paperwork.*

**This charge is found not proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 said in her witness statement *"On 26 September 2018, Reson discharged a patient and gave medication to the patient without seeking advice or referring to the Electronic Discharge Summary ("EDS")… Reson was under my supervision before I went on my break, I said to him to wait for me to come back or ask someone else if he needs help. Reson took it upon himself to give the patient medication and let her go, he did not ask for help or wait for me. The issue with this was the patient could have the wrong medication to go home with, the GP would not have been informed of her discharge or admissions. Reson had not completed the paperwork for discharging a patient."*

Ms 1's supervisory notes stated *"The patient was discharged with out her EDS and her drugs that where given to the patient where not checked off against the drugs on her EDS. After clarify with Resin the drugs he gave to the patient fortuity they where the same drugs and dosages with the patients name on them as to what was on the EDS- I have since sent a copy of the EDS to the patient in the post [sic]".*

You said this patient was not willing to stay in hospital and left the ward with his wife even

though you told them to stay for the proper discharge process. You said the patient felt panicky and said they could not stay and it was taking long for formalities to complete. You said you told Ms 1 immediately on her return to the Ward. In your oral evidence you said that you checked the patient's medications with the pharmacist who checked the EDS.

The panel noted that you do not appear to dispute that the patient left the ward without following the proper discharge procedure. However, the panel determined that it was unclear from the evidence, what paperwork you were required to complete for the discharge process. The panel therefore determined that it could not find charge 4a proved.

**Charge 4b**

*On 26 September 2018 discharged Patient A without;*
*Checking the medication against the electronic discharge sheet ("EDS").*

**This charge is found proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 said in her witness statement *"On 26 September 2018, Reson discharged a patient and gave medication to the patient without seeking advice or referring to the Electronic Discharge Summary ("EDS)."*

Ms 1's supervisory notes stated *"The patient was discharged with out her EDS and her drugs that where given to the patient where not checked off against the drugs on her EDS. After clarify with Resin the drugs he gave to the patient fortuity they where the same drugs and dosages with the patients name on them as to what was on the EDS- I have since sent a copy of the EDS to the patient in the post".*

The panel took into account that in oral evidence you said that you had checked the drugs against the EDS. However, the panel noted your written response said "*There was no time to check his medication against EDS and give them a copy before that the patient had gone out of ward with his wife. I informed my supervisor [Ms 1] immediately once she came back from the ward meeting from the nursing office".* Also in your oral evidence you gave an alternative explanation and said that you checked the patient's medications with the pharmacist who checked the EDS.

The panel had sight of the entry in Patient A's records made by Ms 1 dated 26 September 2018 which stated *"Pt discharged without EDS posted to her address - meds handed to her by Reson he checked doses and names against pt drug chart, this was not ideal I have checked these drugs and doses against the EDS and they are the same".*

The panel found your account of this incident to be inconsistent. Having already found Ms 1 to be a generally reliable witness the panel preferred her detailed and consistent account of the incident. The panel determined, on the balance of probabilities, that you discharged Patient A without checking the medication against the electronic discharge sheet ("EDS"). It therefore found charge 4b proved.

**Charge 4c**

*On 26 September 2018 discharged Patient A without;*
*Giving them a copy of their EDS.*

**This charge is found proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1's supervisory notes said *"The patient was discharged with out her EDS… I have since sent a copy of the EDS to the patient in the post".*

The panel noted that you stated in your written response that "*There was no time to check his medication against EDS and give them a copy before that the patient had gone out of ward with his wife. I informed my supervisor [Ms 1] immediately once she came back from the ward meeting from the nursing office".*

The panel had sight of the entry in Patient A's records made by Ms 1 dated 26 September 2018 which stated *"Pt discharged without EDS posted to her address - meds handed to her by Reson he checked doses and names against pt drug chart, this was not ideal I have checked these drugs and doses against the EDS and they are the same".*

The panel found that you appear to accept that you did not give Patient A a copy of her EDS because *'there was no time'* and it was made clear in the notes at the time that you did not give the patient the EDS. The panel determined, on the balance of probabilities, that you discharged Patient A without giving them a copy of their EDS. It therefore found charge 4c proved.

**Charge 5**

> *On a date on or around 18 October 2018 did not escalate a patient who had not had a drink or passed urine all day.*

**This charge is found not proved.**

In reaching this decision the panel took into account the evidence of Ms 2 and your evidence.

Ms 2 said in her witness statement *"Sister [Ms 1] and I met with Reson on 18 October 2018 for a progress update. I felt like I couldn't sign off Reson because he had not escalated a patient who did not drink anything all day or pass urine. Reson's attitude was*

*it didn't matter that he didn't escalate the patient, as he said that she was confused so it didn't matter".*

The Meeting summary letter from Ms 2 dated 18 October 2018 stated *"I was also quite saddened for you to say that it didn't matter that you hadn't escalated your patient who hadn't drunk all day or passed urine as they were confused and not a normal patient. I explained that this attitude was not acceptable and actually these patients are more vulnerable and that you need to be there advocate even more".*

Your written response was *"I disagree with this allegation. The said patient a female patient was mobilising around the ward . She was ambulating from her bed to toilet and back to her bed. What I told my supervisor was she had not reported me anything so I don't know exactly what to write because she is self toileting".* In your oral evidence you said that if there was a patient who was not drinking or not passed urine, then you would immediately inform the nurse-in-charge.

The panel took into account that Ms 2 does not appear to be a direct witness to this incident. The panel was unable to determine where Ms 2 received this information in relation to this charge. The panel did not have access to the patient's fluid balance chart or records to determine whether they were mobilising around the ward or on bed rest. The panel determined that there was insufficient evidence to find that you did not escalate a patient who had not had a drink or passed urine all day. It therefore found charge 5 not proved.

**Charge 6**

> *On 3 November 2018 did not prioritise Patient B who presented with a respiratory rate of five breaths per minute.*

**This charge is found not proved.**

In reaching this decision the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 in her supervisory notes stated *"Patient presented with a respiratory rate of 5 breaths per minute. Reson said to myself and the band two that he had one more patients drugs to do first and would then come and see to the patient and do a set of obs. I explained to him that the priority was the patient with a respiratory rate of 5. And he then also went on to say that he also had addressing he needed to do first. I made myself very clear to him that the poorly patient was his priority and he needed a full set of observations the nurse to be present with him at all times and a doctor needed to be called. I called the doctors and the next thing I new Reson had left the patients bedside with no expectable excuses. It was at this point we had to call for a peri arrest and I completely took over the patients care [sic]".*

Your written response was that *"Once I was informed from a band 2 nursing assistant about my patient who had this low respiratory rate. I went and did a complete respiratory check and was found to have 9 breaths per minute. I immediately informed my ward duty doctor and my supervisor and later called for a periarrest as he was poorly. I was with the patient all the time and once the periarrest team came and I helped throughout until he was back to normal from his drowsiness. My supervisor was there with me and after all that later in the day my supervisor told me that you did good and improving".*

In your oral evidence you said you had been doing the medications and you were giving a PEG feed to the patient in the side room. You said the carer approached you and told you that the patient's respirations were dangerously low. You said you told her to go find Ms 1 immediately because you were in the middle of doing the medications with the syringes in your hand pushing the medicine and could not leave the bay. You said as soon as you finished the PEG feed, you went and checked the patient and his respiration.

The panel noted that Ms 1 said if you were in the middle of a PEG feed, she would expect this to be completed before you came to assist with the patient. She also said in oral evidence that you stayed with the patient once you attended. The panel noted that it had

no evidence from the band 2 carer who was involved in this incident, and miscommunication about the incident was a real possibility. The panel considered that although there were differences in yours and Ms 1's accounts, both accounts state that you did go and assist after you had finished what you had been doing.

The panel determined that it had not been provided with sufficient evidence that you did not prioritise Patient B who presented with a respiratory rate of five breaths per minute. It therefore found charge 6 not proved.

**Charge 7**

> *On 10 December 2018 did not communicate effectively with a Band 2 nursing assistant about whether the 18:00 skin bundles for your patients had been completed.*

**This charge is found not proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 said in her witness statement *"On 10 December 2018, Reson was given the task of working with the carer to complete skin bundles… Reson had issues with his communication so as part of his SMART objectives we decided to have Reson work with [a carer] and completed skin bundles. I asked Reson if he filled out the skin bundles. Reson said they were all done. I thought that was great, I spoke to [the carer] who told me they had not been done and Reson had not spoken to her yet. I went back to Reson and he told me they were done. I checked for myself and the skin bundles were not done [sic]".*

Ms 1 says in her supervisory notes *"Near the end of the shift I asked Reson how he and his carer where getting on with the 6 o'clock skin bundles he replied with yes they are all done, I then sai have you checked with your band two that all is done he said yes. I said*

*well done this was good. I then went to speak with the band two and asked her if she was ok and how the skin bundles where getting on, she informed me that they were done yet and she was falling behind. A very different story to what Reson had told me. I checked the patients and skin bundle charts they had clearly not been done [sic]".*

Your evidence was that when you asked the carer, she told you that the skin bundles had been done in your bay and that she was moving to the next to assist a colleague. You said that Ms 1 asked the carer who told Ms 1 that they were not yet done. You said you had communicated very clearly to the band 2 nursing assistant.

The panel had not heard evidence from the band 2 carer in this incident. You explained to the panel that band 2 carers wrote notes as they go along and then complete the formal records later and when Ms 1 checked the records these had not been written up, but this did not necessarily mean that the nursing care had not been carried out. Without direct evidence from the band 2 carer, the panel could not determine precisely what questions had been asked and what answers had been given by all three parties. The panel found that there was evidence of miscommunication but not necessarily that you had not communicated effectively with the band 2 carer.

The panel therefore was not able to determine, on the balance of probabilities, that you did not communicate effectively with the Band 2 nursing assistant about skin bundles. It therefore found charge 7 not proved.

**Charge 8**

> *On 31 December 2018 recorded that Patient F had remained continent when in fact you had not checked whether they had been continent or not.*

**This charge is found not proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

In Ms 1's witness statement she stated *"On 31 December 2018 Reson did not check a patient and wrote in the paperwork "remained continent". This patient was a Deprivation of Liberty Safeguard (DoLS) patient. For DOLs patients we carry out Intentional rounding. Intentional rounding means we check on the patients every hour to see if they need the toilet and/or continent or a drink. Reson had filled in the sheet we complete with actions he would do but Reson did not complete any of those actions".*

Ms 1 wrote in her supervisory notes *"Patient on a DOLS refused a wash with the other nurse, Reson had completed hourly intentional filling in the section that the patient had remained continent all morning when he had not actually checked to see if the patient was continent or not. When the patient was actually checked she was extremely wet and looked like she had been for a while. When approaching Reson about this he didn't really have anything to say about it. He was unable to defend his actions".*

The panel had sight of Patient F's intentional rounding check list and noted your signature at 9:00, 10:00 and 11:00. It noted that 12:00 appears to be signed as checked by another band 5 nurse. The panel considered that that band 5 nurse checked Patient F after you and had recorded that Patient F was continent at 12:00. After this 12:00 check the panel notes that there is a gap of 2 hours where there is no record of a check being undertaken. The panel noted that when the carer went and checked at 15:00 Patient F had been incontinent. By then nobody had checked this patient for 2 hours and the last person to check was not you.

The panel found the evidence was insufficient for it to find that you had recorded that Patient F had remained continent when in fact you had not checked whether they had been continent. The panel therefore found charge 8 not proved.

**Charge 9a**

*On 4 January 2019 failed an oral drug competency assessment, in that you;*

*Intended to administer oral medication to Patient C who was "nil by mouth".*

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

Ms 1 was supervising your drug competency assessment and in oral evidence she stated *"He dished it all out into the pot ready to give to the patient, and as he is approaching the patient with the pot, I then said, 'Reson, what are you doing?' And he said, 'I'm giving the medication to the patient.' I said, 'Did you know this patient is nil by mouth.' That's when I then stopped the patient from taking the medication".*

The panel had sight of Ms 1's oral drug competencies write up in her supervisory notes *"Patient was nil by mouth awaiting surgery, he dispensed and went to administer oral medication to the patient, on questioning Reson he was able to tell me that the patient was nil by mouth and deemed giving oral medications as being ok".*

The panel also had sight of your administration of oral medication assessment sheet (the assessment sheet) which also stated that you went to give the patient who was nil by mouth oral medication.

Your evidence was that you would never give a patient who was nil by mouth oral medication.

The panel considered your evidence to be non-specific and lacking in detail. The panel found Ms 1's evidence to be credible and reliable because she was supervising you during the assessment and making a formal record. The panel accepted her detailed account of the incident as supported by the drug competency booklet. The panel determined that by

you dispensing the medication you intended to administer oral medication to Patient C. It therefore found charge 9a proved.

**Charge 9b**

> *On 4 January 2019 failed an oral drug competency assessment, in that you; Signed for the administration of suppositories to Patient D but did not administer them.*

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

In oral evidence Ms 1 stated "*So he had signed for the suppositories, put them on the table and then proceeded to go onto the next patient. So I was very aware that he signed it and hadn't given them and didn't have the intention to give them at that point".*

The panel had sight of Ms 1's oral drug competencies write up *"Reson signed for suppositories and did not administer them he carried on with his drug round and left they on the table".*

The panel also had sight of the administration of oral medication assessment sheet ( the assessment sheet) which also stated that you *"signed for sups did not give them".*

Your evidence was that if you had signed for the suppository, then you definitely would have administered it. You said you do not know what kind of impression led Ms 1 to think that you were not going to give the medication.

The panel considered your evidence to be non-specific and lacking in detail. The panel found Ms 1's evidence to be credible and reliable because she was supervising you during

the assessment and making a formal record. The panel accepted her detailed account of the incident as supported by the drug competency booklet. The panel determined, on the balance of probabilities that you signed for the administration of suppositories to Patient D but did not administer them. It therefore found charge 9b proved.

**Charge 9c**

*On 4 January 2019 failed an oral drug competency assessment, in that you;*

*Left the drug trolley unattended on one or more occasions.*

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

In oral evidence Ms 1 stated *"I was with him but he was told at the beginning to do what he would do if I wasn't there. So there was something not in the drug trolley that he needed, so went off to the treatment room to get it, but coincidentally then left the drug trolley there, open and unlocked".*

The panel had sight of Ms 1's oral drug competencies write up *"Reson left his drug trolley unattended on several occasions. Even when I was not nearby".*

Your evidence was Ms 1 was co-signing for the medications so there were two nurses in front of the trolley. You said you asked Ms 1 if it was okay for you to leave the trolley open and she agreed. You said the trolley was never left unattended and there was always a nurse present (Ms 1).

The panel considered that during your evidence you appear to accept that you left the trolley because Ms 1 was there. The panel determined, on the balance of probabilities, that you failed an oral drug competency assessment, in that you left the drug trolley

unattended as Ms 1 was the assessor and you were expected to behave as though she was not there. It therefore found charge 9c proved.

**Charge 9d**

*On 4 January 2019 failed an oral drug competency assessment, in that you;*
*Were unable to explain why Allopurinol was prescribed for Patient E.*

**This charge is found not proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

In oral evidence Ms 1 stated *"So exhibit 20 is the drug chart where the Allopurinol is, the drug that we're talking about that Reson said that he wouldn't give because he didn't know what it was. But four days prior to this drug assessment, when I asked him, his signature is there and he had already given it to this patient prior to this assessment".* The panel also had sight of Patient D's MAR chart.

The panel had sight of Ms 1's oral drug competencies write up in her supervisory notes *"He was going to administer several oral tablets to a patient, as he was about to give the tablets to the patient I stop him and asked him if he knew what the medications where for he was unable to tell me. Reson had told me during the conversations we had had previously during his assessment that he knew you should never administer a drug without knowing what it was for- this was not a prompt this was Resons answer to a question. Also on 11/12/18 he a learning objective to look up medications in the BNF before administering".* The panel noted there was no specific reference to Allopurinol in the competencies write up.

The panel noted there was no reference to Allopurinol in the drug assessment sheet on the relevant date.

Your evidence was that Ms 1 did not ask you about Allopurinol but another medication which you had never heard of and had not previously administered to Patient E. You said you tried looking for the BNF and if you had found it you would have been able to explain what that medication was for.

The panel determined that there was insufficient evidence for it to establish whether you failed an oral drug competency assessment, in that you were unable to explain why Allopurinol was prescribed for Patient E. It therefore found charge 9d not proved.

**Charge 10**

*On 8 January 2019 did not prioritise your workload.*

**This charge is found not proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

Ms 1's supervisory notes stated *"During this shift Reson made no attempts to prioritise his work load or work within the team. He is well aware of these being goals of his and as a nurses role within the ward. I had to constantly remind him of tasks that needed to be achieved such as observations and dressings. I found him wondering around doing nothing, and he suggested he had nothing to do".*

You said in your written response *"Each and every nurses have their unique way of prioritising their workload for the day and I prioritise my work in a way that most important things will be done first".*

The panel did not hear any oral evidence from any of the witnesses about this charge. It also did not note any evidence on the SMART targets.

The panel saw no other evidence other than the contemporaneous note from Ms 1. The panel considered this note to lack detail. It was unclear what you were doing and what you should have been doing instead. The panel determined that there was insufficient evidence for the panel to find that you did not prioritise your workload on 8 January 2019. It therefore found charge 10 not proved.

**Charge 11**

> *On an unknown date did not treat a dementia patient with dignity and respect in that you left them naked on the floor.*

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and your evidence.

Ms 1's witness statement is that *"There was a dementia patient who was on the floor naked. The curtains were drawn, another patient's relative could see the patient was on the floor, as I was the Nurse in charge he and told me. The patient was Reson's patient. I went to see the patient and I saw Reson. I told him this patient is on the floor. Reson laughed and said he knew, the patient put himself on the floor [sic]".*

During her oral evidence Ms 1 explained that, as she was the nurse in charge, another patients relative came to her on a another part of the ward as he was concerned about the patient on the floor. She firmly stated that when she went to find you to tell you about the patient you were on a drug round and not doing something to assist the patient who was naked on the floor. Ms 1 told the panel that, as a result of her concerns, following this incident she organised for you to spend time with a dementia specialist nurse.

Your evidence is that you told Ms 1 that you knew this patient was naked on the floor but you had left him because you had gone to get clothing for him to dress him but that you remained in sight of the patient. You also said you tried to find a carer to help you get him up because you could not do this alone. You said you did not leave him to continue your medication round.

The panel considered the timeline in each version of the incident and preferred the account of Ms 1. The panel found that your timeline does not fit with your version of events and there were inconsistencies in your account. It found that you were not solely focussed on this patient and appeared to leave this patient on the floor while you attended to something else. Therefore, the panel determined that you did not treat a dementia patient with dignity and respect in that you left them naked on the floor. The panel therefore found charge 11 proved.

**Charge 12**

> *Between 3 April 2019 and 15 January 2020 knowingly worked as a nurse in breach of an interim suspension order on approximately 158 shifts.*

**This charge is found proved.**

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

The panel noted that the interim suspension order was imposed on 25 March 2019. The decision letter informing you of the interim suspension order was dated 26 March 2019 and was sent to your registered address in India. You confirmed in an email sent to the NMC on 19 February 2019 that *"…my address and phone number remains the same as in my NMC portal".*

The panel had sight of a note of a telephone call made by you to the NMC on 3 April 2019:

*"16.22 Telephone call received from reg 07448240765*
*He explained he is currently in Inidia and received documents detailing the hearing went ahead in his absence and he was given an ISO for the period of 18 Months…*
*He explained he wants to speak to someone to clarify whether this suspension means he has been struck off.*
*I explained the ISO is in place for the period of 18 months so that the NMC may conduct a full investigation. This does not mean he has been removed from the register however there is a suspension on his practice [sic]".*

The panel had the witness statement of Mr 3 who stated *"On 9 April 2019 I received a call from the registrant. During the call we discussed ISO imposed by the IC panel. We discussed what an ISO meant and how it differs from the fitness to practise investigation. Once I explained to the Registrant that the ISO is different and is an interim risk management tool the Registrant confirmed he was thinking of requesting an early review of the IO. I asked the Registrant to place this in an email to me so his request can be reviewed. also had sight of a note of a telephone call made by you to the NMC on 9 April 2019, to Mr 3. Mr 3 explained to you the process for the interim suspension order being reviewed".*

The panel heard evidence of Ms 5 *"The registrant was employed by Caring Homes as a Registered bank Nurse on 2 January 2019. He had been unable to work any bank shifts due to his concurrent employment in the HNS. His Bank Contract was terminated on 3 February 2019. The registrant was re-employed on a permanent contract of 48 hours per week as a registered Nurse on 13 February 2019."* She also stated *"In this instance I think it was an immigration audit that was carried out on 16 January 2020 that picked up the issue with the registrant's pin."*

Ms 4's evidence is consistent with Ms 5's *"He was then reemployed on a permanent contract of 48 hours per week as a registered nurse from 13 February 2019".*

The panel also had sight of the shift allocation sheet and pay slips.

The panel determined there was an interim suspension order in place on your registration and that you were aware of the interim suspension order imposed on 25 March 2019 because you had been sent the letter informing you of it to your registered address on 26 March 2019. The letter states *"The effect of this suspension order is that you must not work as a nurse or as a midwife for as long as this order remains in place".* It also has evidence that you had telephone calls with the NMC regarding your interim order. Mr 3 exhibited an email and also stated that you were sent links to the NMC web pages regarding an interim suspension order.

The panel determined, on the balance of probabilities, that you knowingly worked as a nurse in breach of an interim suspension order on approximately 158 shifts. The panel therefore found charge 12 proved.

**Charge 13**

> *Between 3 April 2019 and 15 January 2020 failed in your professional duty to inform your employer that you were subject to an interim suspension order.*

**This charge is found proved.**

The panel first considered whether you had a duty to inform you employer that you were subject to an interim suspension order.

The panel had sight of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) which stated:

> *"23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body**."***

Ms 5 says in her witness statement *“I don’t know if the registrant was directly told that he must inform the Home if he was subject to an ISO or if he was asked at any subsequent point. I would have thought it was a given that a nurse would disclose this information”.*

In Ms 4’s witness statement she says *“We found out about the registrant’s interim suspension order through a routine audit”.*

The panel saw an email dated 27 January 2020 to you from Ms 4 following the audit dated 16 January 2020*:*

- *“You failed to disclose that you have an interim suspension order on your NMC Registration*
- *You continued to come to work during this time in the capacity as a registered nurse, when you did not have the necessary registration to work in this capacity*
- *You failed to inform us of the above”*

Your evidence throughout these proceedings has been that you did not tell your employer that you were subject to an interim suspension order because you thought that you were only suspended from nursing in the NHS and you thought you could work in the private sector such as in a nursing home.

The panel noted that you accept that you did not inform your employer that you were subject to an interim suspension order. The panel determined that you did have a duty to and noted your obligation to disclose set out in the Code. The panel determined that you failed in your professional duty to inform your employer that you were subject to an interim suspension order and found charge 13 proved.

**Charge 14**

> *Your conduct in Charge 13, above, was dishonest in that you knowingly concealed from your employer that you were no longer entitled to practise as a nurse so that you could continue to work as a nurse.*

**This charge is found proved.**

The panel found that you knew about the interim suspension order from 3 April 2019 because it was discussed in the telephone calls between you and NMC staff on the 3 April 2019 and the 9 April 2019. Your interim suspension order was also the subject of ongoing contact between you and the NMC between April 2019 and June 2019 when you sought clarification in relation to requesting an early review of your interim order. The panel considered your evidence that you agree that you knew about the interim order at the time of the telephone call of 9 April 2019 but you thought that you were only suspended from nursing by the NHS and you thought you could work in the private sector such as in a nursing home.

The letter of 26 March 2019 detailing the interim suspension order was sent to your home address in India. This was the address that you confirmed as your NMC registered address in an email from you dated 19 February 2019. The letter details that "*The effect of this suspension order is that you must not work as a nurse or as a midwife for as long as this order remains in place."* The panel find that you had received these documents by the time of the telephone call on 3 April 2019 because in that telephone call it is recorded that "*He explained he is currently in India and received documents detailing the hearing went ahead in his absence and he was given an ISO for the period of 18 Months"* and also that *"He explains he is still in india and so the Investigator would need to send him an email and the reg will call him".* The panel considered your evidence that you were not in India at this time. However, irrespective of whether you were in India on 3 April 2019, the evidence establishes that you had been informed in writing of the existence of the interim suspension order.

The telephone note from Mr 3 on 9 April 2019 says that you called to ask about the appeal process and you agreed with this. The panel note that the appeal process is outlined in the letter telling you of the interim order on 26 March. The panel find that the fact that you rang

to discuss this suggests that you had knowledge of the contents of the documents sent to you by the NMC regarding the outcome of the interim order hearing.

You said in evidence that you did not go to India in April 2019 but that you were there in February 2020. You said you told your wife and family to put all the post sent to you in a cupboard for you to read when you went over. Nobody was checking the contents of any of your mail, or advising you of what had arrived. The panel did not find this to be a credible scenario. Also, it noted the email from you on 20 January 2020 where you stated that "*All the NMC posts which they sent to India to my permanent address and I was not knowing exactly that because my wife received all those communications back in India and not bothered to open it."* The panel finds that this contradicts your statement that you told your family to put all the post in a cupboard without checking it. You said that you became aware of the interim suspension order through an email from the NMC but this email was not before the panel.

The panel considered the evidence of Mr 3. He said that he explained what an interim suspension order meant. His evidence was that you did not ask him about whether you could work in a care home under the interim order as opposed to in the NHS. You agreed that you did not discuss this with him. There is no record of this being discussed in the 3 April telephone call or any of the subsequent emails. The panel found that if you did believe that the interim suspension order did not apply to private nursing homes then you would have mentioned this during your oral and written communications with the NMC but did not do so.

You stated in an email to Mr 3 on 8 May 2019 *"I am extremely desperate to get out of this interim order. I am totally shattered into million pieces both financially... If you could please send me all the complaints sent from Salisbury NHS trust against me, which led to the referral and subsequently the suspension of my license it would be very helpful".* The panel found that this email contradicts your statement that you believed that you were able to work in a care home under the interim suspension order because if you genuinely

believed that you were able to work as a nurse in a private care home this would not impact on you financially.

In your oral evidence you said that you wanted to work in another NHS Trust. However, the panel does not find this consistent with the telephone call record of 9 April 2019 where it is recorded that "*In terms of the Suspension the Registrant said he has no problem working as a nurse but cannot work as a nurse in NHS. The Registrant said the NHS wants it to be superfast which he cannot do."* The panel found that this evidence indicated that you had no wish to work anywhere in the NHS at that time.

The panel considered your email to Ms 4 on 27 January 2020 to your employer when they discovered that you had been working whilst subject to an interim suspension order. You said in the email "*Before going forward with any kind of disciplinary action on me, I need to urgently bring a few important matters into your kind attention."* The panel find that this was a detailed email and that if you had genuinely believed that you were entitled to work in the care home during your interim suspension order then you would have explained this in this email. The panel note that you also do not outline this issue in your initial responses to the charges to the NMC.

The panel also considered that you were working in breach of an interim suspension order for a lengthy period in a care home where the ethos was one of adherence to the Code. The panel do not find it credible that as a trained nurse who is aware of working to policies and procedures that you did not clarify the meaning of your interim suspension order within anyone other than your friend who was also an overseas nurse. Neither you said, did you take the time to look at any of the information online about the meaning of it despite being emailed at least once on 9 April 2019 with a link to the NMC website information on the meaning of your interim suspension order.

As this is a dishonesty charge, the panel has carried out a heightened examination of the evidence. It has applied the two-stage test for dishonesty set out in the case of *Ivey v Genting Casinos* UK Limited (T/A Crockfords) [2017] UK SC67. It considered your actual

state of knowledge or belief as to the facts. It concludes that you were aware that you were working in breach of the interim suspension order but decided to conceal this from your employer. The panel next asked the question whether your conduct was dishonest applying the objective standards of ordinary, decent people and concluded that it was. Ordinary decent people would regard your conduct, in concealing your registration status, dishonest. The panel therefore found charge 14 proved.

**Hearing resumed on 17 October 2023**

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved in charges 1- 11 amount to a lack of competence and whether the charges found proved in charges 12-14 amount to misconduct and, if so, whether your fitness to practise is currently impaired by reason of lack of competence and/or misconduct. 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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

**Your evidence under affirmation**

You said that you worked in the care home in the UK for 11 months after leaving the Hospital where they would have been quick to refer you to the NMC if your practice was not up to standard but they were happy with your practice. You said you had learnt a lot working on the Covid ward in India during the pandemic. You said in the future you want to work in a care home in the UK.

You told the panel that you realise that you did some things wrong and the training you have done recently whilst working in India has helped you professionally. You said that these errors will never happen again.

In relation to medication rounds you said you understand that giving medicines to patients on time is important and it will impact on the patient if not given on time. You said you have gained much more experience giving medications and you are much quicker now. You also said you know the importance of correct medications administration and the dangers of leaving the drug trolley unattended.

You said documentation is very important regardless of how busy things are and you understand that the notes are legal documents and need to be accurate.

You said you have had training on handovers and understand that they are important so that the nurse coming on shift has a complete picture of the patients care and can take action if something goes wrong.

In terms of prioritising deteriorating patients, you said that nurses taking care of patients will normally be the first to realise if something is going wrong so must be able to escalate any concerns quickly.

In relation to discharging patients, you told the panel that each organisation has their own procedures so a nurse must know all the steps required and if unsure should ask for help from a senior colleague.

You told the panel that you now have a better understanding of dementia patients and understand that you need to put yourself in their shoes and you should not leave a patient naked on the floor.

You said in relation to working as a nurse in breach of your interim suspension order and not informing your employer about it is wrong. You said that in all countries there is a nursing council and if there is an issue with your registration you should inform your employer immediately and not carry on working. If you knew of a nurse doing this you said you would think this is wrong, they should not be doing this and you cannot trust such nurses.

You told the panel that you feel very bad that this has happened and these issues will never happen again in the future. You said you have learnt your lesson. You told the panel that your current employer is aware of the NMC proceedings. You said that after the last hearing you informed your employer about the NMC case when you requested the certificates of your training for today's hearing, although you did not specifically detail the charges to them. You have not requested a reference from your employer.

**Submissions on lack of competence**

The NMC has defined a lack of competence as:

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

Ms Williams invited the panel to take the view that the facts found proved in relation to charges 1 – 11 amount to a lack of competence. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the

Code") and identified the relevant standards where the NMC say your actions amounted to a lack of competence.

Ms Williams submitted that your lack of competence involved wide ranging areas of capability which are fundamental to nursing practice. The facts found proved occurred over a period of time and despite extensive support being provided to you by your employer. She submitted that the facts found proved show that your competence at the time was below the standard expected of a band 5 registered nurse.

**Submissions on misconduct**

Ms Williams then addressed the panel on misconduct. She referred the panel to the Code and identified the relevant standards where the NMC say your actions amounted to misconduct. She submitted that once you were aware that the interim suspension order was in place you should have ceased working as a nurse. She submitted that you have demonstrated a flagrant disregard for the rules and you put patients at risk of harm by your conduct.

Ms Williams invited the panel to take the view that the facts found proved fell far below the standards expected of a registered nurse and amounted to misconduct.

**Submissions on impairment**

Ms Williams 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 Williams submitted that limbs a, b, c and d are engaged in the *Grant* test.

In relation to the issue of your lack of competence, Ms Williams referred the panel to the training records you have provided which are mandatory under your current employment and submitted they do not really address the issues.

Ms Williams submitted that you have not taken sufficient steps to address the concerns. She submitted that during your oral evidence you sought to blame your competence issues on the training you had received at the time. She submitted that some of the responses you gave indicate that you have not grasped the seriousness of the concerns and this signifies possible attitudinal problems.

Ms Williams submitted that concerns surrounding dishonesty are difficult to address. She submitted that your reflection was limited and that during your oral evidence you spoke mainly about the training and learning you had undertaken. Ms Williams submitted that you have not taken time to reflect on why what you did was wrong in relation to your dishonesty and that without that reflection there is a risk of repetition of your conduct.

Ms Williams therefore invited the panel to find that your fitness to practice currently impaired by your lack of competence and misconduct.

The panel accepted the advice of the legal assessor.

**Decision and reasons on lack of competence**

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

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

*To achieve this, you must:*

***1.1** treat people with kindness, respect and compassion*

***1.2*** *make sure you deliver the fundamentals of care effectively*

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

*6 Always practise in line with the best available evidence*

*To achieve this, you must:*

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

*8 Work cooperatively*

*To achieve this, you must:*

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

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

*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*

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

*To achieve this, you must:*

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

***18.4** take all steps to keep medicines stored securely'*

The panel bore in mind, when reaching its decision, in relation to lack of competence, that you should be judged by the standards of the reasonable average band 5 registered nurse applicable to the post to which you were appointed and the work that you were carrying out and not by any higher or more demanding standard.

The facts found proved involved concerns around:

- Not completing a medication round in a timely manner
- Medication administration errors
- Incomplete handover
- Not escalating a deteriorating patient
- Not following discharge procedure
- Not treating a dementia patient with dignity and respect

The panel saw evidence that you were made aware of the issues around your competence by your employer. It noted that whilst at the Trust, when you appeared to not be able to cope with the pace of the AMU, you were transferred to the Ward for supervision and a reduced number of patients. This was initially for an eight week period to facilitate an improvement in your clinical skills.

Whilst your progress was initially dealt with using the informal stage of the Trust's Performance Policy, the matter was formally escalated to Stage 1 of the formal stage on 27 November 2018, and Stage 2 on 4 January 2019 before you resigned from your role at the Trust on 3 February 2019.

The panel considered that the concerns took place during a 6 month time frame and covered a range of tasks and skills. The panel was of the view that the tasks required of you were fundamental nursing skills which would be expected of a band 5 nurse in any setting. The panel considered the context in which you were practising. You said that it was a fast paced environment without support but the panel found that it was an environment that had been deemed suitable for training and supporting new overseas nurses before and after your time there. The panel noted that you were provided with support and a reduced patient load at the time.

The panel concluded that your practice fell far below the standard that one would expect of the average band 5 registered nurse acting in your role.

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

**Decision and reasons on misconduct**

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect,*

*involving some act or omission which falls short of what would be proper in the circumstances.'*

When determining whether the facts found proved in charges 12-14 amount to misconduct, the panel had regard to the terms of the Code.

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:

> ***'20 Uphold the reputation of your profession at all times***
>
> *To achieve this, you must:*
>
> ***20.1*** *keep to and uphold the standards and values set out in the Code*
>
> ***20.2*** *act with honesty and integrity at all times,*
>
> *23 Cooperate with all investigations and audits*
>
> *To achieve this, you must:*
>
> ***23.3*** *tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'.*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In relation to charges 13 and 14 the panel found that you had acted dishonestly by working as a nurse in breach of an interim suspension order and failing to inform your employer that you were subject to an interim suspension order. The panel was of the view that your conduct at charges 12-14 was serious and put patients at risk of harm because you had continued to work after a panel of the Investigating Committee had found there to be a risk of harm if you were permitted to continue practising without restriction.

The panel found that your actions at charges 12, 13 and 14 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the lack of competence and/or misconduct, 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 found that limbs a, b, c and d of the *Grant* test are engaged. The panel found that although no patient was caused physical harm as you were being directly supervised. However, patients were put at risk as a result of your lack of competence and misconduct. The panel found that your failings had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty, and practising in breach of an NMC interim order, to be serious.

The panel had regard to whether the lack of competence identified is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated. The panel was satisfied that the lack of competence in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account the evidence of mandatory training you have provided. It noted that this is training required by your current employment and you have not undertaken any additional, targeted training or learning relevant to the areas of concern identified in your competence. During your oral

evidence you did not demonstrate how you have implemented your training in your current practice and what you have learned.

The panel was of the view that dishonesty is more difficult to address. The panel considered that during your oral evidence you failed to demonstrate full insight into your misconduct and how your actions put patients at risk of harm. The panel noted that the regret you showed was in relation to the impact these proceedings have had on you rather than any negative impact on the reputation of the nursing profession. The panel considered that you have not fully reflected on your misconduct or considered what might have led you to behave in this way. You have not provided even a handwritten reflective piece setting out the impact of your dishonesty in relation to patients, the public and the reputation of the profession.

The panel also saw no references from your current employer attesting to your current good practice and honesty.

The panel is of the view that, based on the lack of evidence that you have strengthened your practice or addressed the dishonesty, there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

**Sanction**

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike 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 Williams referred the panel to the SG, in particular 'Considering sanctions for serious cases' She asked the panel to consider the nature of the dishonesty. She submitted that, as a starting point, cases involving dishonesty will always be serious. She submitted that your dishonesty was premeditated, systematic and longstanding. She submitted that your dishonesty also involved personal gain and put patients at risk of harm. She submitted that the dishonesty was serious.

Ms Williams also asked the panel to consider guidance on 'Cases involving dishonesty' and 'Cases involving deliberate breach of an interim order'. She also outlined to the panel what the NMC consider to be the aggravating and mitigating features of this case.

Ms Williams then addressed the panel on the available sanctions starting from the least restrictive. She submitted that to take no further action or impose a caution order would not be appropriate in view of the public protection and public interest concerns identified. She submitted that the concerns surrounding your lack of competence was extensive and a conditions of practice order to address these multiple areas of basic nursing practice

would be too restrictive and amount to a suspension. She submitted that a conditions of practice order would also not address the misconduct found.

In relation to a suspension order, Ms Williams submitted that the case involves serious dishonesty which was directly related to your nursing practice and occurred over a significant period. She submitted that a suspension order would not be appropriate in the circumstances. She informed the panel that the NMC's sanction bid is that of a striking-off order. She reminded the panel that this sanction would not be available if the ground for impairment was solely your lack of competence. However due to the misconduct also found she submitted that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards.

The panel then heard submissions from you regarding sanction. You accepted that the issues raised when you worked in the NHS were surrounding your competency. You said that when you worked as a nurse in breach of the interim suspension order you did this to prove that you were competent to work as a nurse.

You told the panel that you only provided the mandatory training records from your current employer because in India you do not have the opportunity to do any other forms of training. You said if you had the opportunity to you would have. You asked the panel to take into account that you have already been suspended for a long time.

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

**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:

- Lack of insight into your misconduct.
- Lack of evidence that you have taken steps to address the concerns relating to the charges found proved.
- Your conduct put patients at risk of suffering harm.
- Your misconduct occurred over a sustained period of 9 months when you worked as a nurse whilst in breach of an interim suspension order.

The panel also took into account the following mitigating features:

- Personal mitigation. You described experiencing financial pressures at the time of your misconduct.

The panel had regard to the SG in particular ‘Cases involving dishonesty’. The panel was of the view that your rejected defence in relation to your dishonesty is more indicative of a lack of insight than an aggravating feature. It also considered the guidance on ‘Cases involving deliberate breach of an interim order’ which indicates that if a nurse deliberately does not comply with an interim or substantive order this will be taken very seriously. The panel was of the view that you have shown a disregard for the steps the NMC has put in place to keep the public safe or uphold confidence in the professions.

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 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 was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that workable conditions that could be formulated to address the lack of competence. However, the misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, would not protect the public nor would it address the public interest considerations.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel determined that your misconduct was not a single instance but was a sustained period of dishonesty and a deliberate breach of an NMC interim suspension order. The panel saw no evidence that you have repeated your misconduct. However, because of the lack of insight you have demonstrated, the panel was not satisfied that you do not pose a

significant risk of repeating behaviour. The panel also considered that your lack of insight could indicate possible attitudinal issues.

The 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 serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. Despite being given multiple opportunities during the course of these lengthy proceedings, you have failed to demonstrate insight into your dishonesty. This dishonesty involved concealing from your employer that you were subject to an interim suspension order imposed by your regulator. Whilst the imposition of a suspension order might protect the public during the duration of the order, it would not adequately address the need to maintain public confidence in the profession and in the NMC as its regulator.

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

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

The panel was of the view that the deliberate and sustained breach of an order put in place by your regulator in order to protect the public, which included you being dishonest with your employer, is such a significant departure from the standards that must be expected of a registered nurse that it is fundamentally incompatible with you remaining on

the register. The panel find this to be so serious that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This 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 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 Williams. She submitted that an interim order is necessary to the grounds of public protection and in the wider public interest to cover the period of appeal.

You did not respond to the application.

**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 to cover the appeal period.

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

That concludes this determination.