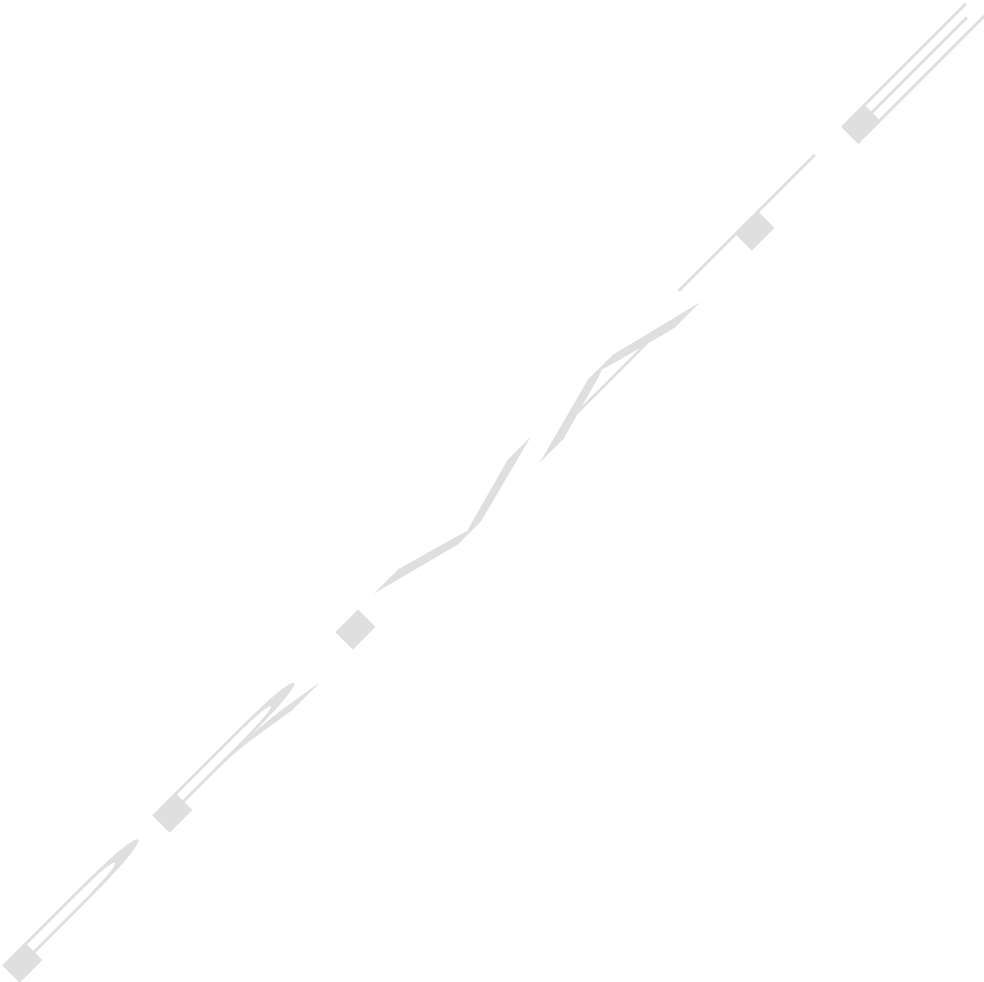
Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 2 October 2023 – Friday 13 October 2023

Virtual Hearing

Name of Registrant:	**Karen Andrea Dixon**
NMC PIN	85K1101E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse (12 April 1993) Registered Nurse – Sub Part 2 Mental Health Nurse (09 August 1988)
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Helen Chrystal (Registrant member) Manjit Darby (Registrant member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Zahra Khan
Nursing and Midwifery Council:	Represented by Ashraf Khan, Case Presenter
Ms Dixon:	Present and represented by Thomas Buxton from Crucible Law
Facts proved by admission:	Charges 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15a, 15b, 21a, 21b and 22
Facts proved:	Charges 3, 16 and 17
Facts not proved:	Charges 13, 15c, 18, 19 and 20

Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**



Details of charge (as amended):

That you a registered nurse;

1. On an unknown date in May 2019, when interviewed by The Sands Nursing and Retirement Home (the 'Home'), failed to declare that you were subject to an NMC Caution Order. **[PROVED BY WAY OF ADMISSION]**

2. Failed to declare, on the Home's application form dated 29 April 2019, that you were the subject of an NMC Caution Order. **[PROVED BY WAY OF ADMISSION]**

3. Your actions in charges 1 and/or 2 were dishonest in that you were attempting to mislead the Home into believing that you were not subject to an NMC sanction at the time of your application. **[PROVED]**

4. On one or more occasions between June 2019 and September 2019 failed to complete 'Resident of the Day' checklists. **[PROVED BY WAY OF ADMISSION]**

5. On one or more occasions on dates unknown failed to complete daily care notes for Residents. **[PROVED BY WAY OF ADMISSION]**

6. On 18 September 2019 failed to sign the stock sheet having administered diazepam to a Resident. **[PROVED BY WAY OF ADMISSION]**

7. On 8 September 2019 failed to record on Resident B's EMAR chart that you had administered Fencino 100mg. **[PROVED BY WAY OF ADMISSION]**

8. On 8 September 2019 failed to record on Resident C's EMAR chart that you had administered a fentanyl patch. **[PROVED BY WAY OF ADMISSION]**

9. On 12 September 2019 failed to record on Resident A's EMAR chart that you had administered a phenobarbital 60mg tablet. **[PROVED BY WAY OF ADMISSION]**

10. On 20 July 2019 incorrectly disposed medication by not placing it into a disposal bin. **[PROVED BY WAY OF ADMISSION]**

11. On 17 July 2019 and/or 19 July 2019 incorrectly signed Resident D's EMAR chart indicating that you had administered Trazadone 50mg to Resident D. **[PROVED BY WAY OF ADMISSION]**

12. On 17 July 2019 and/or 19 July 2019 failed to administer Trazadone 50mg to Resident D. **[PROVED BY WAY OF ADMISSION]**

13. Your actions in charge 11 were dishonest in that you signed Resident D's EMAR chart knowing that you had not administered the medication. **[NOT PROVED]**

14. On 13 September 2019 failed to apply cream designed to deal with scabies to Resident F. **[PROVED BY WAY OF ADMISSION]**

15. On 13 September 2019 failed to;
    (a) Document in Resident F's care notes that the scabies cream had been received. **[PROVED BY WAY OF ADMISSION]**
    (b) Document that scabies treatment had not been provided to Resident F. **[PROVED BY WAY OF ADMISSION]**
    (c) Handover to Colleague 1 that the scabies treatment had not been provided to Resident F. **[NOT PROVED]**

16. On 13 September 2019 failed to make sure that treatment for scabies for Resident F was delivered without undue delay. **[PROVED]**

17. On one or more occasions between 16 September and 23 September failed to make sure that an unknown Resident’s wound dressing was changed without undue delay. **[PROVED]**

18. On 18 September 2019 failed to apply the correct wound dressing to Resident E. **[NOT PROVED]**

19. On 18 September 2019 incorrectly entered on Resident E’s patient notes the wound dressing that was applied to Resident E. **[NOT PROVED]**

20. Your actions in charge 19 were dishonest in that you knew that you had applied the wrong dressing but entered that you had applied the correct wound dressing instead. **[NOT PROVED]**

21. On 2 October 2019 provided Dovehaven Lodge Nursing Home an incorrect employment history by indicating that you were still presently employed at The Sands Nursing and Retirement Home;
    (a) On the application form. **[PROVED BY WAY OF ADMISSION]**
    (b) During the interview. **[PROVED BY WAY OF ADMISSION]**

22. Your actions in charge 21 were dishonest in that you knew your employment had ceased with The Sands Nursing and Retirement Home at the time you completed your application form and/or interview with Dovehaven Lodge Nursing Home on 2 October 2019. **[PROVED BY WAY OF ADMISSION]**

In light of the above your fitness to practise is impaired by reason of your misconduct

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

At the outset of the hearing, Mr Buxton, on your behalf, made a request that this case be held partly in private on the basis that proper exploration of your case involves a family

member's health and your personal matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Khan, on behalf of the Nursing and Midwifery Council (NMC), did not oppose the application.

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

The panel determined to go into private session in connection with your personal matters as and when such issues are raised in order to protect your privacy.

Background

You first entered into the NMC's register in 1988. You were referred to the NMC on 17 October 2019 by Witness 1, the Deputy Matron at the Sands Nursing and Retirement Home ('the Home'). This establishment caters for patients who require residential, nursing and dementia care over three floors.

The following facts are alleged:

Charges 1, 2 and 3 (Failure to disclose caution)

In May 2019, you were employed as a probationary bank nurse at the Home.
Four days after you started working at the home, on 17 May 2019, Witness 2, the Home's Manager, discovered that you had a live Caution Order against your NMC registration.

The Caution Order had been for 18 months and was due to expire in June 2019.

This information was not declared by you in your application form dated 29 April 2019 or during your interview with Witness 1 and Witness 2 in May 2019.

Following checks conducted with the NMC, it was discovered that you had a Caution Order against your registration. You were subsequently asked why you had not disclosed this information, and you responded that the Caution only had one more month until it expired so you decided not to declare it. Your failure to disclose the Caution Order in your application form or at the subsequent interview was allegedly dishonest in that you were attempting to mislead the Home into believing that there were no restrictions on your practise when you knew that there was.

Despite your alleged lack of honesty, after a review of the situation, it was decided that you should be given the benefit of the doubt. The Home Managers were confident they could monitor your progress throughout your probationary period and they were satisfied that the normal channels of induction, training and competency for medication acted as a sufficient safeguard and, if there were any serious concerns, they could easily stop using you as you were employed as a bank nurse rather than a permanent member of staff.

Charge 4 (“Resident of the Day” checklists)

You allegedly failed to complete “Resident of the Day” checklists three times between June 2019 and September 2019. The exercise is done to ensure that all care plans are evaluated, and observations are done on a monthly basis on each resident. Anything that needs completing or reviewing monthly, such as risk assessments, are updated for the resident of the day. There were 25 residents at the time on the unit. The requirement was to complete only one resident each day, which ensures that these checks are done at least once a month. If the resident of the day checklists are not carried out, concerns will not be identified and steps cannot be taken to address any issue in a timely manner.

The checklists, which nurses have to complete in relation to the resident of the day, are randomly audited by Witness 2 and Witness 1. This is to check the necessary tasks are being done in relation to each resident of the day.

Three checklists were not received from you and therefore there is no evidence that the checklists were completed.

Charge 5 (Daily Care Notes)

For each shift, you were required to record something about each resident on their care notes. This could be anything as simple as "all settled" if there was nothing else to report. If an incident did occur and nothing had been recorded for that particular day or night, safeguarding would be dissatisfied with the Home.

Furthermore, recording these notes, helps Witness 1 and Witness 2 maintain oversight or alert them to any incidents which have occurred. You had allegedly failed to complete daily care notes and left them for another nurse, namely Witness 5, to do them.

You were fully aware it was your responsibility to complete these notes. The Clinical Lead at the Home complained to management about you. She had taken over shifts from you and the lack of daily care notes for the residents were increasing her workload.

Charge 6 (Diazepam)

When dispensing medication, the correct practice is to dispense the medicine into a pot when it is displayed on the Electronic Medication Administration Record (EMAR) system that it is due. It should then be recorded on the stock sheet that it had been given. A check of how much stock is currently available should also be included and the stock should be counted with a witness present. Both members of staff are required to sign the stock sheet to indicate that the amount of stock is correct and change the stock total to demonstrate

that medication has been given. The medication is then administered to the resident and both members of staff sign to confirm it has been given.

The process in place is a safeguard to ensure patients get the correct medication, at the correct time and by the correct method. This is the procedure at the Home and is well known by you.

On 18 September 2019, you administered diazepam to a resident. You allegedly failed to record this on the stock sheet. This failure resulted in queries being raised about the stock level, as it was thought diazepam was missing.

Charges 7, 8 and 9 (Failure to document on EMAR)

Witness 3 was doing audits in September 2019. This involved counting the drugs in the controlled drugs cupboard and checking this correlated with what has been recorded on the controlled drugs book; checking this has been signed; and checking that it all married up with what has been signed for on EMAR.

Witness 3's audit revealed there were three incidents which involved you signing for controlled drugs as given in the controlled drugs book but apparently failing to sign for them on the EMAR system. The details of the three incidents are as follows:

On 8 September 2019, a Fencino patch was applied to Resident B. The controlled drugs book suggests that you administered the patch on 8 September 2019 at 13.30. The book suggests Witness 6, a Senior Carer, has witnessed this. However, the electronic patient records show that this administration was not signed for on EMAR. The 'Live MAR Chart' for 9 September 2019 shows your signature next to all other the other drugs on that day, but the patches are missed (Charge 7).

Again, on 8 September a fentanyl patch was applied to Resident C. The controlled drugs book for Resident C indicates that the patch was applied because you had signed for it on

8 September 2019. However, the electronic notes for Resident C suggest they were not (Charge 8).

On 12 September 2019, the controlled drugs book shows you signed for and gave Resident A 60mg of phenobarbital. However, the electronic patient records, which includes the EMAR record titled 'Live MAR Chart', indicated that the medication had not been signed for as having been administered (Charge 9).

It is said that you should have followed the process and signed the EMAR chart to indicate that medication had been given. The controlled drugs book is the first part to that process. Initially this omission would cause staff to think that the resident had not had the medication. This also affects the stock level, which puts safety into question. If the resident had not received that medication, their pain could be ineffectively managed. There is no dispute that the medication was given because it was witnessed and signed for in the controlled drugs book, but you should have followed the required procedure. These procedures are in place to ensure medication is managed at the home safely.

It is said that you should have looked at what medication was due at that time on the EMAR chart, got a trained witness to be present and viewed the controlled drugs book together. You should have checked and counted how many patches were available, in agreement with the witness, and made an entry to include the date that one had been given. You should have then applied the patch and both staff members should have signed the controlled drugs book. Further, you should have then signed on the EMAR chart together to indicate that the patch had been applied. You should have known this was standard practice because you had done a drugs competency assessment.

<u>Charges 10, 11, 12 and 13 (Disposal of Medication)</u>

On 20 July 2019, Witness 3 was on duty at the Home as Clinical Lead at the Home. She went to the treatment room to empty a general waste carrier bag tied to the drugs trolley. Whilst emptying the rubbish into a large bin in the treatment room, she found a variety of

loose tablets and capsules, which had been taken from their blister packs, as well as some tablets and capsules, that were in their medication pots (Charge 10).

The Clinical Lead called for a senior carer to witness what she had found. She recognised one of the medication pots. She also recognised the medicine Trazodone. This was for Resident D, who was the only resident on this medication at the time.

The Clinical Lead checked the EMAR system on the computer, which recorded what medication had been given. It was discovered that this particular medication had been signed for as administered by you. Your signature can be found on 17 July 2019 and 19 July 2019 for this medication (Charge 11).

The Clinical Lead was concerned by what she had discovered. She reported the matter to Witness 2. She also spoke to you seeking an explanation. You explained that you had handed the medication pot to Resident D's husband, who was visiting at the time. You thought that Resident D's husband would administer the medication (Charge 12). You returned to the room afterwards and found the tablets on the table of Resident D's bedroom. You went on to explain that you took them back and disposed of them in the carrier bag, rather than the disposal bin, which is situated in a locked cupboard in the locked treatment room.

In the circumstances, it is said that you were dishonest when you signed for Trazodone being administered on the EMAR system (Charge 13).

<u>Charges 14, 15 and 16 (Scabies Treatment)</u>

On Friday 13 September 2019, Resident F had symptoms of scabies.

At approximately 20:00 on the same day, you allegedly called Witness 1 to ask if you should administer medication. Witness 1 informed you that the doctor instructed that medication must be given. The treatment was a cream that should be applied and washed

off in a bath 24 hours later. This treatment was not to be delayed. It was to ensure the patient was effectively treated and to prevent a wider outbreak in the Home.

Witness 1 was under the impression that the treatment had been administered by you. However, on Monday 16 September 2019, it was discovered that no attempt had been made to apply the cream on the Friday. Witness 4, a Clinical Lead, noted the cream for Resident F had already been delivered, Resident F having been diagnosed. The cream was still in the box and there had been no attempt to apply it. Furthermore, there was no documentation on the medical notes or handover notes regarding the cream. If it had been applied to Resident F, it would have been documented.

Witness 4 also states the cream should have been applied on Resident F on Friday 13 September 2019. The rash would have caused Resident F severe itching and scratching.

On 23 September 2019, Witness 4 informed Witness 1 via email that you had failed to administer scabies treatments to three affected residents.

It is said that you should have recorded that you had received the treatment and the instructions you were given. You should have recorded that you had followed those instructions and recorded that you had administered the treatment.

Your alleged failure to apply cream to Resident F risked causing a scabies outbreak at the Home. You allegedly also put 97 other residents and 120 staff at risk by causing delay in administering treatment.

<u>Charge 17 (Delayed Wound Dressing Changes)</u>

You would allegedly delay changing wound dressings for residents, so you did not have to undertake them, thereby avoiding your responsibilities.

Witness 3 discovered that, between 16 September 2019 and 23 September 2019, you delayed a wound dressing for a female resident.

The Home has a white board for dressings, which highlights the date a change is due. It is also flagged up on the computer system when a dressing is due to be changed.

Witness 3 was aware this Resident's dressing was due to be changed. Following the Registrant's shift, Witness 3 noticed the dressing change had been moved to another date when you were not working.

Witness 3 spoke to the Resident that evening. The Resident told her that you promised her it would be done that day. The Resident was very upset.

The Resident actually required a big leg dressing which required more intensive input. If the dressing is changed less frequently that it should be, the wound would be more prone to infection, which can lead to sepsis.

You should have completed the change during the day. The dressing change should be done by the nurse on duty on the day it is due, according to the whiteboard and the computer system. The due date is based on a dressing regime, which is created either by a Clinical Lead or the hospital. This is a set timetable and nurses should act in accordance with the timetable set.

Charges 18, 19 and 20 (Wound Care)

Witness 5 reported that you applied the wrong type of dressing to Resident E's leg ulcer. On 21 September 2019, Witness 5 was working at the Home. It was a busy morning.

Resident E wheeled himself out of his bedroom complaining his leg was very painful. Witness 5 gave him some paracetamol thinking it was the ulcer on his leg causing him pain. This had no effect, so she looked at the leg again at about 10.00 to assess if the

bandage was on too tight. On examination she found that the correct bandages, known as ‘K-soft’ and ‘K-light’ had not been applied. Instead, compression bandages known as ‘green line’ had been applied.

This is a very tight bandage used to assist circulation. It requires a specialist referral from the vascular clinic. Whilst Resident E had been referred to the vascular clinic, he had not been prescribed compression bandaging. The bandages were immediately removed and replaced with the correct ones.

The records indicated that you had changed Resident E’s dressing on 18 September 2019 and there were no subsequent records.

It is said that you had wrongly recorded in the daily notes for Resident E on 18 September 2019 that you used a K-light bandage. You even recorded that you applied a yellow tubing to the outer dressing. This is a yellow tube-like grip, placed over the top to keep K-light and K-soft bandages in place. It is not actually a bandage. It comes in a small box and is clearly labelled on the package. The green line is a type of bandage, which is cellophane wrapped and it is labelled as ‘green line urgo’.

Your actions were allegedly dishonest in that you knew you had applied the wrong dressing but entered that you had applied the correct wound dressing instead.

<u>Charges 21 and 22 (Dovehaven Lodge)</u>

These charges relate to Dovehaven Lodge Nursing Home.

On 23 September 2019, the Sands Nursing and Retirement Home had informed you that they would not employ you on any more bank shifts due to concerns about your practice.

On 2 October 2019, you applied to, and were interviewed by, Dovehaven Lodge Nursing Home.

You allegedly did not inform your prospective employers that your contract had been terminated by the Sands. You allegedly indicated that you were still employed at Sands and included the Manager as a referee on your application form. Furthermore, you allegedly did not disclose the fact that you no longer worked at the Sands during your interview.

A reference from the Sands was received on 6 November 2019, which highlighted concerns with your practice and confirmed that your contract had been terminated. Dovehaven decided to terminate your contract the same day.

It is said that you deliberately withheld this information from your prospective employer. Your actions were allegedly dishonest in that you were fully aware that your employment with the Sands had been terminated when you completed your application form and/or attended for interview with Dovehaven on 2 October 2019.

Decision and reasons on application to amend the charge

While the panel was retired to consider the disputed charges, it considered that the wording of charge 3 may not accurately reflect the regulatory concerns or the evidence in this case.

The proposed amendment was to ensure that the charge addressed the concern. It was submitted by Mr Khan that the proposed amendment would provide clarity and more accurately reflect the evidence and he supported the proposed amendment as follows:

3. "Your actions in charges 1 and/or 2 were dishonest in that you were attempting to mislead the Home into believing ~~that there were no restrictions on your practise when you knew that there was~~ **that you were not subject to an NMC sanction at the time of your application."**

The panel heard submissions from Mr Buxton that this would not be proper having regard to Rule 28 (1). He submitted that, having regard to the merits of the case and the fairness of the proceedings, the amendment could not be made without injustice.

Mr Buxton submitted that the NMC's case from the outset was that you were actively misleading the Home. He submitted that the issue is whether or not there was any obligation to notify or raise the fact of a caution order. He submitted that the NMC cross examined you on the basis that your caution placed restrictions on your practice. Your defence has always been that there are no restrictions on your practice that you had to declare.

Mr Buxton submitted that, as currently drafted, the charge of dishonesty cannot be found proved because self-evidently there were no restrictions on your practice, nor did the failure to mention it amount to an attempt to mislead the prospective employers. He submitted that, in the panel's written legal advice, its attention was drawn to the NMC's Guidance on Cautions. He submitted that, looking at the particular facts of this case, we know that you filled in an application form. He submitted that at the interview stage, no questions were asked, and Witness 1 was impressed with you during the interview.

Mr Buxton submitted that, because the case was put in charge 3 in the way that it was, you would not have changed anything you said or wanted to add anything as you had explained your actions to us. However, he submitted that he would have sought further clarifications from the witnesses in respect of their actions in regard to giving you the benefit of the doubt, had the charge been drafted as suggested.

Mr Buxton submitted that, if the panel is concerned about this as it has another outcome in mind, it would be moving the goal posts at a late stage, and therefore it would be inherently unfair to allow this application. He submitted that it appears as if the panel wish to find this charge proved but cannot unless the wording of the charge is amended.

Mr Buxton submitted that he is aware that it is a matter for the panel, but he opposed 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). He referred to the case of *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin).

The panel considered the arguments of both Mr Khan and Mr Buxton and reminded itself of its duty to protect the public and uphold the public interest. It considered that the wording of the charge did not reflect the regulatory concern accurately. Further, it considered the submissions by Mr Buxton of potential unfairness, but it felt that these could be mitigated by allowing Mr Buxton to recall witnesses for cross examination. It also noted that Mr Buxton said that you would not have changed your evidence if the wording of the charge had been different.

The panel referred to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision, namely paragraph 23.4:

> ***23 Cooperate with all investigations and audits***
>
> *This includes…*
>
> *To achieve this, you must:*
>
> ***23.4*** *tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment.*

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that no injustice would be caused to either party by the proposed

amendment being allowed and by inviting Mr Buxton to recall relevant witnesses. It was therefore appropriate to make the amendment to ensure clarity and accuracy.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Buxton who informed the panel that you made full admissions to charges 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15a, 15b, 21a, 21b and 22.

The panel therefore finds charges 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15a, 15b, 21a, 21b and 22 proved in their entirety, by way of your admissions.

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

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:

- Witness 1: Deputy Matron at The Sands Nursing and Retirement Home at the time of the incident

- Witness 2: Registered Manager at The Sands Nursing and Retirement Home at the time of the incident

- Witness 3: Clinical Lead at The Sands Nursing and Retirement Home at the time of the incident

- Witness 4: Clinical Lead at The Sands Nursing and Retirement Home at the time of the incident

- Witness 5: Clinical Lead at The Sands Nursing and Retirement Home at the time of the incident

- Witness 6: Senior Carer at The Sands Nursing and Retirement Home at the time of the incident

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. It considered the witness and documentary evidence provided by both the NMC and Mr Buxton.

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

Charge 3

> "Your actions in charges 1 and/or 2 were dishonest in that you were attempting to mislead the Home into believing that you were not subject to an NMC sanction at the time of your application."

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge, including Witness 1's and Witness 2's oral evidence, and your oral evidence.

The panel considered that, under the Code, you had a duty to declare that you were subject to an NMC sanction as you have a duty of candour. This was regardless of the technicalities of a caution order not being a restriction on your practice, or the fact that specific questions were not asked about regulatory findings on the Home's application form or in their interview with you.

The panel was of the view that you knew that you should have declared this, and that you deliberately failed to do so as you wanted the job. By doing so, it was of the view that you were dishonest in not disclosing this to the Home, and that you had attempted to deceive them into believing that there were no concerns with your practice.

The panel noted, during cross examination, your own assessment of your state of mind. It was clear to the panel that it was your deliberate decision not to disclose this information. During cross examination, you said that you knew that you should have disclosed this to the Home.

The panel was of the view that you had a clear obligation to tell your employer. Witness 1 and Witness 2 were recalled today to give additional evidence to their previous evidence after the amendment of the wording of the charge. It noted that, on both occasions, Witness 1 and Witness 2 made it clear that it was an expectation that if you had any issues with the NMC you should have raised these during the interview, and they were surprised that these issues had not been raised.

The panel concluded that you deliberately chose not to share this information and made a conscious decision not to do so. You had a duty to disclose it. The panel determined that an ordinary decent member of the public, having heard all the evidence in this case, would consider your actions to be dishonest. The panel concluded that there is a duty to disclose sanctions regardless of whether it is in the Code or not.

Therefore, the panel found charge 3 proved.

Charge 13)

> "Your actions in charge 11 were dishonest in that you signed Resident D's EMAR chart knowing that you had not administered the medication."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge, including your oral evidence.

The panel was of the view that, your actions in charge 11 were not dishonest, but rather that you failed to follow the Home's Medication Administration Guidance. It noted that, although you should have gone back and realigned the EMAR chart when you found out that the medication had not been given, your intent was not to deceive this as you had signed the chart and intended to give it.

The panel noted that you were aware that you had to give the medication to Resident D, and that the chart had to be signed. It also noted that Resident D was the only resident at the Home on Trazadone, so it was a tablet he should have had. You had dispensed the Trazadone with the intention of administering it, but she initially refused it and you accepted Resident D's husband's offer to try to administer it. The panel was of the view that this is an indication that you had expected Resident D's husband to administer the medication to Resident D on your behalf, as opposed to your intention being to not administer the medication whatsoever.

The panel also noted that. in your oral evidence, you said that you *'knew you should have gone back and amended it'* [on the EMAR system].

The panel was of the view that you came across as being chaotic in your approach to your practice. It noted that you did not undertake your procedures correctly albeit it was not your intention to deceive anyone.

The panel concluded that the NMC have not proved you had a deliberate intention to not administer the medication to Resident D.

Therefore, the panel found charge 13 not proved.

Charge 15c)

> "[That you, a registered nurse, on 13 September 2019 failed to;] Handover to Colleague 1 that the scabies treatment had not been provided to Resident F."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge, including Witness 3's written statement dated 9 April 2021, her oral evidence, and your oral evidence.

The panel noted that Witness 3 could not remember what was handed over, as stated in her written statement:

> *'…I cannot recall what the Registrant handed over to me but she did not inform me about the creams not being applied.'*.

The panel further noted that, in Witness 3's oral evidence, she said that you were in a *'rush to leave'*, *'wasn't sure what unit it was'*, and that you could not remember what was said in the handover.

The panel noted that, in your oral evidence, you could not remember who you handed over to, whether it was Witness 3 or another nurse who was not called to give evidence as a potential witness.

The panel concluded that the NMC have not made out that you failed to handover to Colleague 1 that the scabies treatment had not been provided to Resident F, as Witness 3 could not remember what was handed over, nor could she provide enough detail in her written statement and oral evidence. It was of the view that there was a lack of evidence to say you did not handover.

Therefore, on the balance of probabilities, the panel found charge 15c not proved.

Charge 16)

> "That you, a registered nurse, on 13 September 2019 failed to make sure that treatment for scabies for Resident F was delivered without undue delay."

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge, including your oral evidence.

The panel was of the view that, by failing to make sure that treatment for scabies for Resident F was delivered without undue delay, it would have left Resident D very itchy and uncomfortable.

The panel noted that there is sufficient evidence to support this charge. It noted that, in your oral evidence, you said that you *'did not do it'*, and the other witnesses said that they found the treatment cream unopened and unused.

Further, the panel noted that you admitted to charge 14 which, in the panel's view, is very similar to charge 16. It interpreted the wording of charge 16 to be identical to charge 14 in its effect, noting that charge 14 has been admitted. It also reviewed the evidence and found it proved.

The panel also noted that, in your oral evidence, you said that you called Witness 1 at 16:00. However, in relation to Resident F's Observation Records for the period between 12 September 2019 to 16 September 2019, the panel noted that you made an entry at 20:39 making no mention of the scabies. The Daily Care Note stated:

> *'[Res F] has had all his care needs met by staff ,up in his chair today while his bedroom and bed had a deep clean ,appears a lot more comfortable at time of reporting...'*.

Further, the panel noted that it was not until Monday morning that someone, namely Witness 4, picked this up and that nothing was done over the weekend.

Therefore, the panel found charge 16 proved.

Charge 17)

> "That you, a registered nurse, on one or more occasions between 16 September and 23 September failed to make sure that an unknown Resident's wound dressing was changed without undue delay."

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge, including Witness 1's written statement dated 9 April 2021, Witness 3's written statement dated 9 April 2021, and your oral evidence.

The panel first noted that there was no direct evidence from the unknown Resident, but that the Resident was reported by Witness 3 as being upset about the wound dressing not being changed.

The panel noted that you admitted that you changed the timing on the board once, namely on 13 September 2019. However, although this does not fit the dates listed in the charge, namely between 16 September 2019 and 23 September 2019, the panel was of the view that your evidence was contradictory. Thus, it decided that your evidence was unreliable in terms of dates.

The panel noted that Witness 3 stated, in her written statement, and in relation to delayed wound dressing changes, that it was:

> *'Approximately between 16 September 2019 and 23 September 2019, I discovered that the Registrant delayed a wound dressing change for a particular female resident…'.*

Further, the panel noted that Witness 1 stated, in her written statement, and in relation to delayed wound dressing changes, that:

> *'The Registrant would delay changing wound dressings for residents so that she did not have to undertake them…The Registrant was wiping these out when she was due to change one and moving them to another day. This was an ongoing issue…'*.

On the balance of probabilities, the panel found it to be more likely than not that you failed to make sure that an unknown Resident's wound dressing was changed without undue delay on one or more occasions.

Therefore, the panel found charge 17 proved.

Charge 18)

“That you, a registered nurse, on 18 September 2019 failed to apply the correct wound dressing to Resident E.”

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge.

The panel was of the view that, if Resident E went into the bath on 21 September 2019, the dressing would be removed and another dressing would be re-applied. It noted that you were not working on shift at that time, and so there was not enough sufficient evidence from NMC to link you with the incorrect type of bandage that was found on Resident E.

The panel noted that you said, in your oral evidence, that you have never come across a compression bandage before. The panel found this surprising, given your more than 30 years of experience in nursing and the common use of such bandaging in the care home sector.

The panel had regard to Resident E’s patient notes. It noted your entry to be very specific on 18 September 2019, which stated:

> *‘…An updated entry has been made to the Ulcer on the body map…wound remains slow to heal ,in a difficult area as its in the natural curve of the foot ,leaned with prontasan aquacell ultra put in situ with atrauman with a zetuvit followed by wool wadding and klite bandage .yellow line also in situ for comfort and protection .’ [sic]*.

The panel also considered the amount of time that had passed from your dressing to Witness 5’s dressing (three days). It noted that Witness 5 was not particularly clear, in her oral evidence, about seeing the dressing on Resident E before his bath, and whether she

took it off and redressed it or not. The panel could not determine, on the balance of probabilities, who put the incorrect dressing on.

Therefore, the panel found charge 18 not proved.

Charge 19)

> "That you, a registered nurse, on 18 September 2019 incorrectly entered on Resident E's patient notes the wound dressing that was applied to Resident E."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence for this charge.

The panel had regard to Resident E's patient notes and records and its findings in respect of charge 18. It noted that you made detailed observation records.

The panel was of the view that, on the balance of probabilities, your entry on Resident E's patient notes were accurate.

Therefore, the panel found charge 19 not proved.

Charge 20)

> "Your actions in charge 19 were dishonest in that you knew that you had applied the wrong dressing but entered that you had applied the correct wound dressing instead."

This charge is found NOT proved.

This charge falls away as the panel did not find charge 19 proved.

Therefore, the panel found charge 20 not proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Khan invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Khan identified the specific, relevant standards in the Code where he submitted that your actions amounted to misconduct, namely paragraphs 1, 1.2, 1.4, 3, 3.1, 3.4, 4, 4.1, 8, 8.2, 8.4, 8.5, 10, 10.1, 10.2, 10.3, 14, 14.1, 14.2, 14.3, 19, 19.1, 19.3, 19.4, 20, 20.1, 20.2, 20.3, 20.5, 20.8, 23, 23.4, 25 and 25.1.

Mr Khan submitted that whether the facts admitted/proved amount to misconduct is a matter of judgement for the panel. He submitted that the burden of proof does not apply.

Mr Khan also referred to the cases of *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Mr Khan submitted that the panel need to consider whether the facts proved involve some serious act or omission by you, and in relation to your professional practice. He submitted that the conduct reflected in charges 3 and 22 involved dishonesty. He submitted that the panel also noted that you came across as being chaotic in your approach to your practice and that you did not undertake clinical procedures correctly.

Mr Khan submitted that this pattern of behaviour amounts to misconduct due to its serious nature and the involvement of dishonesty on your part.

Mr Buxton submitted that, for impairment to be found, there has to be a finding that the acts found proved amount to misconduct.

Mr Buxton submitted that, as charge 3 has been found proved and charge 22 has been admitted and both involve dishonesty, it is accepted they amount to misconduct. He went on to submit that the panel must be satisfied that other acts of omissions fell seriously short in order to find misconduct. He submitted that the act of negligence or breaches of the Code do not automatically amount to misconduct, and that the findings or omissions must be serious.

Mr Buxton submitted that, apart from charges 3 and 22, the acts admitted and found proved consist of clinical failings and failures in relation to documentation and record-keeping, as well as medication administration errors. He submitted that, there is a matter in relation to not ensuring that treatment was provided, or not provided, to a patient in respect of scabies.

Mr Buxton submitted that it is not usually the case that one makes individual submissions in respect of misconduct in regard to specific charges. However, he submitted that, in this case, there is one charge that the panel may consider misconduct has not been established, namely charge 17. Further, he submitted, in relation to charge 17, that you accepted and explained that because of poor time management and lack of time, you handed over a dressing change and transferred the date to the next shift.

Mr Buxton submitted that, considering all the circumstances of that charge in accordance with the agreed NMC evidence, it is not uncommon for matters to be handed over and delegated to others when a nurse runs out of time. He submitted that it is a matter for the panel to determine whether the facts found proved amount to misconduct.

Submissions on impairment

Mr Khan 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2), Grant* [2011] EWHC 927 (Admin) and *Yeong v General Medical Council* [2009] EWHC 1923 (Admin).

Mr Khan submitted that impairment is not defined by NMC legislation and that this is a matter of judgement for the panel.

Mr Khan submitted that, in the event that the panel finds that your behaviour amounts to misconduct, it should then proceed to consider whether, by reason of your behaviour, your fitness to practise is currently impaired as of the date of the hearing.

Mr Khan referred to Dame Janet Smith's "test" in the report to the Fifth Shipman Inquiry and submitted that limbs (a) to (d) are applicable in this case.

Mr Khan submitted that your fitness to practise is impaired by reason of your misconduct, both for public protection and in the public interest.

Mr Buxton submitted that the question is whether the panel considers your fitness to practise impaired, and whether or not you are suitable for unrestricted practice in the circumstances of this case.

Mr Buxton submitted that the panel should consider the impairment question for today's date, but also be informed by the past. He submitted that the panel should consider whether you potentially pose a risk to the public, and whether a finding of impairment is necessary and/or whether there's a public interest in making a finding, in order to declare and uphold proper standards.

Mr Buxton submitted that charges 3 and 22 are likely to have a finding of impairment in order to uphold proper standards of behaviour in the profession if misconduct is found. He submitted that it is important with regard to the remaining charges to consider the risk of repetition. He submitted that if there is no risk of repetition at all, it is hard to see how a finding of impairment on public interest grounds is necessary.

Mr Buxton submitted that it is also important to consider the factors that go crucially to assess that risk, including insight. He submitted that, looking at your oral evidence today, and also having regard to the documents you have provided, there is clear evidence of insight on your part. He submitted that you point to a number of features, some very personal, that were playing a part in your life at the relevant time. He submitted that you

do not mention these as an excuse, nor in any way to mitigate or seek to diminish the impact or seriousness, but rather to offer an explanation.

Mr Buxton submitted that you put in your reflective piece that you are confident that this was a period that you will never endure again. Further, that you feel that you will not be affected by those matters in the way that you were affected at the relevant time. He submitted that your behaviour was not deliberate but rather a serious departure from the standards that you know by being chaotic.

Mr Buxton referred to your Curriculum Vitae. He submitted that you have demonstrated that, since 2019 and this referral, you have been open and honest with all your employers and took time away from work before returning and becoming Clinical Lead. He submitted that this aligns with the insight that you have demonstrated in your oral evidence and reflection, which were both candid and honest.

Mr Buxton submitted that you have positive testimonials that speak to safe practice. He submitted that the panel also has your completed training certificates before it, albeit three of them are extremely recent and two were carried out today. Despite this, he submitted that you are demonstrating that you are mindful of what is required in respect of the areas concerned and that there have been no further incidents or causes of concerns since 2019.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Saha-v-GMC* [2009] EHWC 1907 (Admin), *Zygmunt-v-GMC* [2008] EHWC 2643 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *CHRE v NMC and P Grant* [2011] EWHC 927 (Admin), *Ashton –v- GMC* [2013] EHWC 943, *Cohen-v-GMC* [2008] 581 (Admin) and The Fifth Shipman report of Dame Janet Smith.

Decision and reasons on misconduct

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

The panel found 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:

> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay…*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> ***8 Work cooperatively***
>
> *To achieve this, you must:*
>
> ***8.2** maintain effective communication with colleagues*
>
> ***8.3** keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff*

10 Keep clear and accurate records relevant to your practice This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

To achieve this, you must:

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

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

10.3 *complete all records accurately…*

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

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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

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

To achieve this, you must:

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

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection, and*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.*

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…*

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

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

23.4 *tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional healthcare environment, and*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was satisfied that the above paragraphs of the Code are relevant and engaged in this context.

In relation to charges 1, 2 and 3; 10; and 21a, 21b and 22, the panel determined that your acts amounted individually to misconduct and noted that these charges included those involving dishonesty.

In relation to charges 4, 5, 6, 7, 8, 9, 11, 12, 14, 15a, 15b, 16 and 17, the panel determined that, collectively, your actions amounted to misconduct due to your clinical failings, pattern of poor behaviour, and an overarching poor practice. Albeit some charges listed, including 6, 7, 8 and 9, were at the lower end, the panel still found that they breached the threshold of seriousness when looking at the charges collectively.

The panel found that your actions did fall 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 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 finds that patients were potentially put at risk of physical harm as a result of your misconduct. Your misconduct 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 extremely serious. The panel noted that your behaviour had been found to be dishonest by a regulatory panel for the second time.

Regarding insight, the panel carefully considered the evidence before it and determined that your insight was limited. Your admission to charges at the start of the hearing and remorse about the events in 2019 indicated a level of understanding and awareness of the seriousness of the charges. However, the panel was concerned that your explanations about how you have found yourself in front of the regulator for a third time demonstrated a lack of learning. The panel was not convinced that you accepted or understood the seriousness of the potential risk of harm and was concerned about the lack of accountability for your actions.

The panel was concerned that there remained a risk of repetition. Although your practice in relation to clinical failings is capable of remediation, the panel noted that you had repeatedly undertaken medicines administration assessments (and been assessed as competent) but continued to make errors. The panel also noted that you had not disclosed to the most recent assessor that you were before this panel for medicine administration errors.

[PRIVATE].

The panel considered that you have not sufficiently demonstrated an understanding of why what you did was wrong, the potential for harm to patients, how your behaviour affected your colleagues and how it impacted negatively on the reputation of the nursing profession, nor have you sufficiently demonstrated how you would handle the situation differently in the future.

The panel took into account your recent testimonies. However, it noted that your referees have only known you since August 2023 which did not directly address the charges. The panel was of the view that, whilst you had made a good start in your new job, you did not provide enough evidence for it to determine that you have remediated the concerns.
With regard to the dishonesty charges, the panel was concerned that your insight into the gravity of the dishonesty and your lack of learning, having admitted dishonesty to the regulator in the past, raised serious questions about your dishonesty being remediable.

The panel was of the view that there is a high risk of repetition based on your repeated dishonesty and chaotic practice and the fact that your actions had potential to cause harm to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 reasonable and well-informed member of the public would be concerned if a nurse facing such charges was not found impaired. It concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Adjournment Application

After the handing down of the panel's impairment decision, Mr Buxton made an application for an adjournment to the following day to allow time for you to understand the decision that had been made and the implications of Mr Khan's written sanction submission which altered the NMC's original sanction bid from a suspension order to a striking-off order. Having heard advice from the legal assessor and cognisant that sufficient time remained in the listed hearing dates, the panel allowed the application.

Sanction

At the outset, and before hearing submissions on sanction, Mr Buxton called Witness 7 to give evidence to the panel. Witness 7 is the Interim Manager of the Home you are currently working at. She is not a registered nurse. The panel heard that you have made a good start in your two months at the Home and are well regarded by care staff and trusted by Witness 7. Witness 7 believed that you have been honest and open about the regulatory concerns.

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

Mr Khan informed the panel that in the Notice of Hearing, dated 11 July 2023, the NMC had advised you that it would seek the imposition of a suspension order for a period of 9 to 12 months, with a review, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a striking-off order is more appropriate in light of the panel's findings.

Mr Khan submitted that the purpose of any sanction is not to punish you, although it may be punitive in effect. He submitted that the purpose is threefold: namely, the protection of members of the public; the maintaining of public confidence in the profession and the NMC as regulator; and to declare and uphold proper standards of conduct and performance within the nursing and midwifery profession.

Mr Khan submitted that the panel should take into account the fact that any sanction may have a severe impact upon you, and in particular may prevent you from earning a living. However, he submitted that it is necessary to impose restriction in the public interest and for public protection. He submitted that the panel should consider each sanction in ascending order and that it must only move on to the next sanction if the one under consideration is not sufficient in terms of dealing adequately with the issues identified.

The panel also bore in mind Mr Buxton's submissions. He submitted that dishonesty encompasses a very wide range of facts and circumstances, as stated in the case *R (on the application of Hassan) v General Optical Council* [2013] EWHC 1887 (Admin). He submitted that the panel should consider the full circumstances of this case in deciding what is a proportionate and appropriate sanction.

Mr Buxton submitted that the initial sanction bid had been a suspension order. He submitted that this is not a case where you have shown no insight at all, as you made 'full and appropriate' admissions at the outset of the hearing. He submitted that you may not have expressed yourself in the 'perfect' matter, but you have still demonstrated developing insight and understanding. He submitted that you have been working well in your current role, and the panel heard from your line manager yesterday, namely Witness 7. He submitted that you have demonstrated remediation over four years, and most recently.

Mr Buxton submitted that you have personal mitigation, including [PRIVATE]. In relation to dishonesty, he submitted that your acts of dishonesty are properly remediable. He invited the panel to look at the extent and nature of the dishonesty in this case, and whether you caused any loss or harm. He submitted that a suspension order, with a review, would meet the justice of this case as it is immediate, salutary and proportionate.

Decision and reasons on sanction

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

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 was of the view that your dishonesty was repeated and deliberate, and that you received financial gain through employment in both instances. It reminded itself that this is the third time you have been before your regulator, and the second time for dishonesty. In relation to this case, while the panel accepted that your dishonesty was not at the highest end of the spectrum of seriousness, it determined that it was clearly not at the lowest end either.

The panel took into account the following aggravating features:

- Previous regulatory history of a similar nature, including dishonesty, showing complacency and lack of respect for the regulator
- A wide-ranging pattern of misconduct over a period of time, including two separate instances of dishonesty in this case
- Dishonesty is always serious
- Patients were at potential risk of suffering harm
- You apologised many times, but the panel was not convinced of the sincerity of your remorse or that your insight has developed to the point where you have real understanding of the impact of your misconduct
- Lack of duty of candour in relation to the clinical errors you made

The panel also took into account the following mitigating features:

- Your admissions to most of the charges

- Positive testimonies, including from your current line manager

[PRIVATE].

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.

The panel 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 findings. The panel noted that you have received two previous caution orders in 2017 but had gone on to commit similar instances of misconduct in 2019. The panel therefore decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practicable or workable conditions that could be formulated, given the nature of the dishonesty charges in this case. This option would only have been potentially appropriate if your misconduct had solely been related to your clinical failings. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that 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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with your remaining on the register. The panel found that you deliberately breached the professional duty of candour in not revealing your regulatory sanction or employment status respectively in your two job applications, and that your actions led to a potential for direct risk to patients.

This was not a single instance of misconduct, but a pattern of behaviour. Whilst the panel did not find your deception and your clinical failures to be maliciously motivated, your chaotic approach to your practice was indicative of attitudinal problems. The panel did not find your insight to be sufficiently developed to be confident that you would be safe to return to practice after a review.

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

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

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

The panel considered that your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with your remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. It also considered that you have now been before the regulator a total of three times.

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 themselves, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

This will be confirmed to 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 Mr Khan. He submitted that an interim suspension order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest. He submitted that this was required to cover the 28-day appeal period and, if you do appeal the decision, the period for which it may take for that appeal to be heard. He submitted that the reputation of the profession would be significantly undermined if, despite the panel's findings, an interim suspension order was not in place, and you were allowed to practise unrestricted during the appeal period.

Mr Buxton did not oppose this 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 28-day appeal period and any period which an appeal may be heard.

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.