Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 19 June 2023 – Friday 7 July 2023
Monday 11 September 2023 – Friday 15 September 2023

Virtual Hearing

Name of registrant:	Sabitha Joseph
NMC PIN:	05K0389O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 17 November 2005
Relevant Location:	Bolton
Type of case:	Lack of competence
Panel members:	Penelope Titterington (Chair, Lay member) Jonathan Coombes (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	Ian Ashford-Thom (19 June 2023 – 7 July 2023) Richard Tyson (11 September 2023 – 15 September 2023
Hearings Coordinator:	Petra Bernard (19 June 2023 – 28 June 2023); 4 July 2023 – 7 July 2023) and 11 September 2023 – 15 September 2023 Jumu Ahmed (29 June 2023 – 3 July 2023)
Nursing and Midwifery Council:	Represented by Amanda Bailey, Case Presenter
Miss Joseph:	Present and not represented (19 June 2023 – Friday 7 July 2023) and(12 September 2023 – 15 September 2023) Not present and not represented (11 September 2023)
Facts proved:	Charges 1, 2, 3, 4a, 4b, 5, 6a, 6c, 7, 9a, 9b, 9c, 10a, 10b, 13, 14a, 14b, 14c,14e, 15a, 15d,15e, 16, 18, 19a, 19b, 21a, 21b, 21c

Facts not proved:	Charges 6b, 6d, 8,11a, 11b, 12a, 12b, 14d, 15b, 15c,17a, 17b, 19c, 20
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you, between June 2017 and November 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) Inappropriately sent a patient for a scan without being accompanied after they had suffered a hypoglycaemic attack.

2) Incorrectly administered 1g of paracetamol to a patient when they were prescribed 500mg.

3) Failed to administer intravenous Frusemide to a patient.

4) On 20 April 2018 whilst looking after a diabetic patient on an insulin variable rate sliding scale:

    a) Used the incorrect monitoring form
    b) Failed to carry out blood sugar level checks with sufficient regularity.

5) On 20 April 2018 failed to provide assistance to a patient who was then at risk of choking.

6) On 04 May 2018:

    a) Incorrectly documented a patient had eaten a full meal when the patient had eaten only a small part of the meal.
    b) Inappropriately provided a patient who was on a thickened fluid diet with ice cream.

c) Inappropriately continued to feed Patient B when Patient B was not alert and was suffering delayed and reduced swallowing ability.
d) Failed to treat Patient B with care and compassion in that you shouted ‘open your mouth, open your mouth’ or words to that effect at the patient.

7) On 18 June 2018 failed to provide safe and effective patient care in that you failed to monitor and act upon a patient’s absence of fluid output.

8) On a date (unknown) between September and October 2018 carried out an unnecessary blood sugar assessment on a patient who was not diabetic and did not require a blood sugar assessment.

9) On a date or dates (unknown) in December 2018:

a) Failed to administer Fentanyl pain relief to a patient who required it.
b) Pre-completed documentation relating to a patient up to 12 noon before 9.30am.
c) Whilst dealing with the controlled drugs, failed to check the drugs were correct before signing the controlled drug book.

10) On a date (unknown) between 28 December 2018 and 11 February 2019, in relation to a patient:

a) Incorrectly calculated the risk assessment for nutrition
b) Incorrectly calculated the Waterlow (risk of pressure sores) score.

11) On 4 January 2019:

a) Incorrectly advised a colleague that 15 minute observations were not necessary for a post blood-transfusion patient.
b) Failed to document intravenous fluids on a patient’s fluid balance chart.

12) On 11 January 2019 Failed to provide adequate patient care in that you:

a) Inappropriately provided personal care on your own when the patient required two members of staff to provide personal care.
b) Failed to treat a patient with care and compassion in that you spoke harshly to them saying ‘you are not cooperating, you need to help me move your arm’ or words to that effect.

13) On 15 January 2019 failed to carry out GCS neuro observations on a patient who had suffered an unwitnessed fall.

14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:

a) Incorrectly recorded a patient fall.
b) Failed to document a risk of climbing over bed rails
c) Incorrectly recorded the patient as having adequate eyesight
d) Recorded irrelevant details in the mobility section
e) Failed to record an issue with balance.

15) On 19 March 2019:

a) Failed to provide safe and effective care in that, when asked by a colleague to confirm a patient’s fluid intake, you ripped up the fluid balance sheet and told the colleague to ‘write another one out’ or words to that effect without confirming the patient’s fluid intake.
b) Refused to assist a patient in using the toilet when requested to do so by a colleague using the words ‘I will do it in my own time and not when you tell me’ or words to that effect.
c) Failed to prioritise patients and preserve safety by leaving a vulnerable patient unattended.
d) Refused to stop feeding a patient who had independent feeding ability when required to do so by a senior colleague.

e) Handled a patient roughly and without care thereby causing the patient to sustain a skin tear.

16) On 04 May 2018 took Patient A's capillary blood sugar reading without first cleaning the patient's finger.

17) On 26 September 2019:

a) Omitted to administer prescribed medication to a patient
b) Made inadequate records in a patient's medical notes.

18) On 27 September 2019 failed to work professionally in that you completed patient observations independently having not been assessed as competent to do so.

19) Between 24 September and 11 October 2019:

a) Failed to communicate appropriately or at all with a patient
b) Used inappropriate language in that you referred to a patient suffering with dementia as being 'demented'
c) Failed to provide safe and effective care in that you refused to attend to a patient who was bleeding when requested to do so by a colleague.

20) On 11 October 2019 failed to follow instructions from a senior colleague in that you attempted to take patients' blood independently having been told you must only do so under supervision.

21) Failed to work collaboratively and as part of a team in that you failed, without notifying anyone, to attend for duty on the following dates:

a) 29 July to 16 August 2019
b) 09 September to 23 September 2019
c) 12 October to 15 October 2019.

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

Decision and reasons on application for hearing to be held in private (Day 3)

Ms Bailey made a retrospective request that this case be held partly in private on the basis that proper exploration of your case may involve matters arising relating to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application to the extent that any matters relating to your health should be heard in private.

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 decided that the interests of preserving the confidentiality of matters relating to your health outweighed the public interest in holding such parts of the hearing in public. Accordingly, the panel directed that any references to your health should be marked as private.

Decision and reasons on application to amend the charge (Day 4)

The panel heard an application made by Ms Bailey, on behalf of the NMC, to rectify the year in the date of charge 16.

The proposed amendment was to rectify the incorrect year in the given date of the charge. She submitted that this was a typographical error. It was submitted by Ms Bailey that the proposed amendment would provide clarity and more accurately reflect the evidence.

Original charge

> ‘That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:
>
> 16) On 04 May 2019 took Patient A’s capillary blood sugar reading without first cleaning the patient’s finger.
>
> And in light of the above, your fitness to practise is impaired by reason of your lack of competence’

Proposed amended charge

> ‘That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:
>
> 16) ‘On 04 May ~~2019~~ **2018** took Patient A’s capillary blood sugar reading without first cleaning the patient’s finger.
>
> And in light of the above, your fitness to practise is impaired by reason of your lack of competence’

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment was in the interests 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 to ensure clarity and accuracy in line with the evidence.

Decision and reasons on application to admit Ms 1's written statement into hearsay evidence (Day 4)

The panel heard an application made by Ms Bailey under Rule 31 to allow the written statement of Ms 1 into evidence. Ms 1 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present. Ms 1 was unable to attend today, having notified the NMC that she would be out of the country on holiday with her family. She submitted that there appeared to be nothing controversial in Ms 1's evidence and that it would be fair and relevant for her witness statement to be read out in evidence.

You did not object to the application. However, as you are unrepresented, the panel did not treat this as a decisive consideration.

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

The panel gave the application in regard to Ms 1 serious consideration. The panel noted that Ms 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 1 to that of a written statement.

The panel took into account that you had been provided with a copy of Ms 1's statement in advance and informed that the NMC would seek to have the statement admitted in

evidence. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel was aware that there would therefore be no opportunity to question Ms 1. However, as her evidence appeared largely if not wholly uncontroversial, this would not result in prejudice to you.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Ms 1, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit Ms 2's written statement into hearsay evidence (Day 4)

The panel heard an application made by Ms Bailey under Rule 31 to allow the written statement of Ms 2 into evidence. Ms 2 was not present at this hearing and, despite significant efforts over a long period of time to contact her to ensure her attendance at this hearing, she has not responded or attended. Ms Bailey told the panel that these efforts had included applying to the High Court for a witness summons to compel her to attend. The summons was duly issued. Unfortunately, however, it appeared that the NMC Case Officer responsible for serving the summons may have omitted to do so.

You did not object to the application. However, as you are unrepresented, the panel did not treat this as a decisive consideration.

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

The panel gave the application in regard to Ms 2 serious consideration. The panel noted that Ms 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 2 to that of a written statement.

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The panel considered that as you had been provided with a copy of Ms 2's statement in advance. The panel also accepted that numerous efforts had been made to secure her attendance and a witness summons had, at least, been obtained. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel noted that there was an apparent explanation for Ms 2's failure to engage linked to a personal change in circumstances. There was no reason to think it was a reflection on the validity of her evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Ms 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge (Day 7)

The panel heard an application made by Ms Bailey, on behalf of the NMC, to rectify the incorrect month in the date of charge 10.

The proposed amendment was to correct the month in the stem of the charge.
She submitted that this was a typographical error. It was submitted by Ms Bailey that the proposed amendment would provide clarity and more accurately reflect the evidence of Witness 5.

Original charge

> 'That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

10) On a date (unknown) between 28 December 2018 and 11 January 2019, in relation to a patient:

a) Incorrectly calculated the risk assessment for nutrition

b) Incorrectly calculated the Waterlow (risk of pressure sores) score.

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

Proposed amended charge

'That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

10) On a date (unknown) between 28 December 2018 and 11 ~~January~~ **February** 2019, in relation to a patient:

a) Incorrectly calculated the risk assessment for nutrition

b) Incorrectly calculated the Waterlow (risk of pressure sores) score.

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment 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 to ensure clarity and accuracy in line with the evidence.

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 Bailey on behalf of the NMC and those made 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.

Background

The charges arose whilst you were employed as a Band 5 Nurse at the Bolton NHS Foundation Trust (the Trust) from 12 June 2017 until your dismissal on 13 November 2019.

You had been subject to an action plan since September 2017 and had at no time progressed from supernumerary status. As a result, you were progressed to the Trust's formal capability process until their dismissal at a stage four capability review meeting on 13 November 2019. You were referred to the NMC on 15 November 2019, and the areas of concern included:

- managing patients unsupervised;
- responding to the needs of deteriorating patients;
- confidence and initiative;
- provision of personal care;
- communication concerns.

You were assigned to Ward [PRIVATE], when you commenced your employment at the Trust. You completed a four week induction period where you worked in a supernumerary capacity. You came off supernumerary practice for two weeks but were then placed back into supernumerary practice as there were concerns with your practice in the areas of medication management, management of diabetes and the safe transfer

and escort of patients. An incident then occurred where you allegedly sent a hypoglycaemic patient for a radiology scan unaccompanied by a nurse after the patient had suffered a hypoglycaemic attack.

Following this incident, you attended a meeting with the Matron of [PRIVATE] on 25 September 2017 and you were placed on a supportive informal action plan, which had several objectives designed to support your transition into independent practice.

You then struggled to complete the initial action plan on [PRIVATE], however, this was said to be due to a change in management on [PRIVATE], which led to you not being provided with the supervisory support you needed. On 5 December 2017, you were moved to another [PRIVATE] ward, which was [PRIVATE], as it was felt that you would receive the support you needed in order to complete your action plan.

[PRIVATE] is a 24-bedded [PRIVATE]. The patients on the Ward had a wide range of abilities and a variety of needs, including difficulties with speech, mobility and eating. Some patients had cognitive problems alongside their physical issues.

On 6 March 2018, you attended a meeting with Ward [PRIVATE] Ward Manager, Witness 6, where you were placed on an updated action plan as you had failed to meet the objectives set in the initial action plan. It is said that after this meeting, you continued to require constant prompting from nursing staff to perform routine tasks.

While you continued to work in a supernumerary capacity on [PRIVATE], further concerns and incidents arose which led to you being placed on a capability plan.

On 11 May 2018, you attended a meeting with Witness 1 and you were placed on a stage one formal capability plan in line with the Trust's capability process. Shortly after commencing the capability plan, further incidents occurred which led to you being required to attend a capability review meeting on 24 May 2018. At this meeting, Witness 1 discussed the incidents with you, and it was decided you would continue on the capability plan and attend weekly supervision meetings with Witness 6.

On 30 August 2018, you attended a capability review meeting with Witness 1 and two areas of concern with your practice were discussed, namely your ability to recognise

and respond to an unwell patient, and your ability to recognise and care for a patient suffering from dysphagia. Further incidents regarding your management of patients with dysphagia, which had been reported to Witness 1 since the previous review meeting, were also discussed and it was decided that you would be escalated to stage two of the formal capability process. You continued to work on [PRIVATE] from August until September 2018.

On 1 October 2018, you commenced a four week trial on [PRIVATE], which was the [PRIVATE]. Due to concerns being raised about you appearing to be disinterested in the patients and providing care to them, you were then transferred back to [PRIVATE] in November 2019 to continue on stage two of the capability plan.

An incident then occurred on 11 January 2019, where it was alleged that you undertook personal care for a stroke patient on your own when the patient required the assistance of two people. It is said that you began washing the patient without the assistance of another member of staff to attend to the patient's personal hygiene needs. You were heard raising your voice to the patient and telling the patient that they were not co-operating and needed to move their arm. There was allegedly no compassion and the patient was shouting and crying out in response to your actions. The Trust commenced a local investigation into this incident.

This led to Witness 1 holding a meeting with you on 23 January 2019 at which it was explained to you that there were ongoing concerns with your:

- communication;
- ability to identify and respond to deteriorating patients;
- ability to provide personal care without causing pain to patients;
- lack of professional behaviour;
- unwillingness to follow instructions or assist colleagues with patients;
- failure to respond or assist when there were obvious signs of deterioration in the patients in their care;
- lack of empathy and communication skills;
- failure to respond to patients presenting with pain or discomfort;
- lack of basic understanding of the conditions and presentation of the patient group they cared for and their inability to care plan accordingly; and

- record keeping.

In light of the above and the ongoing lack of improvement, you were moved to stage three of the Trust's formal capability process.

On 19 March 2019, two further incidents occurred which were reported to Witness 1 by Witness 2. It was alleged that:

- You failed to adhere instructions from Witness 2 to stop feeding a patient who was cable of feeding themselves and assist another patient who was not capable of feeding themselves; and

- A patient had sustained a skin tear while receiving care from you.

On 21 March 2019, the Trust's [PRIVATE] Ms 1 wrote to you informing you that a disciplinary hearing would be held in relation to both incidents. On 5 July 2019, you attended a disciplinary hearing. Whilst the facts were upheld, the panel were satisfied that you had not caused any intentional harm to the patients on 11 January 2019 and 19 March 2019. The Trust wrote to you on 2 August 2019 informing you that you had been given an 18 month final written warning as a result of the incidents and that you could continue on the stage three capability process.

On 24 July 2019, you then returned to work and attended a capability review meeting with Witness 1. You were informed that you had failed to compete your action plan and meet its objectives, and that the outstanding objectives included identifying and responding to deteriorating patients, lacking competence in managing a team of patients, which was the ability to work independently, and providing personal care to patients. It was decided that you would be transferred to [PRIVATE], an [PRIVATE] ward on 29 July 2019.

On 24 September 2019, you attended a final stage three capability review meeting with Witness 1. It was explained to you that you had five weeks remaining to meet the objectives of their stage three capability plan. At your request, it was agreed that you could work five short shifts per week.

On 22 October 2019, you attended a stage three capability review meeting with Witness 1 and due to your failure to complete the objectives of your capability plan, you were escalated to stage four of the Trust's capability process, which was a final capability hearing.

On 23 October 2019, Witness 1 wrote to you and informed you that you had been progressed to stage four of the Trust's capability process and invited you to attend a stage four capability hearing which was held on 13 November 2019.

At the hearing, you were dismissed from your role as a Band 5 Nurse and referred to the NMC.

Chronology of employment dates and alleged events

17 November 2005	You joined the NMC Register.
12 June 2017	You commenced employment at the Trust on [PRIVATE].
11 September 2017	Concerns were raised with your clinical practice on [PRIVATE].
25 September 2017	You were placed on a supportive informal action plan.
2 October 2017	Concerns were raised about your medication calculations.
3 November 2017	Concerns were raised about your assessment of postural blood pressure for a patient.
1 January 2018	You were placed on an informal capability plan.
6 March 2018	Further concerns arose with the care provided by you to deteriorating patients and timeous intervention. Witness 5 placed you on an updated informal capability plan.
20 April 2018	You failed to conduct hourly blood checks and complete blood sugar monitoring forms for a diabetic patient.

	You failed to respond to a request from a healthcare assistant to provide suctioning to a patient who had difficulty swallowing their food.
4 May 2018	You did not take blood glucose readings correctly, did not complete food charts accurately, and fed a patient who was not alert.
16 June 2018	You failed to act on poor urine output.
18 June 2018	You failed to document a patient's fluid balance chart and flush their catheter.
10 September 2018	First stage two formal capability discussion.
24 September 2018	Action plan amended.
December 2018	You signed the controlled drugs book without checking if the drugs administered were correct before signing.
4 January 2019	You informed an agency nurse that they did not need to undertake 15 minute observations post blood transfusion.
	You failed to escalate a patient's usually low heartrate of 50 bpm.
11 January 2019	You tried to move a stroke patient who had a right sided weakness without the assistance of another member of staff.
14 January 2019	The Trust wrote to you informing you that a local investigation had been commenced into the incident on 11 January 2019
15 January 2019	Concerns were raised related to your failure to complete neurological observations after a patient fall.
w/e 8 February 2019	You incorrectly completed risk assessments for nutrition / Waterlow scores for new admission.

11 February 2019	Escalated to stage three capability.
1 March 2019	You failed to adequately complete a falls risk management plan for a patient.
19 March 2019	You failed to respond to a reasonable request to stop what you were doing and assist with feeding a patient who could not feed themselves independently. You caused a skin tear to a patients arm while you were moving them.
21 March 2019	The trust wrote to you informing you that the terms of reference for the local investigation into the incident on 11 January 2019 would be expanded to include the incidents on 19 March 2019.
4 May 2019	You took a blood glucose finger prick that gave an unexpected result due to your failing to wash the patient's finger in advance. You inaccurately recorded the amount and type of meal a patient had consumed and recorded this prior to them eating the meal. You shouted at a patient who was not alert to open their mouth whilst continuing to spoon in the food, in spite of it falling out of their mount.
May 2019	The Trust completed its local investigation upholding the allegations in relation to each incident.
5 July 2019	Disciplinary hearing for concerns from 11 January 2019 and 19 March 2019. You were given a final written warning for 18 months and allowed to continue on stage three capability plan on PRIVATE.
8 July 2019	You were transferred to the [PRIVATE] Ward.

August / September 2019	Period of unauthorised absence.
25 September 2019	You failed to actively participate in providing patients with their lunches.
26 September 2019	You failed to administer a medication to one of the patients and had to be prompted to do so by one of your colleagues.
27 September 2019	You had been completing observations for patients independently when they had been instructed not to do this unsupervised.
11 October 2019	You had been completing observations for patients independently when you had been instructed not to do this unsupervised.
12 October 2019	Concerns were raised regarding your poor communication, your absence of gaining of patient consent and your poor professional conduct.
23 October 2019	Outcome letter from stage three final notification of concern.
13 November 2019	Stage 4 capability review meeting leading to dismissal.
15 November 2019	Referral received by the NMC.
13 December 2019	A panel of the Investigation Committee (IC) made an Interim Suspension Order (ISO) for 18 months.
20 January 2020	Interim Order review hearing. A panel of the IC confirmed and continued the ISO.
13 July 2020	Interim Order review hearing. A panel of the IC confirmed and continued the ISO.

4 January 2021	Interim Order review hearing. A panel of the IC confirmed and continued the ISO.
9 June 2021	High Court extended the ISO.

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

- Witness 1: Matron responsible for [PRIVATE] at the Trust, at the relevant time
- Witness 2: Band 6 Nurse and [PRIVATE] at the Trust, at the relevant time
- Witness 3 Ward manager [PRIVATE] at the Hospital, at the relevant time
- Witness 4 Healthcare assistant [PRIVATE], at the relevant time
- Witness 5 Ward manager on [PRIVATE], at the relevant time
- Witness 6 Staff nurse / Junior sister on [PRIVATE] at the Trust, at the relevant time

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, including advice on the approach to hearsay evidence. It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 1

That you, between June 2017 and November 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) Inappropriately sent a patient for a scan without being accompanied after they had suffered a hypoglycaemic attack.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 1 and to the signed (undated) letter from Mr 1. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel noted that the account of this incident was mainly hearsay evidence via Mr 1 to Witness 1. It considered the written statement of Witness 1 in which he states:

'...I am aware of this incident as it was handed over to me by [Mr 1] when it was requested that [you] transferred to [PRIVATE]...I would have expected [you] to send the patient to the scan escorted by a Registered Nurse or to have re-scheduled the scan. This incident occurred whilst [you] were working in the numbers. [You were] the nurse who had approved the patient leaving the Ward unaccompanied and therefore the patient was [your] responsibility. A patient who had been hypoglycaemic would have received emergency remedy medication and would have been vulnerable to further episodes of hypoglycaemia. I would have expected a Registered Nurse to be aware of this...'.

You told the panel that the ward was understaffed and that you were supernumerary at the relevant time and that *'you were not in charge'*. The panel noted that Witness 1 stated that you were *'working in the numbers'* at the relevant time. The panel note that Mr 1's (undated) letter indicates that this incident occurred whilst you were in the numbers on the Ward and so working independently.

The panel preferred Witness 1's evidence and the corresponding (undated) letter of Mr 1. Witness 1 was not a direct witness; however, he had close professional contact with your manager Mr 1 and was very fair, reasonable and considered. The panel had no reason to disbelieve his account. The panel had regard to the official record of the incident made by Mr 1 and noted that you did not specifically dispute it. The panel found the letter to you from Mr 1 to be sympathetic and supportive.

The panel considered whether or not you were supernumerary at the time of the incident. It was of the view that irrespective of whether you were supernumerary or in the numbers, you were still under the same duty to ensure patient safety and care. The panel was of the view that supervision can be more remote at times but as the panel found you were the person who approved the patient leaving the ward unaccompanied. The panel determined that you should have organised an escort for the patient and you did not do so. It decided that you did not make the right decision and did not do what you were duty bound to do.

In these circumstances, the panel decided that it was more likely than not you inappropriately sent the patient for a scan without being accompanied after they had suffered a hypoglycaemic attack.

The panel finds this charge is proved.

Charge 2

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

2) Incorrectly administered 1g of paracetamol to a patient when they were prescribed 500mg.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 1 and to the letter dated 10 September 2018 from Mr 1 to you. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel noted that the account of this incident was mainly hearsay evidence communicated by Witness 5 to Witness 1. It considered the written statement of Witness 1 in which he states:

> *'...there was an incident that occurred where [you] had administered an incorrect dose of paracetamol to a patient with liver cancer. [You] administered 1g of paracetamol when the prescribed dose was 500mg. This was concerning as [you] had not followed the prescription for the patient. There was no harm caused to the patient but this was luck rather than action...'*

The panel was of the view that although the incident was relayed to Witness 1 by Witness 5, it found their evidence to be credible. The panel considered that in your oral evidence, you accepted that you gave 1g, you said that the dose was prescribed as 'as required' 500mg to 1g and that, after that event, you went to see the doctor and the doctor prescribed 1g a day dosage. However, the panel was not provided with a prescription sheet so that it that could verify this prescription. The panel noted that at the time you gave 1g the prescribed dose was 500mg, therefore you have gone outside of what was the prescribed dose and not followed the prescription.

The panel noted that in Witness 1's oral evidence, he stated that the patient was at risk of liver damage and that your action was a failure of a basic nursing skill. Witness 1 said

that at the relevant time, you had been a qualified nurse of around thirteen years and that the incident was brought to his attention by Witness 5. The panel determined that you failed in what was a basic nursing skill for a registered nurse.

The panel finds this charge proved.

Charge 3

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

3) Failed to administer intravenous Frusemide to a patient.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 1 and to the letter dated 10 September 2018 from Witness 1 to you. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

In Witness 1's written statement, he states:

'...[You] omitted to administer all medication for this patient as she could not obtain an aspirate. This is the correct process for oral medication however once of the medications, Frusemide was intravenous. Frusemide is used for patients with excess fluid to remove fluid from the body. It was an incorrect action to omit the medication and it could have caused harm to the patient. [You] should have administered the Frusemide intravenously. This would have been detailed on the patient's medication chart. The ability to interpret a medication chart is a core standard of a Registered Nurse. There was no patient harm caused as [Witness 5] was able to respond to the situation...'.

The panel took account of the letter dated 10 September 2018 from Witness 1 to you which states:

> *'...[Witness 5] identified how you had explained that you had omitted intravenous frusemide because you believed it to be an as required medication. [Witness 5] explained that as intravenous frusemide is only given on the ward to unwell patients, it would not be an as require medication. We would expect you to already be aware of this...'.*

The panel also took account of Witness 1's witness statement and oral evidence in which he said that Witness 5 at the time intervened to administer the Frusemide to avoid harm to the patient.

You also told the panel in your oral evidence that you were not allowed to give intravenous medication. The panel determined that even if you were under supervision you should have given the medication and you did have a duty to do so as the person doing the drug medication round. Further, it determined that it was your responsibility to seek another member of staff if you if you felt at the time that you could not administer the Frusemide medication.

The panel therefore determined that you failed to administer the Frusemide to the patient.

The panel finds this charge proved.

Charge 4a

4) On 20 April 2018 whilst looking after a diabetic patient on an insulin variable rate sliding scale:

a) Used the incorrect monitoring form

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 2, It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

In Witness 2's written statement, he states:

> *'...At around 08:00, [Witness 5] asked [you] to look after an unwell patient and perform all the necessary tasks for the patient. The patient was within my remit and I was available in a supervisory role. The tasks included carrying out clinical observations of the patient, escalating if necessary to a Doctor or Senior Nurse. The patient had been unstable for a few days and had a few clinical needs.*
>
> *The patient was a diabetic patient on an insulin variable rate sliding scale. An insulin sliding scale is used for patients whose blood sugars are uncontrollable. The blood sugar level can change quite regularly, and the insulin sliding scale is a way of titrating the insulin to ensure the blood sugar level is not too high or too low. If the blood sugar level goes up the level of insulin can be increased, and if the blood sugar level drops too low there may be a need to decrease the level of insulin received. With an insulin sliding scale, you need to carry out regular blood sugars check, there is a specific protocol and depends on the patient how often you conduct it, this patient was unstable so needed it hourly. There is an algorithm to alter the insulin which is calculated from the result of the sliding scale.*
>
> *Around 10:00 to 10:30 to my estimate, I checked in on [you] and asked her how it was going. I noticed that [you] was not using the correct forms and had not conducted the blood sugar assessments as she should have done.*
>
> *There are different blood sugar monitoring forms that are used on the Ward for different situations. [you] was using a green form for the patient, which is the standard blood sugar monitoring sheet. When I asked [you] why [you were] using that form [you] said because the patient was on insulin. I explained that because the patient was on an insulin variable rate sliding scale a red form should be*

used. There are different forms used because there is a table on the back of the red form which has the blood sugar rates. If the blood sugar level gets to a certain rate on the table the insulin level should be altered to reflect that. [You] had been using the green form and did not check whether the insulin level needed to be altered. If [you] did not have the relevant knowledge then [you] should have raised it and made it clear when [you were] made to look after the patient in that position.'

The panel considered Witness 2's oral evidence in which he states:

'It's a variable rate insulin regime. So you have two forms... green and red forms...
She should have been using the red form and as that would give you the instructions on how to change a sliding scale...the green form would be just standard blood sugar monitoring for a standard diabetic patient'..

In Witness 2's oral evidence the panel noted that he stated: *"...I had to inform her that there was a separate sheet on the back..."*

The panel considered Witness 2's written statement, local contemporaneous statement and oral evidence and determined that it was clear, detailed and consistent. When questioned by the panel you said that you do not recall any of this or of the different colour forms.

The panel also considered your oral evidence where you said that you were not sure which form to use and that you used what was there. The panel was of the view that the patient was on a variable rate and therefore you should have used the red form and you did not.

The panel determined that on the balance of probabilities this charge is found proved.

Charge 4b

4) On 20 April 2018 whilst looking after a diabetic patient on an insulin variable rate sliding scale:

b) Failed to carry out blood sugar level checks with sufficient regularity.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 2 and to Witness 2's local handwritten note stated to have been written on 20 April 2018. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel considered the evidence outlined in Charge 4a. It found Witness 2 to be clear, detailed and consistent in relation to this incident. The panel accept Witness 2's evidence that you did not carry out blood sugar checks as often as you should have done for a patient on a variable rate insulin regime.

The panel finds this charge proved.

Charge 5

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

5) On 20 April 2018 failed to provide assistance to a patient who was then at risk of choking.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 1 and to Witness 2's local handwritten note stated to have been written on 20 April 2018. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel took account of Witness 1's written statement in which he states:

> *'...Whilst [you were] managing the insulin patient, the patient in the adjoining bed started to choke...An experience Health Care assistant ("HCA"), whose name I cannot recall, asked [you] for assistance, however you declined to assist as [you] felt it was more important to stay with the patient undergoing the infusion...'.*
> *...*
> *'The actions that [you] prioritised were not urgent and the request by the HCA, who was experience in stroke care, was for urgent assistance. A patient choking could have led to respiratory distress depending on the cause...'.*

It also took account of the witness statement of Witness 2, which states:

> *'...After the incident I asked [you] why [you] did not help with the patient or get any help. [you] said the patient on Bed 2 was her patient, and the patient on Bed 1 was not. I was concerned about the incident because the patient was in a precarious state and there was a delay of a few minutes in me being able to get to the patient. [You were] right next to the patient but did not assist.'*

The panel noted that Witness 2 was on duty when Ms 4 informed him that you refused to help when asked to do so. The panel noted that Witness 2 stated in his written statement, that,

> *'...About three or four minutes later after I finished inserting the cannula I went straight into Bay 3. It seemed like the patient was having an absent seizure...Throughout this [you were] with the patient in Bed 2 writing notes. [You] did not provide any assistance at any point'.*

In your oral evidence you said that you were asked to look after the patient and would check and not ignore a patient if they were choking. The panel noted that you made no argument at the time that you did not realise that the patient was choking.

The panel was of the view that you were present the whole time during this incident and you did not provide assistance as requested and were not prioritising a patient who was choking. The panel determined that, by virtue of your NMC registration as a registered nurse, you were under a duty to assist in this potential emergency situation.

The panel determined that this charge is found proved.

Charge 6a

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

6) On 04 May 2018:

    a) Incorrectly documented a patient had eaten a full meal when the patient had eaten only a small part of the meal.

This charge is found proved

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 4 and Witness 6, and to the local statement of events letter dated 4 May 2018 from Witness 6. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel took account of the written statement of Witness 6, which states:

'At lunchtime on 4 May 2019 [SIC should be 2018] [you were] documenting food intakes for the patients. I went around and checked the food charts to make sure they were accurate. This is something that I do with all staff members. I noticed that [you] documented that a patient had eaten all of their food even though they had not. [You] documented "full meal" on the food chart but when I looked the patient had only just started to eat and the full meal was still in front of them. I cannot remember the specific patient's name.

The food intake should be documented after every meal once the patient had finished and the trays were being collected. The correct procedure would be that the nurse should only document what the patient had eaten. This would be documented on the food chart. For example, if the patient had only eaten half a meal or a quarter of a meal that is what should be documented. If the nurse is documenting fluids this should be done after every drink or hourly and should be recorded in millilitres on the fluid chart so it is precise. It is important to document the food and fluid intake accurately so you know what the patient is getting.'

It also took account of the written statement of Witness 4, which states:

'I found [your] conduct concerning because if [you] documented that a patient had finished their meal when they had not or had more drink than they had this would give the wrong impression to the dieticians. If patients were not finishing their meals the dieticians would provide supplements, so if they thought the patient was eating properly the supplements would not be provided.'

The panel also had regard to Witness 6's statement of events letter date 4 May 2018, which states:

'On the same shift I observed [you] writing down the intake of a patient at lunchtime when I checked the documentation the food chart stated "all meals" all ice cream". The patient's meal was still in front of him, he had started to eat but only just!'

You said that you disagreed with the charge. You said that you didn't know why you would write it down if the food had not been eaten. You suggested that the patient may have got better and eaten the food.

The panel considered the evidence of Witness 6 to be evidence of this particular incident, whereas Witness 4's evidence was about your general behaviour. The panel found that the evidence of Witness 4 corroborates the evidence of Witness 6.

The panel took account of Witness 4's written statement where she states:

> *'...Additionally, I noticed on numerous occasions that [you] did not complete the fluid and food charts correctly...'.*

It also took into account that Witness 6 had stated that other nurses could have relied on the written information that you wrote in the patient's food chart thereby potentially putting patients at risk.

The panel found the evidence of Witness 6 to be consistent and reliable. Witness 6 was a direct observer and her account was recorded close to the time and was corroborated by Witness 4. Therefore, on the balance of probabilities the panel finds this charge proved.

Charge 6b

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

6) On 04 May 2018:

   b) Inappropriately provided a patient who was on a thickened fluid diet with ice cream.

This charge is found NOT proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 6. It also heard submissions from Ms Bailey on behalf of the NMC and those made by you.

The panel considered the written witness statement of Witness 6, which states:

> *'...[You] had also given the patient ice cream on the tray when the patient was not allowed it. This particular patient had swallowing concerns and was on a thickened fluid diet. This means that the patient could not drink normal fluids as they would not be able to control the swallow. Ice cream should not be given to anyone that is not on a normal diet as there is a risk of it sliding down the throat which could make the patient asphyxiate. As this particular patient was on a thickened fluid diet the wrong meal could cause concern'*
>
> *...*
>
> *'When the Speech and Language Therapists conduct swallow assessments they would inform us what level of diet the patient would be on. This is also provided on the board behind the patient and is stated during the handover. [You] would have been aware of the patient's dietary needs as this would be contained on the board and they would have been in the handover at the beginning of the shift to receive this information. I do not have access to the handover for this patient on 4 May 2019 as the handovers are destroyed at the end of every shift...'.*

The panel took account of your oral evidence when you told the panel that you gave the patient what was delivered on his table. The panel noted that in the written local statement of events dated 4 May 2018 from Witness 6, she states: *'...in fact it was a mousse that had been given'* and went on to explain why it was a problem that you had recorded ice cream being given when in fact it was mousse. The panel was of the view that this statement was contemporaneous with events at the time and therefore it preferred this statement to her written witness statement produced at a later date which

states you had given the patient ice cream. The panel took into account that the charge specifically refers to ice cream. The panel had no information as to the thickness (or otherwise) of the mousse involved, or whether or not its consistency was similar to that of ice cream.

The panel therefore finds this charge not proved.

Charge 6c

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

6) On 04 May 2018

c) Inappropriately continued to feed Patient B when Patient B was not alert and was suffering delayed and reduced swallowing ability.

This charge is found proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel had regard to the written statement and oral evidence from Witness 1 and Witness 6 and the local written statement of events from Witness 6 dated 4 May 2018.

The panel took account of Witness 1's written witness statement, which states:

> *'On 4 May 2019 [SIC should be 2018] [you] had been observed by [Witness 6] feeding a patient. [You were] feeding a patient with delayed and reduced swallowing ability. The concern was that food was falling out of the patient's mouth but [you were] continuing to feed the patient. As the patient had a high risk of dysphagia there was a high risk of choking...'.*

The panel also took account of Witness 6's written witness statement, which states:

'On 4 May 2019 [SIC should be 2018] [you were] feeding Patient B porridge for breakfast....I asked [you] to assist with feeding Patient B. I was behind the curtain on the next bed and could hear [you] shouting "open your mouth, open your mouth" to Patient B. [You were] not speaking in a pleasant manner and was shouting at Patient B. The tone was harsh enough that I came from behind the curtain and asked why they were shouting at the patient. [You] did not have any communication with Patient B other than shouting at him.'

...

'When I opened the curtain I noticed that Patient B was not alert. [You were] standing over Patient B. There was food dribbling down Patient B's face but [You were] still trying to put food into their mouth. I told [her] to stop as Patient B was not awake, would not be able to swallow the food and that they may choke. There was also food falling back out of the patient's mouth. I again told [her] to stop and took the food out of Patient B's mouth and made sure there was no residue. After I made sure Patient B was safe I asked [you] what they were doing. [You] responded that [you] were just feeding the patient and did not seem to be overly concerned about what I was saying. [You] should first have ensured that the patient was awake and able to take the food. If the patient was awake [you] should be sat down by the side of the patient, not standing over the top of them as they were doing with Patient B. [You] should also have communicated with the patient, ensured that the patient was safe and that the patient wanted to eat the food. If the patient was not alert they should not try to give the patient food. It should be documented that the patient was not alert enough to eat and the food should be left on the chair. This is something that [you] should have known as it is basic common sense not to push food into a patient's mouth when they are not able to swallow it.'

You told the panel that you did not and would not do this as the patient was at high risk of choking. The panel found both Witness 6's written and oral evidence to be consistent and based on a direct observation recorded at the time. It noted that she said in her oral evidence that this was a basic skill of any nurse.

The panel therefore finds this charge proved.

Charge 6d

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

On 04 May 2018

d) Failed to treat Patient B with care and compassion in that you shouted 'open your mouth, open your mouth' or words to that effect at the patient.

This charge is found NOT proved.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case.

The panel had regard to the written witness statement of Witness 6, which states:

'...I was behind the curtain on the next bed and could hear [you] shouting "open your mouth, open your mouth" to Patient B. [You were] not speaking in a pleasant manner and was shouting at Patient B. The tone was harsh enough that I came from behind the curtain and asked why they were shouting at the patient. [You] did not have any communication with Patient B other than shouting at him...'.

The panel noted that in Witness 6's local written statement of events dated 4 May 2018 in which she states: *'...I heard [you] continuously trying to gain Patient B'[s] attention saying 'Patient B Patient B open your mouth'.*

The panel decided that Witness 6's more contemporaneous statement of 4 May 2018 in which she said you had said 'open your mouth' was more reliable than that of her written statement made at a later date which stated you shouted at the patient.

The panel therefore find this charge not proved.

Charge 7

> That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:
>
> On 18 June 2018 failed to provide safe and effective patient care in that you failed to monitor and act upon a patient's absence of fluid output.

The panel finds this charge proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 5. It also had regard to Witness 5's note of the incident dated 18 June 2018 at 19:00.

The panel noted in Witness 5's written statement in which she states:

> *'... I asked [Witness 4]... whether the patient had passed urine during the day...[Witness 4] said that the Night Staff had emptied 100mls in the morning'. [Witness 4] apologised that they had not noticed that the patient had not passed any urine during the day...'*
> *...*
> *'I looked at the fluid balance chart which, because a registered nurse is required to write a comment every 4 hours that they are not concerned about the patient' fluid intake/output. [You] had signed for the morning that there were no concerns...'.*

The panel consider Witness 5's oral evidence that when she asked you about it at the time, as you signed the charts as the person responsible you had apologised for it. When questioned by the panel about this incident, you told the panel that you were '*not sure'* and you said *'I was not looking after this patient'.*

The panel found Witness 5's evidence to be credible. It determined that you failed to provide safe and effective patient care in that you failed to monitor and act upon a patient's absence of fluid output.

The panel determined that this charge is found proved.

Charge 8

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

On a date (unknown) between September and October 2018 carried out an unnecessary blood sugar assessment on a patient who was not diabetic and did not require a blood sugar assessment.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 4. It also had regard to Witness 4's signed local written statement of dated 1 January 2019

> *'...There was an incident in September or October 2018 when the Registrant went to see a patient to conduct observations. The patient had capacity and her speech was fine. The Registrant started to do a blood sugar assessment on the patient. The patient explained that she was not diabetic and did not need a blood sugar assessment but the Registrant continued to take the blood sugar. After the incident the patient buzzed for assistance and I went to speak to her. The patient explained what had happened to me and was quite upset and distressed that the Registrant had not listened to her. She explained that she was not diabetic but the Registrant had taken her blood sugar anyway. The patient also said she did not want the Registrant to look after her again. The patient's husband was also in the room at the time and he also raised concerns...'*

In your oral evidence you said that sometimes a doctor asks for blood sugar to be tested on patients without diabetes. The panel noted that that there were no patient records showing what that patient required and no detail from Witness 4 in relation to the specific needs of that patient at that time. The panel accepts that the evidence shows that you did a blood sugar test on the patient and that the patient was not a diabetic. However, the panel find that there are other circumstances where blood sugar may need to be taken. The panel find that this was likely to be an incident of poor communication but it has not been proved that the blood sugar test was unnecessary and not required by the patient.

The panel determined that this charge is found not proved.

Charge 9a

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

9) On a date or dates (unknown) in December 2018:

a) Failed to administer Fentanyl pain relief to a patient who required it.

This charge is found proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 5. It also had regard to the signed weekly meeting notes dated 28 December 2018 between you and Witness 5.

The panel noted in Witness 5's written statement, which states:

'[Ms 5] said that Patient 1 was receiving end of life care and was being cared for by [you]. [Ms 5] said that the patient needed pain relief which had not been

provided by [you]. There was a lack of awareness from [you] that Patient 1 was in pain and a Fentanyl patch was not administered, Fentanyl is a pain medication. [You] raised to me in the meeting that [you] were not aware of how to order the patch because there were none available on the ward. [You] did not inform anyone at the time that [you] did not know how to order one...'

You told the panel that you were not aware how to order the patch and that you told someone it was out of stock. The panel were of the view that the Fentanyl was prescribed and that you failed to administer the Fentanyl as prescribed to the patient and you should have done more to highlight the issue and find a solution.

The panel therefore determined that this charge is proved.

Charge 9b

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

9) On a date or dates (unknown) in December 2018:

b) Pre-completed documentation relating to a patient up to 12 noon before 9.30am.

This charge is found proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 5. It also had regard to the signed weekly meeting notes dated 28 December 2018 between you and Witness 5.

The panel noted in Witness 5's written statement, which states:

'[Mr 2] alerted me that Patient 2 comfort round documentation had been completed up to 12:00 by you at 09:30. [You] had also documented that the

patient had a cup of tea at 12:00 on the fluid balance chart when it was only 09:30.'

The panel noted that this was hearsay evidence but it was reported by a senior nurse at the time. You told the panel when questioned that you would do some things differently but at the time you did not bring it up. You said that you should not have done that and that you would have corrected the notes.

The panel was of the view that even on you own evidence you say that you may have corrected it later. It was also of the view that you signed the meeting notes of Witness 5 that mentioned the incident but no comment was recorded for this incident although it was for others. The panel therefore finds that you pre-completed the documentation.

The panel therefore determined that this charge is found proved.

Charge 9c

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

9) On a date or dates (unknown) in December 2018:

c) Whilst dealing with the controlled drugs, failed to check the drugs were correct before signing the controlled drug book.

This charge is found proved.

In reaching this decision, the panel took into account written statements and oral evidence of Witness 5 and Witness 6.

The panel considered Witness 5's statement, which states:

'[Witness 6] informed me that they were administering a controlled drug and the policy is that 2 nurses must perform a check on the date, the type of drug and the dosage, so they asked [you] to check it. [You] said it was fine and went to sign off the second check without reading the vile[sp] and checking anything. [Witness 5] had to prompt [you to actually check the controlled drug and said that they must always be fully check[ed]'

The panel also had regard to the Witness 5's local meeting note dated 28 December 2018, which states:

'[Witness 6] on 27.12.18 commented that [you] had not checked the CD being drawn up by [Witness 6], [you] had agreed that the drug was correct without actually reading the vial and needed to be prompted by [Witness 6] to read the drug name.'

The panel considered Witness 6's statement. which states:

'I cannot recall the exact date but there was an incident that occurred with [you] in December 2018. I had asked [you] to check controlled drugs with me in the treatment room. When we get controlled drugs from the pharmacy two members of staff have to check the medication, document what medication had arrived in a controlled drug book, check this alongside another book to ensure that the correct drug had arrived, and then put the medication into the cupboard straightaway.

[You were] signing the book without checking that the drugs were correct. I was showing [you] the medication but [you] were not looking at them. I was concerned because I could have done anything with the drugs and [you were] just signing their name to them. I explained that if [you were] putting [your] name to the medication [you] should check them properly. I also explained the policy was for two people to check the drugs.

...

Shortly after this I went to take a controlled drug out of the cupboard to administer to a patient. [You] just signed the book again and did not check the drugs. I reiterated that [you] should check the drugs. [You] said "I trust you [Witness 6]" or words to that effect...[You] did not seem to listen and made the same mistake within seconds of me highlighting it to [you]. [You] also did not seem to comprehend that you should not sign something without checking for it'.

...

[You] should have been aware of this procedure as it is something that is done as a student nurse. There is no specific training provided about this but I did explain the process to [you] as we went along.'

The panel was of the view that Witness 6 witnessed that you failed to check that the drugs were correct and had to be prompted to check the controlled drugs book. The panel was of the view that Witness 6 in her oral evidence was very clear that the drugs had to be checked by two people and that she would not risk patient safety or her Personal Identification Number (PIN). The panel determined that Witness 6's written and oral evidence was fully aligned and consistent. You said you did check the drugs but the panel preferred the detailed account of Witness 6 that was reported to a senior nurse and documented at the time. When questioned, you said you were aware of the policy.

The panel therefore finds this charge proved.

Charge 10a

10) On a date (unknown) between 28 December 2018 and 11 February 2019, in relation to a patient:

a) Incorrectly calculated the risk assessment for nutrition

This charge is found proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 5.

The panel noted Witness 5's written witness statement, which states:

> *'On 11 February 2019 I met with [you] for our weekly meeting to discuss progress. I raised with them concerns raised by Ms 1...Ms 1 told me that Patient 3 was admitted to the Ward, so they asked [you] to carry out a risk assessment for nutrition and skin integrity on the patient as part of the admission. A risk assessment is a lengthy process that covers observations and body maps to give a breakdown of the patient's condition'.*

It also had regard to the weekly meeting notes dated 11 February 2019 between you and Witness 5, which states:

> *'[You] calculated the nutrition score as 0 low risk calculating that the patient has a good appetite and was eating most meals...Had no difficulty in swallowing and had no stress factors...Ms 1 intervened and explained to [you] that the score ought to be 8 which is a high risk.'*

The panel noted that the meeting notes of Witness 5 were signed by you and you had a chance to comment on the incident at the time of the meeting, but you did not. You told the panel in your oral evidence that you *'...would have corrected it...'.*

The panel considered that Ms 1 had reported the incident at the time and this was clearly recorded by Witness 5 weekly meeting notes. The panel took account that you said you would have corrected the error. However, the panel determined that it was not just the error that was to be corrected but that you incorrectly calculated the risk assessment for nutrition.

The panel therefore finds this charge proved.

Charge 10b

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

10) On a date (unknown) between 28 December 2018 and 11 February 2019, in relation to a patient:

b) Incorrectly calculated the Waterlow (risk of pressure sores) score.

This charge is found proved.

On the same evidence that the panel finds charge 10a proved, it finds that this charge is also proved.

Charge 11a

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

11) On 4 January 2019:

a) Incorrectly advised a colleague that 15 minute observations were not necessary for a post blood-transfusion patient.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's witness statement, which states:

'On the 4th January 2019 an Agency Nurse, I cannot recall their name but they had worked on the ward before asked [you] about the policy for drug

transfusions. The Agency Nurse wanted to know specifically the time periods for checking the observation scheduling for pre and post transfusions for a patient

...

During the meeting I raised with [you] that on 4th January 2019 the Agency Nurse made a verbal statement to me that [you] had informed the Agency Nurse that 15 minute observations post the blood transfusion commencing were not necessary and that only the pre and post observations were required. This is not correct, observations must be taken 15 minutes post the blood transfusion per the policy at the time.'

The panel also had regard to the weekly meeting notes of Witness 5, which states that you had informed an agency nurse that 15 minute observations post blood-transfusions commencing were not necessary and that only pre and post observations needed to be done.

The panel noted that this is hearsay evidence and that they had no further information in relation to the agency nurse other than mentioned in this charge. The panel were of the view that the meeting notes are brief and lacking details that would add credibility. It noted that you disputed that this event occurred at the time the meeting notes were recorded. The panel therefore finds on the balance of probabilities, this charge is not proved.

Charge 11b

That you, between June 2017 and November 2019 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you:

11) On 4 January 2019:

b) Failed to document intravenous fluids on a patient's fluid balance chart.

This charge is found NOT proved.

On the same basis that Charge 11a has been found not proved, it follows that this charge is also found not proved.

Charge 12a

12) On 11 January 2019 Failed to provide adequate patient care in that you:

(a) Inappropriately provided personal care on your own when the patient required two members of staff to provide personal care.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement and Witness 2's witness statement and exhibit. The panel also took into account the interview record dated 6 February 2019.

In Witness 2's witness statement, it was stated:

' […] A lot of the patients on the Ward need assistance with washing and brushing their hair. I told [you] to start washing one of the patients and then get some assistance to assist her in moving the patient. This particular patient had a stroke and had a right sided weakness. The patient also had speech issues. As long as a nurse is not moving and handling a patient and can wash the patient whilst maintaining their dignity it is fine to start washing the patient individually. I then went over to the other side of the Ward.'

I came back into the bay shortly after, 30 minutes to my estimation, and the Therapy Assistant, [Ms 4], *informed me that there was a commotion behind the curtain where [you] was with the patient. I was told that one of the Band 6 Occupational Therapists*, [Ms 5], *had gone in to speak to [you].*

I went around the curtain where the patient and [you] were and saw the patient hanging off the bed. The patient was halfway down the bed lying diagonally, but the patient's legs were touching the floor on the left hand side of the bed, which is the side where the patient's chair was. It seemed as if the patient was flopped backwards and was not able to correct herself. The patient was screaming and was very tearful. It seemed like the wash had been completed as the patient's nightie was on, but [you] was trying to get her out of bed.

[you were] just shouting and saying the patient could not move her arm. I asked [you] what was going on and she said "she takes two" and "she cannot move her arm" or words to that effect. I could not understand why [you] was saying that as we knew that the patient had a right side weakness as part of her stroke.
…

It is appropriate to wash a patient individually as long as the patient agrees and as long as the nurse is not trying to move the patient. As long as the nurse can maintain the patient's dignity there is nothing wrong with washing a patient individually. If the patient is able to they can also assist to a certain degree by rolling in bed for example. This particular patient was able to assist by rolling in the bed. If however the nurse was trying to get the patient out of bed then two people would be required to transfer the patient. For example, if the patient is being moved from the bed to a chair then two staff members would be required.'

The panel also noted from Witness 2's statement:

'I would not have expected [you] to try and transfer the patient from the bed to the chair alone. She should not have tried to get her up. If a patient is in bed [you] should have covered her with a blanket and then asked for assistance from another staff member to move her. Even if the patient is waiting for a few minutes it is safer for them to wait than try to move the patient alone without assistance from another staff member or any equipment.'

The panel had sight of Witness 2's handwritten statement dated 11 January 2019.

The panel noted that you were asked to start caring for the patient, and to ask for help if you required help.

Within the interview record dated 6 February 2019, the panel noted:

> *'Mr 3* *When this patient usually requires two staff for hygiene needs. Can you explain what happened?* […]
>
> *[You]* […] [Witness 2] *came and said did I mind if I start washing patient, single member of staff. He said you do what you can and then someone else will come and help. Patient on pink bay. When I have washed her before she is cooperating. She has moved to different bays. I said 'Ok I will start washing her.'* [Witness 2] *said 'If I need a hand to let us know' She is fine, she opened her bowels, when I tried to turn her she was stressed, screaming. I asked for help.*'

The panel also noted from Witness 2's statement:

> *'I would not have expected the Registrant to try and transfer the patient from the bed to the chair alone. She should not have tried to get her up. If a patient is in bed the Registrant should have covered her with a blanket and then asked for assistance from another staff member to move her. Even if the patient is waiting for a few minutes it is safer for them to wait than try to move the patient alone without assistance from another staff member or any equipment.'*

The panel finds that the evidence shows that the patient did not require two nurses at all times but that a nurse can properly provide some personal care alone. A nurse can wash the patient alone and the patient can assist with rolling in bed such that two nurses are not required. Two nurses are required to get the patient out of bed. You were told by a senior nurse to start washing the patient alone and ask for help when required. You said you tried to turn her you said you asked for help. The patient was screaming. Witness 2 observed her to be hanging off the bed with her legs touching the floor.

However, the panel finds that there is insufficient evidence to show that you attempted to provide personal care to a patient that required two people.

In light of this, the panel determined, on the balance of probabilities, that the evidence did not establish that you inappropriately provided personal care on your own when the patient required two members of staff. The panel therefore finds charge 12(a) not proved.

Charge 12b

12) On 11 January 2019 Failed to provide adequate patient care in that you:

> (b) Failed to treat a patient with care and compassion in that you spoke harshly to them saying ‘you are not cooperating, you need to help me move your arm’ or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2’s witness statement and exhibit.

The panel took into account Witness 2’s witness statement:

> *‘...an incident occurred on 11 January 2019 which led to a disciplinary. The incident involved [you] providing personal care to a patient where her standard of communication was felt to be poor by the patient. [you] was washing a female patient that usually required two staff members to assist for hygiene needs. A witness heard the patient shouting and crying and therefore came to assist [you]. I am unable to recall the name of the witness. It is alleged that [you] was treating the patient without compassion. It is also alleged that [you were] heard saying to the patient "you are not co-operating, you need to help me and move your arm". Following the incident the patient was in discomfort and remained distressed for some time.’*

...

[You were] just shouting and saying the patient could not move her arm. I asked [you] what was going on and she said "she takes two" and "she cannot move her arm" or words to that effect. I could not understand why [you were] saying that as we knew that the patient had a right side weakness as part of her stroke.'

The panel also took into account Witness 2's written statement dated 11 January 2019, which states:

'...when asked what was going on [you] replied 'she takes two' and 'she cannot move her arm...'

You told the panel in your evidence that you were not shouting.

The panel finds that the evidence does not show that you spoke harshly to a patient. The evidence suggests that you were speaking to Witness 2 not the patient and the statement in January 2019 nearer the time does not mention shouting it only says *'replied'*, which does not suggest harshness. The panel prefers the more contemporaneous evidence and therefore does not find it proved that you were shouting or that you spoke harshly to the patient.

The panel therefore, found this charge not proved.

Charge 13)

13) On 15 January 2019 failed to carry out GCS neuro observations on a patient who had suffered an unwitnessed fall.

This charge is found proved.

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

In Ms 1's witness statement, it stated:

'Neurological observations are required to assess a patient's neurological condition and whether they are deteriorating following a stroke, head injury or fall. The tool used for a neurological observation is the Glasgow Coma Scale ("GCS"). GCS monitoring is assessing the patient's best verbal response, their motor response and eye response. GCS monitoring is dependent on reason for doing them and is patient specific. The frequency of monitoring is dependent on the patient. It is the nurse allocated to that patient that is responsible to conduct this monitoring and report deterioration to medical staff. If not check or recorded properly a deterioration of a patient's neurological condition could be delayed or missed.'

You told the panel that you have no recollection of this incident.

The panel considered Ms 1's handwritten statement dated 15 January 2019, which states:

'That you were 'looking after a patient who had fallen out of his supportive seating which was unwitnessed. The patient was on neuro observations adhering to the Trust's falls policy. [You were] fully aware of the care plan for this patient and unfortunately did not do GCS observations at the time they were due, even though I had clearly given her instruction and time to do so. I completed the neuro observation myself as they were already late.'

The panel accepted Ms 1's handwritten statement which was written on the day of the incident dated 15 January 2019. As the panel admitted the hearsay evidence of Ms 1, it was of the view there was no reason as to why Ms 1 would fabricate her evidence and as it was written on the day of the incident as a formal record. The panel therefore relied on Ms 1's written statement.

The panel determined, that on the balance of probabilities, it is more likely than not that on 15 January 2019, you failed to carry out GCS neuro observations on a patient who had suffered an unwitnessed fall. The panel, therefore, finds this charge proved.

Charge 14a

14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:

a) Incorrectly recorded a patient fall.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 5, and the exhibit which includes the fall management plan dated 1 March 2019.

The panel took account of Witness 5's witness statement, which states:

> *'There were a number of issues with the plan that I noticed when I read it:*
> *1. [You] completed the post falls assessment section about the patient haven fallen at 15:50 on 01 March 2019. This was not correct because the plan also stated at the beginning that there were no falls noticed. The interventions after fall section is only to be completed when an actual fall occurs because it looks at what happened, why it happened and how it can be prevented.'*

The panel had sight of the Falls Management Plan. It noted that you recorded:

> *'The patient is admitted on 16/02/19 H/O fall. There is no further fall noticed. Falls re-assessment forms completed.'*

The panel found that your entry states that there were no falls since 16 February 2019 and yet within the Falls Management Plan, you recorded a fall on 1 March 2019 at 15:50.

In light of this, The panel determined, that on the balance of probabilities, it is more likely than not that you failed to accurately complete a falls management plan for a patient in

that you incorrectly recorded a patient fall. The panel, therefore, finds charge 14(a) proved.

Charge 14b

> 14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:
>
> b) Failed to document a risk of climbing over bed rails

This charge is found proved.

In reaching this decision, the panel took account of the witness statement of Witness 5, and the exhibit which includes the weekly meeting notes on 1 March 2019.

The panel took account of Witness 5's witness statement:

> *'There were a number of issues with the plan that I noticed when I read it:*
>
> *[You] failed to document that the patient was at risk of climbing over bed rails, so they were not appropriate for this patient, this was the reason that the bottom half of the rail was left down.'*

This was consistent with Ms 5's weekly meeting notes with you on 1 March 2019:

> *'Bedrails institu would be inappropriate for the patient as at risk of climbing out and bottom half of rail left down for this reason.'*

The panel noted that there was no other evidence before it in support of this charge. It accepted that there was no documentation that there was a risk of the patient climbing the bedrail. However, the panel accepted Witness 5's assertion that there was a risk of the patient climbing over the bedrail. It accepted that there was a risk and observed from the Falls Management Plan that you should have recorded this risk, which you

failed to do anywhere on the documentation. The panel determined that there was a duty of you to record this risk as you were completing the assessment form.

The panel determined that, on the balance of probabilities, that you failed to accurately complete a Falls Management Plan for a patient in that you failed to document a risk of the patient climbing over the bed rails. It, therefore, finds charge this proved.

Charge 14c

> 14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:
>
> c) Incorrectly recorded the patient as having adequate eyesight

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 5, and the exhibit which includes the weekly meeting notes on 1 March 2019. The panel also took into account your oral evidence.

The panel took account of Witness 5's witness statement:

> *'There were a number of issues with the plan that I noticed when I read it:*
>
> *[You] documented that the patient's eyesight was okay but this was incorrect because the patient had lost their glasses at Fairfield Hospital prior to being transferred. It was regularly handed over that the patient had not had their glasses replaced, so their eyesight was poor.'*

You told the panel, in your oral evidence, that you did see the patient's glasses as they were on the table.

This was consistent with Ms 5's weekly meeting notes with you on 1 March 2019:

‘Patients eyesight documented as okay when regularly handed over that the patient had lost her glasses at Fairfield and this was an issue with regards her vision.’

The weekly meeting notes with you and Ms 5 were signed by you, which suggests that that you agreed to them as you did not make any comment regarding it when you had the opportunity to do so, as you have for other disputed meeting notes.

The panel determined, on the balance of probabilities, it is more likely than not that you failed to accurately complete a Falls Management Plan for a patient in that you incorrectly recorded the patient as having adequate eyesight. It therefore finds this charge proved.

Charge 14d

14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:

d) Recorded irrelevant details in the mobility section

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 5, and the exhibit which includes the weekly meeting notes on 1 March 2019 and the Falls Management Plan dated 1 March 2019.

The panel took account of Witness 5’s witness statement:

‘There were a number of issues with the plan that I noticed when I read it:

[You] recorded in the mobility section ensuring waterlow scores have been completed, whether there are any pressure sores and if so, was a pressure

mattress being used. This was irrelevant information because the mobility section covers assessing the patients mobility, answering whether the patient can walk, do they require assistance and what footwear they need.'

The panel noted from the weekly meeting notes on 1 March 2019 between you and Ms 5:

'Regular turns are not relevant for this patient and are not relevant to falls careplan but are added as an intervention to prevent a fall.'

The panel took into account what was written by you on the Falls Management Plan. It noted that what you wrote was not addressing the points listed in the form. However, it was of the view that what you wrote was relevant to the patient's mobility.

In light of this, the panel found this charge not proved.

Charge 14(e)

14) On 01 March 2019 failed to accurately complete a falls management plan for a patient in that you:

e) Failed to record an issue with balance.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 5, and the exhibit which includes the weekly meeting notes on 1 March 2019 and the Fall Management Plan dated 1 March 2019.

The panel took account of Witness 5's witness statement:

'There were a number of issues with the plan that I noticed when I read it:

[You] failed to note that because the patient had a stroke in the back of their brain, they had issues with balance. The patient was very unsteady, they were not aware of where they were with special awareness. [You] also omitted that only the physiotherapists should mobilise the patient because of the special handling that was required.'

The panel accepted Witness 5's assertion that the patient had an issue with balance. It found on the basis of the Falls Management Plan that you had failed to record this issue.

In the absence of this information, the panel determined, that on the balance of probabilities, it is more likely than not that you failed to accurately complete a falls management plan as you failed to record a patient's issue with balance. The panel, therefore, finds this charge proved.

Charge 15a

15) On 19 March 2019:

a) Failed to provide safe and effective care in that, when asked by a colleague to confirm a patient's fluid intake, you ripped up the fluid balance sheet and told the colleague to 'write another one out' or words to that effect without confirming the patient's fluid intake.

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's witness statement, Ms 2's local handwritten statement to the Trust dated 19 March 2019 and the local interview record at the Trust dated 11 April 2019. The panel also took into account your local interview record dated 17 April 2019.

The panel took into account Ms 2's witness statement:

‘I went over to [you] in one of the side rooms to ask about the Patient's fluid intake. [You] then took the fluid balance sheet from me and ripped it up in front of me. I said to her that she could not do that [your] response was "write another one out", or words to that effect. I questioned further whether the patient in Bed 6 had the fluids or not and the registrant replied "just do another one", I cannot recall whether [you] confirmed or not about the fluid intake"

The panel had sight of Ms 2’s local handwritten statement to the Trust dated 19 March 2019 which was the same day of the incident.

“I questioned why [you] had wrote 250 on [the patient’s] fluid chart without giving her the fluids she took the file off me and ripped it up I said not to do that as there was other information on from fluid out balance she told me to do another one”

The panel took into account Ms 2’s local interview record at the Trust dated 11 April 2019:

‘Mr 3 You have provided a statement based on an incident on 19th March 2019 on [PRIVATE] ward, please explain what you recall happened on the 19th March 2019?

Ms 2 Yes. I started off my shift working with [you] in the Pink Bay, there was another nurse, I am not sure of her name, she was an agency nurse. [You] doing medication; the other nurse was helping me. Patient A was in bay 6, there was 250ml fluid on the fluid chart. I went to [you], Is this medication, or has she drunk this?' [You] snatched and ripped it up, I said to her not to, as I had already put other information on the fluid chart. The patient had not drunk 250ml.

There was a patient. Patient B with high risk of falling, and another patient, Patient C went across to her to help me with patient B, whilst [you] sat there and did not get up to help.’

The panel noted from your evidence that you said that you did not tear up the patient's fluid balance sheet and that you suggested that you tore your own notes up.

The panel preferred the evidence of Ms 2. It had no reason or evidence before it to suggest that Ms 2 would have any reason to fabricate this, particularly as it was written on the same day of the incident. The panel was also of the view that when you were answering your questions about this incident in the interview within the Trust, you did not state you had ripped up your own notes.

In light of this, The panel determined, that on the balance of probabilities, it is more likely than not that you failed to provide safe and effective care in that, when asked by a colleague to confirm a patient's fluid intake, you ripped up the fluid balance sheet and told the colleague to 'write another one out' or words to that effect without confirming the patient's fluid intake. The panel, therefore, finds this charge proved.

Charge 15b

15) On 19 March 2019:

b) Refused to assist a patient in using the toilet when requested to do so by a colleague using the words 'I will do it in my own time and not when you tell me' or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 2's witness statement and exhibit, namely the local interview notes at the Trust dated 11 March 2019 and the local statement of Mr 6.

The panel took into account Ms 2's witness statement:

'The incident with the patient who required assistance to go to the toilet

Between 10:00 and 11:30 a patient buzzed from Bed 4 because they wanted to go to the toilet, I cannot recall their name. The patient required two people to move them because they had suffered from a stroke in the past so they had limited mobility. I asked [you] for help but she said that she was busy. I managed to get […], a physio, to assist me. Just before we moved the patient, Nurse […]asked me to attend another ward to cover for a HCA so that the breaks could be taken.

I explained to Nurse […] that I was just about to move the patient with Mr 6. Nurse […] said that [you] was not doing anything and that she would get her to assist Mr 6 to move the patient. I believe [you were] sat outside the room we were in, with [your] notes out.

As I left to go to the other ward, I witnessed directly Nurse […] ask [you] to help Mr 6 because one of the patients needed to use the toilet. [You] replied "I will do it in my own time and not when you tell me", or words to the effect.

The nurses normally deal with the medications and then they help with the carers, only after which they complete their notes. [You] did not help me with any of the caring duties.

I was gone for around 30 minutes, when I came back I asked Mr 6 whether the patient in Bed 4 had been to the toilet. Mr 6 replied that [you] never came to assist him. I went over to the patient to find her very upset because she had soiled herself. I apologised to her and cleaned her up. [you] never came near the patient for the rest of the shift.'

The panel took into account Ms 2's local handwritten statement at the Trust dated on the day of the incident 19 March 2019. In this statement Ms 2 wrote that you "*argued that she was doing her writing and ended up leaving the patient"*

The panel also took into account Mr 6's written statement to the Trust dated 19 March 2019. The panel was of the view that this was consistent with the evidence provided by Ms 2 in her local handwritten statement.

Mr 6 says you *"responded saying that she was too busy to assist with the transfer as she was about to start writing patient files"*

The panel then took into account Ms 2's local interview at the Trust on 11 April 2019:

> *'I was with [Mr 6], helping a lady onto the commode. [Ms 8] said '[Ms 2] I need your help, can you help purple men and [you] will come in here.' She asked [you] for help and [you] said [you were] writing [your] notes. I heard her say 'I will do it in my time; I need to go to the toilet.' I saw the other patient and then I went back to [Mr 6]. [Mr 6] said [you] had not come to help and patient D had soiled. I helped him get her on the commode.'*

The panel noted that half of the words written in the charge were mentioned at this time.

The panel then considered the written statement of Ms 2 made to the NMC in January 2021:

> *'As I left to go to the other ward, I witnessed directly Nurse […] ask [you] to help [Mr 6] because one of the patients needed to use the toilet. [you] replied "I will do it in my own time and not when you tell me", or words to the effect.'*

This is the only time Ms 2 had given evidence that the words used within the charge were stated by you.

The panel was of the view that there was insufficient evidence to support this charge. Ms 2 had only mentioned those words in her written statement to the NMC in January 2021. The panel was of the view that Ms 2's evidence, in particular those words, had altered over time. No other witnesses had mentioned those specific words at all. The notes closest to the time were consistent about the nature of your response. The panel

finds your response to be different in nature to the words in the charge. The panel therefore finds this charge not proved.

Charge 15c

15) On 19 March 2019:

c) Failed to prioritise patients and preserve safety by leaving a vulnerable patient unattended.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 2's witness statement and exhibit, namely the local interview notes at the Trust dated 11 March 2019 and the local statement of Mr 6.

The panel considered Ms 2's witness statement, which states:

> *'I asked [you] whether [she was] staying and she said to me directly that she would stay with Bed 2....When I returned to Bed 2, [you were] not present and the patient was out of Bed, being assisted by another unsteady patient, I helped both patients back into their beds because they were at risk of falling, no harm came to either patient. I asked [you] why [you] had left Bed 2 unattended...I did not receive any effective response back, [you] often did not listen to me...'.*

The panel then considered the Trust's interview record notes between Ms 2 and Mr 3 dated 11 April 2019. The panel noted that Ms 2 says in this interview that you were '*still there'* at the time of the incident.

The panel took close account of the wording in the charge which is that you left a vulnerable patient unattended. On the evidence before it, the panel was of the view that you were there and in attendance.

The panel noted that the contemporaneous interview notes of Ms 2, provided closest in time to the incident, states that you were present and her later witness statement states

that you were *'not present'.* The panel also considered the local written statement of Ms 2 in which she states: *'...[You] just sat there and watched without offering any help'.* The panel was of the view that Ms 2's witness statement contradicts her local contemporaneous statement. The panel determined that Ms 2's evidence was conflicting. The panel took the view that the contemporaneous statement was more likely to be correct.

The panel considered the meaning of the word *'unattended'* and took it at its natural meaning which is that you were not present. The panel determined that on the basis of Ms 2's conflicting evidence on whether you were there or not at the relevant time, the panel therefore determined that this charge is found not proved.

Charge 15d

15) On 19 March 2019:

d) Refused to stop feeding a patient who had independent feeding ability when required to do so by a senior colleague.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Ms 2's respective witness statements and exhibits, which included the Trust's incident report dated 19 March 2019.

The panel considered Witness 2's witness statement in which he states:

> *I went and spoke to [you] and explained that the patient could feed herself. [you] raised her voice and responded by saying "I am feeding her" or words to that effect, and that the patient was not able to feed herself. I asked [you] to step out of the bay so I could speak to her. [you] said "I am going nowhere with you" or words to that effect and stayed at the patient's bedside'*

The panel also had sight of the Trust's incident report dated 19 March 2019. It also had regard to Witness 2's interview record of the account of the incident dated 11 April 2019.

In your oral evidence you told the panel that you did not refuse to stop feeding the patient.

The panel noted that Witness 2's oral evidence was consistent with his witness statement, incident report and interview.

The panel determined that the respective witness evidence to be persuasive and consistent with each other.

The panel therefore finds this charge proved

.

Charge 15e

15) On 19 March 2019:

e) Handled a patient roughly and without care thereby causing the patient to sustain a skin tear.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, Witness 2 and Ms 2's respective witness statements and exhibits, which included the Trust's incident report dated 19 March 2019.

The panel considered Witness 2's witness statement, which states:

> *'I asked the Registrant to go to the patient across from her to assist her with feeding. I then went over to the treatment room on the male side of the Ward.*
>
> *A few minutes later I heard a scream. There was a patient in one of the side rooms who had a tendency to scream out and I assumed it was her who had*

screamed. I went back into the bay were the Registrant was feeding the patients and asked whether the patient in the side room had had her painkillers. When I went into the bay I noticed that it was the patient who I had asked the Registrant to give a meal to who had screamed.

The patient normally was placed on her right side by the physiotherapists to try to dampen the movement on that side as she was overactive on that side. When I got to the patient I noticed that she was in a twisted posture with her legs were facing towards the left but her body was facing forwards. It looked like someone had pulled the patient over from the left side, had put their arms on the patients ride side and pulled her around so she was sat upwards to have her tea.

There were two Healthcare Assistants in the bay, [Ms 6] and [Ms 2] who asked whether I had seen the patient's arm. The patient was upset and was saying "she has hurt me, she has hurt me". The patient did have cognitive problems but I was concerned because she was screaming. I looked at the patient's arm and saw that there was a fresh wound, which had started to bleed. The patient's skin looked like tissue paper. The skin had split and rolled back like it had been pulled underneath. There was no blood on the bed but it had started to drip so it looked fresh.

... The Registrant said that the wound was already there, but no other staff members had seen the wound before and the Registrant was the only staff member in the bay at the time of the incident.'

The panel considered Witness 1's witness statement in which he states:

'On 19 March 2019 there was also another concern that a patient developed a skin tear during care provided by [you]. The patient sustained a skin tear to the right forearm. [you] had been with the patient and left the patient with the skin tear present. There was concern how the skin team has occurred and what [you]'s response was to it...[you] denied the incident...'

The panel had regard to Witness 2's interview record of the account of the incident dated 11 April 2019, which states:

'...The patient said 'She's hurt me, she's hurt me'. I asked the two HCA's to calm the patient down.

[You] came back with dressings in her hand, no trolley. I said to her 'What are you doing?' she replied 'I need dress arm'. I told her not to go near the patient. I told the HCA not to let her near the patient. I bleeped [Ms 7]. Me and [Ms 8] wanted to keep the arm free to show her it was bleeding, there was no blood on the bed, it was dribbling, it was done recently and [you were] the only one who had been in the bay. Me and [Ms 8] dressed the wound'.

The panel determined that you were the last person to attend with the patient. The panel took account that in your oral evidence you admit that there was a skin tear when you were present with the patient. The panel took into account that there was no evidence to suggest that there was anyone else at the bedside of the patient immediately before you arrived. Witness 2 who was an experienced nurse, gave consistent and credible evidence that the skin tear was a fresh wound. The panel determined that something had happened for the patient to scream. The panel determined that the patient was in a different position on the bed to how you found her when you arrived. The panel determined that you handled the patient roughly in relation to her condition and rougher than she ought to have been handled considering her skin condition which the patient had for a while and you were or should have been aware of it.

The panel determined that it is more than likely not that you handled the patient roughly and without care. The panel therefore finds this charge proved.

Charge 16

16) On 04 May 2018 took Patient A's capillary blood sugar reading without first cleaning the patient's finger.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, which states:

> *'I cannot recall the date but there was an incident where [you] had taken a patient's capillary blood sugar without cleaning the patient's finger. It is essential to clean the patient's finger for a accurate reading. This incident was witnessed by [Witness 6].*
>
> *The process for taking a capillary blood sugar would be to wash the patient's finger with soap and water before drying the finger. An alcohol swab could also provide for inaccurate readings. This process would be covered in any core nursing training. [you] would also have been expected to take blood sugars in both of her previous roles in Day Care and on [PRIVATE] at the Hospital.'*

The panel also took account of Witness 6's witness statement, which states:

> *'I asked [you] to check Patient A's blood sugar by performing a blood glucose finger prick.*
>
> **...**
>
> *[You] had taken Patient A's blood sugar and gave a reading of 19.8mmol. Patient A's blood sugar levels had been 12.2mmol in the morning and they had been given insulin following that. I thought it was unusual that their blood sugar level would have increased by that much three hours later especially if they had been given insulin. The blood sugar level would generally go down instead of up after a patient had been given insulin.*
>
> *I questioned [you] and asked [you] if [you] had washed Patient A's hand before taking the blood sugar level. [You] said they had washed the patient's hand. I asked Patient A whether their finger had been washed and they said it had not. [Ms 9] also confirmed that [you] had not washed Patient A's hand. I redid the blood glucose finger prick after washing Patient A's hand and the blood sugar reading came down to 11.4mmol.'*

The panel considered the evidence before it and determined the statement of Witness 6 to be consistent with her statement made on 4 May 2018. Witness 6 documents a direct observation by both Patient A and Ms 9. The panel considered your oral evidence and determined that you repeated an account of would you do, rather than specifying what actually happened.

The panel determined that the patient was diabetic and insulin dependent which makes it more important to get the blood sugar reading correct. The panel had no reason to doubt that the patient's hands were not washed as they should have been which therefore produced an inaccurate blood sugar reading.

The panel therefore finds this charge proved.

Charge 17a

17) On 26 September 2019:

a) Omitted to administer prescribed medication to a patient

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement, which states:

> *'...During the medication round [you] had missed a medication for a patient and had to be prompted to administer it. I believe the member of staff who witnessed this concern was [Ms 10]...[you] as a qualified nurse of a number of years, should be aware of how to administer medication (right route, right dose, right patient, right time medication)...I am unable to recall the medication which was missed and therefore am unable to comment on how serious this incident would have been. It is important to note, that the patient did receive the medication that was missed due to [Ms 10] being present and administering it.'*

The panel considered this evidence and determined that it is mainly hearsay evidence from another member of staff. It noted that Witness 3 could not recall which medication was missed or any detail about it. It further noted that Ms 10 had not been called to give evidence and there was nothing put before the panel in relation to Ms 10 who is alleged to have been present when this incident occurred.

The panel also had sight of the Capability debrief sheet dated 27 September 2019, which states that you needed to be prompted as you missed out one medication. The panel was of the view that this did not give much information and was lacking the detail that the panel would require in order to find that there was an omission.

The panel noted that in your oral evidence you did not recall the incident.

The panel therefore finds this charge not proved.

Charge 17b

17) On 26 September 2019:

b) Made inadequate records in a patient's medical notes.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement.

The panel was of the view that it had not been provided with any evidence of copies of the patient's medical notes and therefore cannot test the adequacy of it in that respect. The panel considered Witness 3's witness statement, which states:

> *'[you] also completed documents in a patient's medical notes which were not up to the expected standard of a registered nurse. The notes were very generic and lacked detail and it seem like [you] had copied and pasted the plan provided by the doctors in the Ward round into her own writing.'*

The panel considered that the standard required has not been specified nor has it seen a copy of the notes to test the adequacy of any entries in it. The panel determined that

there has been no evidence put before it in relation to the detail of the *'copy and paste'* element of the notes made.

The panel determined that the evidence put before it in relation to this charge was very non-specific and possibly subjective, it is on this basis that the panel find this charge not proved.

Charge 18

18) On 27 September 2019 failed to work professionally in that you completed patient observations independently having not been assessed as competent to do so.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement, which states:

> *'I received feedback from a member of staff who I think was [Ms 11]. She reported that [you] had disappeared and she later found her completing observations independently. [You] had previously been instructed that she was not able to complete this task independently.*
> *...*
>
> *[You] had been away from clinical practice for some time and therefore I had concerns in relation to competence. Completing clinical observations incorrectly or recording them incorrectly could have resulted in not identifying a patient becoming acutely unwell which could have in turn caused a delay in treatment...'*

The panel took account of Witness 3's oral evidence and noted that the information was corroborated by Ms 11 who had fed the information back to her.

The panel also had sight of the Weekly debrief notes dated 27 September 2019 in which it is noted:

'Feedback has been that [you] has completed observations independently – we discussed that she need to be competency assessed therefore still requires direct supervision. [You] appears to be lacking in confidence, assertiveness, communication and being proactive'.

The panel noted that in you oral evidence you said that you were generally completing observations independently. The panel determined that you were not authorised to do so.

The panel determined that you were told that you had to be assessed as competent prior to completing observations on your own. It determined that you undertook completing observations which was outside of your assessed competency. The panel therefore finds this charge proved.

Charges 19a and 19b

19) Between 24 September and 11 October 2019:

a) Failed to communicate appropriately or at all with a patient
b) Used inappropriate language in that you referred to a patient suffering with dementia as being 'demented'

The panel finds these charges proved.

In reaching this decision, the panel took into account Witness 3's witness statement, which states:

'I unfortunately don't recall the date but I received a patient complaint in relation to [you]'s communication. The patient was in one of the side rooms and had a diagnosis of dementia. The patient complained that [you] had ignored her and that she felt uncomfortable with her. She explained to me that [you] had been in to her room to complete her blood pressure and then left. This led to the patient being upset.

...

When I discussed the incident with [you] she called the patient 'demented' and said that was the reason she did not communicate with her. I explained the she should not refer to patients with dementia as being 'demented'. [You] said that the patient often gets angry. I informed her that part of being a nurse is to demonstrate excellent communication skills on all levels especially with patients who have a cognitive impairment. [You] did not provide any insight into this and did not respond to the concern which was of great concern to me.'

The panel also had regard to the witness statement of Witness 4, which states:

'..A lot of concerns with [you] centred on communication and how she spoke to patients. For example, when I assisted [you] with patients requiring two staff members for washing she did not explain what she was doing to the patient or that we were going to wash the patient. She also did not communication when we were going to move the patients or change the patients' clothes. This happen on most occasions when we washed patients together.

[you] also ignored patients and relatives quite often.'

The panel also had sight of the weekly debrief notes of 11 October 2019, which states:

'No communication from [you] to multiple patients when assisting them with personal hygiene. We discussed that it is essential when providing personal care to interact with patients throughout, especially for patients who have previously been self-caring...'.

The panel finds that the evidence shows that there was a complaint from a patient around an incident of lack of communication and you accepted at the time that you did not communicate with them because you gave a reason at the time for not doing so. In your oral evidence, you said that there was an unreasonably high level of communication expected of you by other staff. The panel finds that there was a complaint about the incident, there were concerns from other colleagues about your communication generally and the panel finds that the reason given for not communicating was not acceptable. The panel therefore finds that you did not

communicate appropriately with the patient. The panel finds that you were under a duty to do so as a care provider.

The panel referred to the evidence outlined above and accept the evidence of Witness 3 that you used this phrase. The panel find that the nature of the phrase is such that Witness 3 would have reason to recall it and it was documented at the time. The panel find that this is inappropriate language for a clinical setting. The panel therefore finds this charge proved.

The panel therefore find both charges proved.

Charge 19c

19) Between 24 September and 11 October 2019:

c) Failed to provide safe and effective care in that you refused to attend to a patient who was bleeding when requested to do so by a colleague.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement, which states:

'Unfortunately I cannot recall the date, however it was brought to my attention that [you] refused to attend to a patient who was bleeding. I did not witness this incident directly and the incident was brought to my attention by [Ms 12].

From what I can recall the patient's cannula had fallen out and the patient was bleeding. [Ms 12], asked [you] to tend to the patient but [you] declined, [you] did not provide a reason or rationale for failing to tend to the patient...'.

The panel also took account of your oral evidence in which you strongly denied that this occurred. You told the panel that if you had seen it then you would have gone and attended to the patient.

The panel notes that there was no contemporaneous record of this incident. Despite there being a meeting between you and Witness 3 on 11 October 2019 where other incidents were documented. The panel determined that whilst there is surrounding evidence to say that you did not attend to the patient there is insufficient evidence that this was your responsibility at the time.

The panel notes that in her statement Witness 3 says:

> *'The HCAs on the ward can usually deal with these situations however if there is an excessive amount of blood they are expected to inform a registered nurse. which the HCA did. In relation to this incident, there was an excessive amount of blood and therefore. this was reported in line with what I would expect.*'

The panel accepts the evidence that a registered nurse is only required if there is an excessive amount of blood. However, there is no contemporaneous note that this was the case. Witness 3 was not present at the time and the panel finds that whether an amount of blood is excessive could be a subjective judgement.

The panel do not find it proved that you were under a duty to attend to this patient. The panel find that there is insufficient evidence before it to meet with a finding of a failure to provide safe and effective care.

The panel therefore finds this charge NOT proved.

Charge 20

20) On 11 October 2019 failed to follow instructions from a senior colleague in that you attempted to take patients' blood independently having been told you must only do so under supervision.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement and the internal memorandum from Ms 11 to Witness 3 about the incident, as follows:

> *'I explained to [you] that she could take the blood but she needed supervision on this. I asked [Ms 13] to observe [you] in this. As I was talking to the [you], [you] proceeded to go to the patient independently whilst [Ms 13] was in the treatment room. I asked [Ms 13] to follow [you] and observe [you] taking the blood.'*

The panel finds from this evidence that you were being supervised during the procedure itself.

Witness 3 continued:

> *'Shortly after this [you] had prepared a second tray to take another patient's blood. I informed [you] that [you] would again need to be supervised in this however [you] went to go to the patient independently once again. I asked [Ms 11] to follow [you] and observe [you] taking the bloods.'*

The panel also had regard to the email from Ms 11:

> *'...on 11 October 2019 when [you] attempted to perform venepuncture on [Service User 1]. [You] not only failed to explain the procedure effectively but did not discuss the reasons why it was necessary to obtain blood. During the procedure [you] appeared unsure of the equipment that she had brought to the patients bedside to perform the venepuncture, having used a butterfly needle [you were] then unsure of how to collect the blood...I therefore asked [you] to stop the procedure and remove the needle however, [you] continued with [your] attempt to obtain blood. I asked [you] again to remove the needle but it was not until I insisted for the third time that [you] stopped the procedure and removed the needle.'*

The panel took account of your oral evidence. You said that you were confident and that you were being supervised. You told the panel that this was a procedure you had done

a lot of times and would wait until you were asked to start the procedure and would not do it unless someone was there to supervise you.

The panel finds that as Ms 11 witnessed events in the run up to and during the procedure, she was therefore present and so you were being supervised throughout the procedure. The panel also finds from Witness 3's evidence that you were supervised by Ms 13 during the procedure itself and therefore you did not attempt to take patient's blood independently.

The panel determined that this charge is found NOT proved.

Charge 21

21) Failed to work collaboratively and as part of a team in that you failed, without notifying anyone, to attend for duty on the following dates:

a) 29 July to 16 August 2019
b) 09 September to 23 September 2019

c) 12 October to 15 October 2019.

The panel finds this charge proved

In reaching this decision, the panel took into account Witness 3's witness statement and corresponding exhibits.

> *'On 29 July 2019 [you] did not turn up for work so I escalated this to the Matron...who contacted the divisional office to see if they could make contact with [you]...the divisional office worker, informed me that he had tried to get in touch with [you] numerous time alongside [Ms 3], but there had been no response. [You] did not attend the Ward on 29 July 2019 or 30 July 2019.'*
> **...**

On 12 October 2019 [you] did not attend on the shift. I was concerned about [your] welfare as I could not get a hold of [you]. I escalated my concerns to [Ms 11], who advised me to contact [your] husband...I had tried to contact [your] husband by phone and had been unsuccessful. I emailed [your] husband and explained that I was concerned about [your] welfare. ...As I had not received a response and was very concerned I went to [your] home address to see if anyone was in but no one answered the door. On returning back to the Ward [your] husband contacted me to say that [you] had informed him that it was [your] day off and he was unsure what was wrong...'.

The panel considered the note of discussion between you and Witness 3, entitled: *'Discussion with [You] Regarding Unauthorised Leave 18/10/19'*

This states:

'...[You] report[ed] that [you] received an email which told [you] that [you] had been given annual leave on the 12th. I explained to [you] that when unavailability is put on the roster, it generates and email. In error, I had put [you] down for paid leave on 12th and amended this to the 11th (the date that [you were] sent home early...'.

...

I revisited the conversation that I had with [you] on Friday 11th where I told [you] that I would be working with [you] on 12th October, and asked why we would have had that conversation if I had granted AL for the same day; [You] didn't seem to understand that [you] had not been given AL....During 12th October whilst [you] had taken unauthorised unpaid leave, it was noted that [you were] at a family function.'

The panel determined on the basis of the information before it that you failed to work collaboratively and as part of a team in that you failed, without notifying anyone, to attend work. The panel listened to the explanation for your absences but find that you had not been granted leave in advance and you did fail to attend without notifying anyone in advance.

The panel determined that this charge is found proved.

On Friday 7 July 2023, the hearing was adjourned part-heard due to lack of time to complete the hearing.

Decision and reasons on service of Notice of Hearing (heard on Monday 11 September 2023)

The panel was informed at the start of this hearing that Miss Joseph was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 31 July 2023.

Ms Bailey submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Joseph's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Joseph has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Joseph and on granting an adjournment

The panel heard from Ms Bailey who updated the panel on the attempts made to contact Miss Joseph up until this morning's hearing. She informed the panel that whilst

in preliminary discussions earlier this morning with the legal assessor and the hearings coordinator, Miss Joseph telephoned the hearings coordinator. Miss Joseph informed her that she was confused as to when this hearing was due to resume and thought that this hearing was due to be resumed in October 2023, which is the date in which her High Court Interim Order Extension application is to be heard.

Ms Bailey further informed the panel that Miss Joseph told the hearings coordinator that she had not seen the email from her dated Friday 8 September 2023, which included the Microsoft Teams joining link and other details about this hearing, but in any event, she was unable to join this hearing today as she was not ready. She said she will be ready to join this hearing the next day but could not confirm her availability for the entire duration of the hearing. However, she said that she would update the panel during the course of the hearing tomorrow. The hearings coordinator confirmed that this was the content of the telephone conversation she had with Miss Joseph this morning.

Ms Bailey submitted that she was ready to move to the next stage to make submissions on lack of competence and impairment and continue in the absence of Miss Joseph. However, she submitted that in consideration of Miss Joseph's update this morning as to her attendance, and in the interest of fairness, the panel may wish to decide to grant a one day adjournment in order to secure her attendance.

The panel heard and accepted the advice of the legal assessor who referred the panel to rule 32(2) of the Rules:

> ***'32.***
>
> *(2) A Practice Committee considering an allegation may, of its own motion or upon the application of a party, adjourn the proceedings at any stage, provided that*
>
> *(a) no injustice is caused to the parties; and*
> *(b) the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor.*

(4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to

(a) the public interest in the expeditious disposal of the case;
(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
(c) fairness to the registrant.'

The panel has decided not to proceed today in the absence of Miss Joseph. In reaching this decision, the panel has considered the submissions of Ms Bailey and the advice of the legal assessor. It has had particular regard to the overall interests of justice and fairness to all parties. It considered that:

- Miss Joseph has requested an adjournment on the basis that she is not ready to join the hearing today;
- Miss Joseph has made it clear she wishes to engage with the process and attend a hearing and has attended all previous hearing dates; and
- Miss Joseph has said she will provide an update on her availability to attend the remainder of the hearing.

In relation to the overall public interest in the speedy and efficient disposal of these proceedings, the panel expressed some concern about being able to complete this case this week. However, it considered that this concern was outweighed by the interests of justice and in order not to prejudice Miss Joseph's right to a fair hearing, she should be able to participate personally in these proceedings as she had done previously.

The panel therefore determined that it would be fair and in the interests of justice to grant a one day adjournment of this hearing and resume tomorrow morning, 12 September 2023 at 9:30am.

The hearing resumed on Tuesday 12 September 2023 and you attended.

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 amount to a lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on lack of competence

The NMC in its Guidance states:

> *'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'*

Ms Bailey invited the panel to take the view that the facts found proved amount to a lack of competence.

Ms Bailey submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment of your competence?

Ms Bailey submitted that the NMC invite the panel to take the view that your repeated failings over a prolonged period in the facts found proved, show that your competence at the time was below the standard expected of a Band 5 registered nurse and amount to a lack of competence.

Ms Bailey submitted that as a consequence of your lack of competence, patients in your care were exposed to an unwarranted risk of harm. She submitted that support given to you was extended and continued and, notwithstanding some progress in some areas, for example, medical competencies following training, support and local reflections, there remained repeated concerns by the Trust which were serious enough to keep you supervised and monitored. She submitted that some of the concerns were more serious than others and relate to fundamental aspects of nursing practice, were wide-ranging and occurred on more than one occasion.

She submitted that the panel may benefit from reference at this stage to the case of *Holton v GMC* [2006] EWHC 2960 (Admin). She submitted that in this case, when considering the factors to be taken into account when considering lack of competence, performance is to be measured as against that which is expected of a reasonably competent nurse of the same grade. She reminded the panel that that you were employed within the Trust, in a hospital ward based position as a Band 5 nurse.

Ms Bailey referred the panel to the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), where the Court held that for lack of competence to be

established, the practitioner's professional performance must be *'unacceptably low'* and must generally be demonstrated across a *'fair sample of work'* albeit that one incident that is '*very serious indeed'* may suffice.

She submitted that in *Holton*, the test for lack of competence is objective in that facts and factors personal to a clinician are not relevant when making an assessment. Factors such as education, training and personality are irrelevant. She submitted that the panel will also note in *Holton,* that external factors such as pressure at work, any lack of resources, and professional isolation due to the lack of or absence of colleagues are relevant factors.
However, the Court in *Holton* reiterated that professional isolation due to the practitioner's, personality or behaviour, is not a factor to be taken into account. She submitted that the panel should carefully consider each of your shortcomings separately and decide if any one charge is *'very serious indeed'* so as to amount to lack of competence and to consider the numerous errors cumulatively and collectively.

Ms Bailey submitted that it is the NMC's position that your professional shortcomings involved basic areas of nursing practice and knowledge, and involved several patients over a protracted period of time. She submitted that the panel may consider that the charges found proved in this case illustrate that your shortcomings relate to core and critical functions such as observations, communication, medication administration, record keeping and carrying out instructions at the request of more senior staff.

She submitted that, notwithstanding the level and intensity of support provided to you by the Trust, you were unable to make the required progress.

Ms Bailey invited the panel to form the view that when considering your professional shortcomings cumulatively and collectively, they represent a fair sample of your work over a protracted period of time, they were in some cases repeated and, as they related to basic areas of nursing practice, they were unacceptably low for a Band 5 registered nurse.

Ms Bailey submitted that, looking at your case objectively, there is a clear concern with your clinical practice and despite best efforts by you and everyone involved, there remained a lack of competence. She invited the panel to find that the charges proved do amount to lack of competence.

Submissions on impairment

Ms Bailey 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). She referred the panel to the guidance formulated by Dame Janet Smith in her *Fifth Shipman Report*:

> *'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. ....'*

Ms Bailey submitted that your shortcomings in this case were in basic areas of nursing practice, occurred over a protracted period of time and despite a significant degree of intervention and support from the Trust, your lack of competence continued to be of concern. She told the panel that it is of note that structured plans were set by the Trust with reasonable objectives and time for you to improve and meet them. However,

despite having brief episodes of success in the short term, you went on to repeat the errors and your level of competence was again brought into question.

Ms Bailey submitted that limbs a, b and c of the test in *Grant* are engaged as to your past, current position and future practice. She submitted that you have not worked since being dismissed from the Trust and you have not completed any training and have not provided any reflections since the incidents. She acknowledged that you have made reference to some personal circumstances around caring and being the main breadwinner and that the panel may consider taking this and any information into account as mitigating factors at any later stages if and when that stage is reached.

She submitted that the panel should have regard to whether your lack of competence is easily remediable and whether it had been remedied and whether it is likely to be repeated. She submitted that the panel should take into account that your lack of competence does not relate to an isolated incident and involves repeated and similar shortcomings over a wide-ranging set of basic nursing skills.

In relation to insight, Ms Bailey submitted that the panel may well have concerns about your lack of insight into your lack of competence and / or the lack of any remediation into the areas of concern and / or the lack of any positive testimonials.

Ms Bailey submitted that the panel may acknowledge any difficulties you have faced in remediating your lack of competence due to being away from nursing or a clinical setting for approximately four years. She submitted that, when fairly taking into account all of the relevant factors and information before the panel at this stage, the NMC submit that there is no evidence before it of any constructive steps taken towards remediating your lack of competence, and accordingly the panel may decide that you have not remediated and as a consequence there is a likelihood of repetition.

Ms Bailey submitted that the panel may wish to also take into consideration the communication and borderline attitudinal issues identified in this case, noting that some of the charges found proved relate to failing to carry out proper instructions.

Ms Bailey submitted that the panel should bear in mind at this stage that the overarching objective of the NMC is to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In light of this, Ms Bailey invited the panel to make a finding of impairment on the ground of public protection and also in the wider public interest.

Your evidence on lack of competence and impairment

You gave evidence under oath. You said you had nothing to say regarding the charges. You had read the determination on the facts. You said that you would think differently about how you can improve and now would not make these mistakes again. You need to think about how to manage things and situations differently as you cannot go back to work in this situation with all these issues. You suggested that a return to your previous role in an assessment clinic would be best for you.

You were asked and answered some questions by the panel:

Has anything changed since the time of the incidents?

You mentioned that during the time of the incidents it was a very stressful time for you at work and in your family life. You said you needed to work however kept being unwell all of the time. You said you would need to do things differently both in your professional and family life and move on.

Anything to tell the panel about what you think about the incidents now?

You said that you have not worked independently for three years and that you like to work independently. You said that you have a long career with experience in the nursing profession. You said that you did training but there were still the same issues there. You said you understand the charges but need to know what the plan is going forward. You said that when you worked in private care homes and clinics for two years there were no issues and you were very happy to work in that setting. You told the panel that at the Trust you did not know what you were doing, you felt bored and there were lots of issues everywhere, with colleagues and managers. You said it was quite difficult for you.

Have you done anything outside of work?

You said you are jobless since leaving the Trust and busy with this issue.

Do you want to tell us anything in private about your health?

You said not, but due to the stress you made lots of mistakes and were unable to concentrate on one thing; but when you worked in clinics you did not have these issues.

You were asked and answered some questions by Ms Bailey:

Do you remember last time in the hearing you said you found it very difficult to be supernumerary because you wanted to work independently as a nurse and did not like being on the capability procedure because of this. You were placed on four different wards, what do you think you need to fix all of these issues?

You said you had a lot duties at the time including patient washes, five to ten trips to pharmacy, transferring patients, x-rays, helping with the food etcetera, and there was no time to take breaks. You said some of these jobs were stressful. You said you would like to concentrate on one particular area.

You did some reflection, but the last reflection in these matters was five or six years ago now, are you planning on doing any reflections on risk of harm to patients as a result of your issues and on colleagues?

You mentioned about how to improve things on the ward, how to manage, how to be polite with managers and that sometimes shortage of staff and workload makes it stressful.

Any thought to the risk patients face where you were not competent?

You said that is why you are asking to work independently and not be on a capability plan.

Do you still really want to be a nurse?

You said that you need confidence to work in the medical field to do the job. If you have these issues you are always thinking of the issues. You said that nursing is a precious and valuable job and you feel good to know when you go into hospital that there are very good nurses there.

Have you kept in touch with nursing, reading, to show your ongoing interest in nursing; any training, articles?

You said not that much. You said that you cannot only be thinking of the profession. You said you have no family support, no parents here with you and no support to improve your career.

Going forward, if you want to stay in nursing and value it as a career for you, there are still issues that need to be fixed; things didn't work out at the Trust, how would you feel about more training, supervision, etcetera and doing it all again?

You said you failed in the ward team area. You said that working in another different area of nursing care, not on the ward and not in a hospital but in a clinic, would assist.

Have you given any thought to a return to practice course?

You told the panel that you would need to think about it. You said you want to focus on working independently and being an independent nurse is the main thing.

You were asked a further question by the panel:

Have you worked at all since you left the hospital?

You responded no, you are jobless.

The panel heard and accepted the advice of the legal assessor which included reference to a number of legal authorities, these included: *Cohen v GMC* [2008] EWHC 581 (Admin) and *Grant.*

Decision and reasons on lack of competence

The panel were concerned about your overall low level of understanding of the issues in this case as demonstrated in your oral evidence throughout. The panel was not provided with any information to explain any problems with understanding and therefore did not speculate about any cause. However, the panel was satisfied that you had sufficient capacity to take a meaningful part in these proceedings.

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard.

The panel found the following charges to be more serious, either as a result of a risk caused to patients or the low standard of performance in comparison to what would be expected.

Charge 5

The panel was of the view that it is inherent upon a nurse of any band to take action; where there is a significant risk to the patient, in this case a patient at risk of choking. The panel determined that the patient was at potential risk of harm and you did not take action when you ought to have done.

Charge 6c

The panel determined that feeding a patient when the patient was not alert and suffering a delayed swallowing ability presents a significant risk to a patient of choking.

Charge 7

The panel determined that not to have monitored and acted upon a patient's absence of fluid output could have had a serious impact on their health and by not doing so, you put the patient at risk of harm. The panel considered the patient's particular health issue and was of the view that you should have known about them. It determined that it was your responsibility to see that those actions were done and you failed to do so.

Charge 9a

The panel determined that a prescription was written up for Fentanyl for pain relief to a patient. By you not administering the prescribed Fentanyl you left the patient at risk of severe pain.

Charge 9b

The panel determined that completing the patient's record of care to indicate that action or observations had been taken by you before they had actually occurred was very serious. It determined that colleagues coming onto a shift after you rely upon another colleagues accurate recording in the patient's documentation in order to safely provide ongoing care.

Charge 9c

The panel considered that you were the second checker of controlled drugs prescribed to be administered by nursing staff. The panel was of the view that the second checker process is put into effect in order to avoid potentially serious errors related to the administration of medication. The panel was of the view that these drugs are controlled for good reason and that they must be dealt with carefully and according to policy. The panel determined that it was a serious failing on your part in that, whilst dealing with the controlled drugs, you failed to check whether the drugs were correctly dispensed before signing the controlled drug book. The panel found this to be particularly serious because you were spoken to about the need to second check the drugs and yet you then failed to check them again immediately thereafter.

Charge 13

Your failure to carry out Glasgow Coma Scale (GCS) neuro-observations on a patient who had suffered an unwitnessed fall would mean that any deterioration in condition would not be noticed. As such, this failing put the patient at significant risk of harm.

Charge 15a

The panel determined that you made a recording, which was part of the patient's notes which need to be maintained and retained. You ripped up the record sheet and told the colleague to write another one out. The panel heard evidence that a colleague did not know how much or little fluid the patient had. The panel found this to be unacceptable behaviour and the risk to the patient was potentially serious.

Charge 15e

The panel was concerned in relation to the rough handling element of this charge which was enough to cause the patient to sustain a skin tear. The panel was of the view that you would have been aware that due to the patient’s condition you should have been more careful in handling them. The panel noted that in this instance, the patient’s skin

was torn and this was caused by your handling them '*roughly*'. The panel determined that this is unacceptable and did cause the patient harm.

Charge 19a

The panel determined that communication is one of the key requirements of a nurse in the performance of their duties and the inability to communicate appropriately and effectively is of concern.

Charge 21

The panel was of the view that you were on the roster to be on duty on these occasions and whether you are supernumerary or otherwise, you have a duty to turn up for work. The panel was of the view that not to have notified anyone of your absence was unreasonable and a significant concern, as patients were put at risk by you doing so.

The panel found that the charges above individually and all the charges viewed collectively demonstrate your lack of the key skills that are required of a Band 5 nurse. These were repeated errors that occurred over a significant time period in a wide-ranging number of clinical areas, despite a number of measures that were put in place to assist you. These areas included:

- managing patients unsupervised;
- responding to the needs of deteriorating patients;
- confidence and initiative;
- provision of personal care;
- communication concerns.

The panel was of the view that the lack of competence demonstrated an unacceptably low standard of performance judged by a fair sample of your work.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was far below the standard that one would expect of any registered nurse.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*

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*

The panel determined that there has been no evidence put before it to demonstrate any learning and that this risk was present in the past and in the future.

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

The panel determined that informed members of the public would take the view that you have and would in the future bring the nursing profession into disrepute.

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*

The panel determined that by your omissions and actions, you did not treat patients with dignity or deliver safe care to numerous patients in a number of settings. In light of your lack of insight, reflection and remorse the panel determined that you were liable to do the same in the future.

d) *...*

The panel found that patients were put at risk and some were caused actual physical harm as a result of your lack of competence. Your lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that the matters found proved showed a variety of failings, involved a number of patients and occurred over a number of years, therefore they were not isolated incidents. The panel also noted the high level of support provided to you by the Trust during the relevant times.

It went on to consider whether there is a risk of repetition and in doing so it assessed your current insight, remorse and remediation. The panel had no evidence before it to demonstrate any insight or remediation taken. It noted that you had not provided any evidence of reflection and that you have not worked since your dismissal from the Trust and therefore have not had any opportunity to strengthen your practice.

In relation to remorse, the panel found no evidence of this, either by way of written reflection or in your recent oral evidence.

The panel considered that the lack of competence in this case is capable of remediation. However, the panel has received no evidence that you have remediated your practice. Accordingly, it cannot be said that this lack is highly unlikely to be repeated.

The panel 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 concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and 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.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been provided in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel heard and accepted the advice of the legal assessor.

Submissions on sanction

Ms Bailey informed the panel that the original Notice of Hearing, dated 18 May 2023, included the NMC's original sanction bid that it would seek the imposition of a conditions of practice order for a period of 12 months with review, if it was found that your fitness to practise is currently impaired. She submitted that often in a lack of competence case there is a focus on a sanction that allows the nurse a way, with support, to remediate the issues identified and indeed the panel has identified that the issues here are potentially remediable.

She submitted that during the course of the hearing, the panel has found many serious areas of widespread lack of competence across very many varied areas and, despite considerable support over a protracted period, you were unable to meet the necessary level of competence as identified in the charges. She said that she counted eleven of the charges as being identified by the panel as serious in and of themselves. She submitted that, notably, the panel have found very poor insight, no remorse and no remediation from you.

Ms Bailey submitted that a number of patients were put at real risk of harm and some were actually harmed. She submitted that a mitigating feature is that you are fully

engaged in these proceedings and this is against a background, as you told the panel earlier in the hearing, that English was not your first language.

Ms Bailey submitted that it is the NMC's position that neither taking no action nor imposing a caution order would be appropriate due to the seriousness of the case and the public protection issues identified.

In reference to the original sanction bid of a conditions of practice order for a period of 12 months, Ms Bailey took the panel through the factors in the SG where conditions of practice are appropriate. However, she submitted that it is ultimately a matter for the panel to determine whether it would be possible in this case to formulate relevant, appropriate and workable conditions which would address your lack competence, and in particular whether you have the ability and willingness to comply with any conditions of practice, in view of your poor understanding and lack of insight.

Ms Bailey submitted that if the panel were to impose any conditions it saw fit, she suggested that the conditions would have to be very stringent and include the following:

- Direct supervision
- Very regular reporting back from a nominated person of suitable seniority by manager or supervisor
- Very detailed, specific and structured personal development plan
- The standard conditions of reporting back and disclosing conditions
- A requirement to inform the NMC of any course of study at any institution
- A requirement to immediately inform the NMC of any new concerns or investigation

Ms Bailey also submitted that the panel may want to carefully consider the length of any such order against the original sanction 12 months.

Ms Bailey further submitted that the panel may well question the workability of conditions of practice, no matter how stringent, structured and personalised they may be. She submitted that the panel may decide that conditions are not the appropriate

sanction in all the circumstances of this particular case. She submitted that were the panel to take a proper *"bottom up"* approach, it may wish to go on to consider whether a suspension order is the sufficient and appropriate order to make, bearing in mind the public protection and public interest concerns identified in this case. She referred the panel to the relevant parts in the SG in relation to suspension orders. She informed the panel that a striking off order is not available as a sanction at this stage in lack of competence cases such as this.

Your representation on sanction

The legal assessor asked you the following questions to assist you:

The panel today has to decide whether you can continue as a nurse with conditions similar to an action plan or whether you can't work as a nurse at all for a period. Do you understand those two options? Do you understand them?

You indicated that you did.

Do you think that you could work as a nurse with a strict action plan?

You said that an action plan includes similar like insulin and accident forms. So you can work and take action yourself.

When you had an action plan at the Trust, did you find it difficult to work with that?

In essence, you said that the action plans everywhere were different. So they will put the action plan in place to improve the policies and procedures.

Could you work as a registered nurse and do your nursing duties with conditions, such as: being supervised on matters like medication, write a reflective piece. have regular meetings with your line manager rather similar to the capability plan you had at the Trust, but this time the NMC?

In essence, you said if you were to say yes, would you have a choice and is there any other option? You said you still have doubt as you would like to be an independent nurse.

The Chair clarified to you that if the panel were to impose a conditions of practice sanction, you would have to adhere to it as the only other option available is a suspension order whereby you would not be able to work as a registered nurse for a period of time.

You confirmed you had read the determination. You were invited by the panel to pause for ten minutes think about what had been explained to you and to rejoin the hearing to ask any questions you may have.

The legal assessor asked if you remember what the two available sanction options open to the panel were?

You indicated that you did and said that you would be happy with the first option of a conditions of practice order. You confirmed that there was nothing else you wanted to say.

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 also had regard to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified following areas to have been breached in this case: 1.1, 1.2, 1.4, 2.1, 2.6, 4.1, 6.2, 8.2, 8.5, 9.2, 10.2, 10.3, 10.5, 13.1, 15.2, 18.2, 19.1, 19.4, 20.1, 20.3, 20.5, and 20.8.

The panel took into account the following aggravating features:

- You demonstrated a consistent lack of competence in a wide range of fundamental nursing practice with a large number of patients over a considerable period of time
- Your lack of competence put patients at harm and / or at risk of suffering harm.
- You demonstrated a lack of insight into your failings
- You demonstrated an inability to maintain or complete the Trust's capability plans

The panel also took into account the following mitigating features:

- Personal mitigation, experiencing periods of stress
- You achieved some of your action plans over some period of time such as the administration of medication and the taking and recording of blood pressure
- Frequent changes in respect to action plan management

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG in relation to when a conditions of practice order is appropriate, in particular:

- *Identifiable areas of your practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions of practice that could be formulated given the nature of the charges in this case, the wide range of failures in fundamental nursing practice, the number of patients involved and the period of time over which your failings occurred. The panel found that the charges and your subsequent interaction with these proceedings provide clear evidence of a general, indeed very significant, lack of competence. There are no specific identifiable areas of retraining that could be said to address this general lack of competence at this stage. The serious incidents outlined in the charges occurred over two years whilst you were subject to supervision and were working to agreed action plans aimed at improving your performance. You lack insight into your failures and have failed to express remorse. The panel find that when giving evidence you expressed a resentment in relation to the supervision you were previously receiving. The panel consider that these factors give reason to doubt that you would comply with conditions or respond positively to retraining. Therefore a conditions of practice order would not protect the public.

The panel considered the SG on when suspension orders are appropriate and in particular took into account this factor:

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

In light of this the panel decided that a suspension order was the only appropriate sanction in this case.

The panel did not go on to consider whether to impose a striking off order as this sanction is not available for use at this time.

The panel noted the hardship such an order may well cause you. However this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for the maximum period of 12 months was appropriate and proportionate in this case. This would mark the seriousness of the lack of competence and to begin to allow you sufficient time to address your failings.

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

Any future panel reviewing this case would be assisted by:

- An indication of your intention to continue to be a registered nurse
- Your attendance at any future hearing
- Whether you have applied for or started a return to practise course
- Whether you have completed and passed an NMC recommended English language test
- You providing any relevant references
- You providing information about any paid or unpaid work relevant to the healthcare sector you have undertaken
- You providing a reflective piece covering your failings identified in this determination

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the suspension order sanction takes effect.

Submissions on interim order

The panel considered the submissions made by Ms Bailey that an interim suspension order should be made to cover the appeal period. She submitted that an interim order is necessary for the protection of the public and to protect the wider public interest.
Ms Bailey invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

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

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary for the protection of the public and to protect the public interest. The panel had regard to the seriousness of the lack of competence and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel did consider whether the order is also in your own interest but did not pursue that ground because it did not have enough evidence about your background circumstances. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

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

This will be confirmed to you in writing.

That concludes this determination.