

Professional conduct annual report 2002–2003

**NURSING &
MIDWIFERY
COUNCIL**

Professional conduct annual report 2002–2003

Protecting the public through professional standards

Contents

Foreword	4
Trends and issues	6
Case studies	12
Further information	19

Foreword



Jonathan Asbridge



Mary Hanratty

Welcome to this first professional conduct annual report of the Nursing and Midwifery Council (NMC). The Council was established under the Nursing and Midwifery Order 2001 and came into being on 1 April 2002. The NMC has taken over the work of the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

The primary mandate of the NMC is to safeguard the health and well-being of the general public. We do this by keeping a register of all nurses, midwives and health visitors and ensuring they are fit to practise. We also set the standards for the education, training and conduct of those on the register, and this number currently stands at around 650,000.

Anyone who has a serious concern about the conduct of a registrant or their fitness to practise due to ill health can report this to us. If a case is proved, one of the sanctions available is to remove the practitioner's name from the register. Most of the procedures for dealing with allegations during the period 2002–2003 were the same as for the UKCC. These procedures will also govern the work of the NMC during the next reporting year 2003–2004, but there will be changes the following year.

Following extensive public consultation in 2003, the NMC is drawing up new fitness to practise procedures that are required under powers given in the Nursing and Midwifery Order 2001. Professional conduct will become part of a broader remit within the Council's role and will be called fitness to practise. The new fitness to practise rules will come into effect in April 2004 and next year's report will carry an overview of these changes. Some aspects of fitness to practise will be similar, while others will change radically. For the year under report, we summarise the work carried out by the NMC using the existing UKCC professional conduct procedures.

It was another extremely busy year, not only working towards preparing for the new legislation, but also in completing a record number of professional conduct cases. Thanks to the huge

efforts of committee members and staff we increased the number of hearings by 24 percent. This was in spite of a considerable focus on analysing the new legislation and needing to work within strict budget parameters that actually slowed the rate of hearings at the end of the year. As part of the cost efficiencies, we sought to use all available spare space in the NMC offices, occasionally working in less than optimum conditions. Although there were fewer Health Committee meetings, the number of cases heard increased due to greater efficiencies in processing.

The Council approved a set of competencies for members sitting on committee panels and for the chairs of panels. These will help ensure a consistency of approach and skills. Staff numbers were also increased and this, combined with on-going training, resulted in increased efficiency throughout the Department.

A Fitness to Practise Working Group was set up to plan for the work required for the new legislation. The group includes the chairs of the practice committees and Council members. This work will continue well into 2004 as we make preparations for familiarising and putting into practice our new fitness to practise rules and procedures.

Overall, it was another hard working year with achievements we can be proud of. Council members and staff have contributed enormously to the successes of the year – the results of which you can read about in this report. You will also find our usual case studies that focus this year on how the NMC can protect the more vulnerable members of our community.

Jonathan Asbridge

NMC President

Chair of the Professional Conduct Committee

Mary Hanratty

NMC Vice President

Chair of the Preliminary Proceedings Committee

November 2003

Trends and issues

The NMC's remit, like its predecessor the UKCC, is to protect the public. The current Council is a transitional body and has until April 2004 to draw up and implement a set of rules that will govern the new fitness to practise procedures. Until then, the existing rules will prevail. By 2005, a new Council will also be elected and appointed.

For the year under report, the NMC's Professional Conduct Committee (PCC), Preliminary Proceedings Committee (PPC) and Health Committee (HC) dealt with allegations of misconduct and unfitness to practise due to ill health.

New allegations of misconduct

The number of allegations of misconduct against registered nurses, midwives and health visitors dropped marginally this year, although remaining at the high end of recent annual figures. In 2002–2003, the NMC received 1301 complaints.

UKCC 1998–1999	UKCC 1999–2000	UKCC 2000–2001	UKCC 2001–2002	NMC 2002–2003
1077	1142	1240	1304	1301

Who makes the complaints?

Anyone can make a complaint, but in practice the largest number (40%) come from employers, usually in association with disciplinary proceedings at the workplace.

The NMC also gets complaints from the police, who are obliged to inform the regulatory body of any criminal conviction received by a practitioner on the NMC register. Last year the NMC was notified of 247 convictions – many of which were minor matters unlikely to lead to any further action. However, the NMC is also notified of serious convictions involving rape, other violent crimes and dishonesty.

Complaints are also received directly from the public, colleagues, supervisors of midwives, the National Care Standards Commission and others.

Where do the complaints come from?

While complaints are received from all four countries of the United Kingdom, the majority come from England as indicated on page 7. The percentage of practitioners resident in each country during the year is also shown.

Country	Number of complaints	% of practitioners resident in each country	% of complaints in each country
England	1109	79.1%	88.5%
Wales	69	2.85%	4.1%
Scotland	97	10.1%	5.3%
Northern Ireland	14	2.65%	1.5%
Outside the UK	12	5.3%	0.6%
Total	1301		

What happens to new complaints?

When a complaint is received, it is considered by a panel of the Preliminary Proceedings Committee. The PPC decides whether there is a case to answer and whether there is enough evidence to support the complaint. The PPC takes as its starting point the fact that the professional conduct procedures are, as set out in the legislation, ‘... proceedings for removal from the register’. For this reason, some complaints will be recommended for immediate closure by the PPC. This could be because they are trivial, not supported by evidence, or relate to matters that would not call into question the registrant’s fitness to practise. Many convictions fall into this category.

However, if the allegations are serious and the PPC believes they could lead to removal from the register, solicitors will investigate and report on the strength of the evidence available to support the charges. The criminal standard of proof is applied and solicitors will advise as to whether this high standard can be reached. This is a higher standard of proof than is required in, for example, employers’ disciplinary hearings.

During 2002–2003, the PPC considered 1585 cases and made the following decisions as shown in the table below. The comparative UKCC figures for 2001–2002 are also given.

	UKCC 2001–2002	NMC 2002–2003
Case closed	805	819
Further investigation required	352	418
Referred to professional screeners (for consideration of health cases)	66	66
Cautioned	75	42
Referred to the Professional Conduct Committee	316	240
Total	1614	1585

The above figures include some cases that will have been considered twice.

Cautions

A caution may be issued by the PPC if three criteria are satisfied:

- ▶ the offences are serious enough to lead to removal from the register
- ▶ the practitioner admits the facts of the charges and that they constitute misconduct
- ▶ the practitioner provides mitigation which persuades the committee that they are not a risk to the public and that removal would not be appropriate.

However, the PPC will still refer a case for a hearing if it decides that removal is appropriate.

Recording action taken

Records of cautions are retained for five years. Any employer or member of the public who checks the practitioner's registration with the confirmation service during that period is informed of the caution. If the practitioner is referred again to the PPC or the Professional Conduct Committee during that five year period, the committee will be informed of the caution.

Professional Conduct Committee

Professional Conduct Committee (PCC) hearings are held in public. This reflects the Council's commitment to transparency and accountability in its professional conduct work. The press is usually present, as are those who wish to attend as observers. Sometimes, some respondents and their employers want proceedings to be held in private. However, the only reason the PCC may agree to hold all or part of a hearing in private is to protect the identity of a victim of the alleged offences in particularly sensitive circumstances, such as child abuse cases. The potential embarrassment of the respondent or the business reputation of the respondent's employer are never accepted as reasons for holding the hearing in private.

The PCC usually sits in the country where the case originated. During 2002–2003, the committee met at the NMC's offices, other venues in London and a range of other UK-wide locations. These covered Accrington, Bath, Belfast, Birmingham, Blackpool, Bristol, Cardiff, Chester, Darlington, Edinburgh, Exeter, Gateshead, Glasgow, Hull, Manchester, Nottingham, Norwich, Preston, Sheffield, Torquay, Truro, Wakefield, Wigan and York. The committee meets most frequently in England as that is where most of the cases originate.

During the year, the PCC sat on 370 days and considered 326 cases of alleged misconduct and 19 applications for restoration to the register. Again, this represents a significant overall increase in the committee's workload during the year. By comparison, during 2001–2002 the PCC sat on 297 days during and considered 291 cases of alleged misconduct and 11 applications for restoration.

Categories of misconduct

Issues concerning clinical practice – including failing to keep accurate records – were the biggest category of offence during 2002–2003, accounting for almost 30% of the charges made. As in previous years, there was also a large number of cases of physical, verbal or sexual abuse of patients. These made up 26% of the charges, down on last year's figure of 32% which had been an all-time high.

Eight per cent of the charges were non practice-related and typically related to the reporting of criminal convictions. A registrant can be called to account for behaviour which is not related to work if it is considered that public trust and confidence in the professions would be undermined, or if such behaviour constitutes a risk to the public.

Dishonesty accounted for 4.5% of the charges and included non practice-related dishonesty as well as theft from patients and clients. A further 8% of charges related to staffing issues, including the sexual harassment of colleagues and failing to work collaboratively.

Professional Conduct Committee decisions

Judgement	2001–2002	2002–2003
Removed from the register	113	154
Cautioned	61	66
Misconduct proven but no further action	10	6
Facts or misconduct not proven	8	15

Applications for restoration to the register

During 2002–2003, the committee considered 19 applications for restoration to the register and accepted one. This compares with five successful applications from a total of 11 the previous year.

Anyone who has been removed from the register can apply to have their name restored to it. In practice, it is recommended that no application should be made within 12 months of removal. Applications are discouraged from those who have clearly made little or no effort to address the issues that led to their removal in the first place. Finally, as a matter of policy, no practitioner who has been removed from the register after committing a serious criminal offence will be re-admitted to the register if it is considered that this would undermine public trust and confidence in the professions.

All applications for restoration are considered by the PCC. The applicant must attend so that they can be questioned by the committee. Restoration cases are heard on a designated day and the committee is always chaired by the president. Two references must be supplied, one of which must be from a current employer who is fully aware of the circumstances surrounding the removal from the register.

The onus is on the practitioner seeking restoration to demonstrate that, having been removed, they are now a fit and proper person to be restored. The committee will take into account whether or not the practitioner:

- ▶ accepts that removal from the register was justified
- ▶ has addressed the issues that led to removal and changed their behaviour or attitudes
- ▶ shows genuine regret
- ▶ has made amends.

The committee must also consider whether public confidence in the professions is likely to be maintained if that practitioner was to be restored to the register. If the answer to any of these questions is negative, the application will be rejected. When a practitioner has been restored to the register, the previous removal will be disclosed to those confirming the practitioner's registered status for a period of five years from the date of the restoration.

Unfitness to practise due to ill health

Allegations that a registered nurse, midwife or health visitor is unfit to practise for reasons of ill health are considered under Health Committee (HC) procedures. The main reasons for referral to the HC in the year under report were alcohol or drug dependence, mental health problems and a smaller number of physical health problems.

A person may be referred to the HC in one of two ways. It may be by a direct referral, for example by an employer. There were 34 such referrals during the year. Alternatively, during the course of considering a professional conduct case, a referral may be made from either the PPC or the PCC if it appears that the practitioner is unwell. Sixty-six referrals were made by the PPC to the professional screeners and two from the PCC during the year.

If the screeners feel there may be a current health problem, the practitioner is invited to be examined by two medical examiners. The medical evidence enables the screeners to decide whether to refer a practitioner to the HC. During the year, the screeners met on 36 occasions and considered 205 cases. Eight cases were closed and 112 were referred to the HC. The remaining cases are still in progress.

Health Committee

The HC meets in private because of the confidential nature of the medical evidence involved. During 2002–2003, the committee met on 38 days and considered 204 cases. The HC has one more option to exercise than the PCC as it can suspend a practitioner's registration. This has the same effect as removal but the practitioner's name remains on the register. In order for the suspension to be lifted, the practitioner must apply in the same way as someone seeking to be restored to the register.

The committee, like the PCC, has the power to postpone judgement and this power is much more commonly used by the HC. A practitioner may, for example, have a history of drug addiction problems. They may currently be in good health and practising satisfactorily, supported by an employer who believes that the individual is on the way to full recovery. The committee may wish to be sure that this is the case and may decide to postpone judgement for a year. At the end of this time, the practitioner would be required to appear again before the committee with relevant reports from a psychiatrist, together with a reference from the current employer. A further examination by two medical examiners would also be required.

Health Committee decisions

Decision	2001–2002	2002–2003
Fitness not impaired – case closed	49	77
Fitness impaired – suspended	46	37
Fitness impaired – removed	5	13
Judgement postponed	41	24
Adjourned for further medical reports	19	43
Total	160	194

The Health Committee also considered nine applications to terminate suspension, of which eight were accepted and one was referred back to the PPC.

Interim suspension

The regulatory body has the power to order the suspension of registration while an investigation is under way. The committee uses this power if it appears that there is a serious risk to the public in allowing an individual to practise pending the outcome of an investigation by the regulatory body. A practitioner under police investigation for a serious criminal offence against patients would almost certainly be subject to interim suspension. It may also be imposed if it is considered to be in the practitioner's own interest. This includes situations, for example, where practitioners are accused of stealing drugs for their own use. The practitioner who is being considered for interim suspension has the right to be present at the hearing and to be represented.

Appeals and judicial reviews

In the period 2002–2003 there was one application for a judicial review of an HC decision not to terminate suspension of registration, and one appeal against an HC decision to suspend registration.

The application for judicial review was not granted but this decision was reversed on appeal and the judicial review was expected to be held in the autumn of 2003.

The appeal against suspension was based on two points: first, that the HC was unfair in amending the Notice which stated the grounds for holding the hearing; and second, that the committee had given inadequate reasons for deciding that the appellant's fitness to practise was seriously impaired. The court found that in the particular circumstances the HC had not been unfair in amending the grounds in the Notice and that the committee had given adequate reasons to explain its decision. Accordingly, the appeal was dismissed.

Case studies

In previous UKCC professional conduct annual reports the case studies have focused on non-practice related issues, abusive behaviour, and cases of dishonesty. This first report of the new NMC looks at poor practice and, in particular, the care of elderly, vulnerable patients. This category of case made up almost 30% of complaints during 2002–2003.

The four cases studies outlined here describe situations where respondents failed to take appropriate action in emergencies, failed to keep records, lacked competence in the area of drug administration and failed to assess patients appropriately and make adequate care plans.

Two of the cases concern the failure of a practitioner to deal appropriately with elderly patients who had falls. This type of incident is not uncommon and raises concern among the committee members who consider these cases about the training and awareness of staff about the potentially serious implications of falls for the elderly.

Registrants are encouraged to seek representation if they are facing allegations of misconduct. However, many respondents neither attend the hearing nor are they represented in their absence. In these circumstances, the committee has no opportunity to hear the respondent's side of the case, nor to hear any mitigation to help it reach a decision.

Case study 1: Assessment and care deficiencies

The Professional Conduct Committee considered the case of a registered general nurse who was employed as acting manager of a nursing home for 30 frail elderly residents. She did not attend the hearing and was not represented.

The acting manager faced allegations of failing to ensure the adequate preparation of care plans and adequate admission assessments of patients. She also faced allegations of failures in the care of a diabetic patient and of a patient with pressure sores. It was further alleged that she failed to evaluate the care plan of a patient on Warfarin and failed to ensure that the staff in the nursing home were aware of the implications of a drug error involving Warfarin. Finally, it was alleged that she failed to ensure that appropriate action was taken following a patient's fall which had resulted in a shoulder dislocation.

The respondent admitted the facts and therefore the committee found that the facts were proved.

Background

A complaint was made to the registration officer at the health authority by a doctor at the local hospital because of his concerns at the condition of a patient he was admitting from the nursing home. Her pressure areas concerned him and there had been delay in seeking treatment following a shoulder dislocation.

Complaints had also been received about another patient's condition on admission to the hospital from the nursing home, in particular her groin abscess and her pressure areas.

As a result of the complaints the nursing home was inspected. The inspector was very concerned by the apparent lack of admission assessments for one patient, and about the inadequate care plan which had been drawn up for a diabetic patient which didn't address the management of her damaged pressure areas, her diabetes, her oral care or her pain.

In giving evidence the nursing home registration officer confirmed that the respondent would have had responsibility for assessing patients' needs on admission, and for ensuring that a care plan was based on that assessment. She said she would also have had responsibility for teaching, and for assessing and auditing care plans. She confirmed that the respondent, as acting manager, would have remained accountable for the care of the patient at all times and gave evidence that the nursing home had been inspected three times following the reported concerns.

The nursing home registration officer also gave details about a patient who had been admitted to hospital with severely broken down pressure areas but there was no record of this in the notes, and about another patient with a discharging right groin abscess for whom there was no plan for managing her pain.

Finally, she confirmed that on appointment as manager of the home, the respondent would have been received written guidelines from the nursing home inspectorate, including guidance on record keeping.

The committee heard from the hospital doctor who had admitted one of the patients who had a dislocated shoulder. The dislocation, he said, was clearly noticeable and would have been present for more than a couple of days. He also observed that there was long standing ulceration of the skin over the pressure areas.

Decisions on misconduct

The committee was advised that the respondent had admitted misconduct in relation to all the charges except for one charge where she had not been on duty on that day. The committee accepted this exception, and found misconduct in all the other charges.

Previous history

The committee heard that the home had been served with an enforcement notice in relation to record keeping prior to the subject matter of these allegations.

There were letters detailing the respondent's employment history from the home owner who also wrote in support of her.

Judgement

The committee decided to remove the nurse's name from the register because she had been found guilty of misconduct on a number of charges involving vulnerable patients. The committee found that she had been persistently neglectful over a considerable period of time. It said that the committee's function was to protect the public and therefore her name was to be removed from the register.

Case study 2: Lack of care for an elderly patient

The Professional Conduct Committee heard the case of a nurse on part 12 of the register who had been employed for nine months as an agency nurse at a nursing home. Prior to this she had been a member of the full-time staff of the nursing home for about 18 months. The nurse, who was not present nor represented, faced allegations that she failed to call for medical attention for a patient following a fall.

Background

The incident took place in a 30-bed unit for the elderly mentally ill, which was one of six units in a 180-bed nursing home.

The committee heard evidence from the manager. She said there was one qualified nurse on duty at night with two care assistants, and that a senior night sister covered all six units and could be contacted by an interlinking telecom system between the homes.

She said that each resident retained their own GP and if medical support was needed at night, the relevant GP should be contacted.

Further evidence was given by a care assistant who had worked at the nursing home for three years. She had been on duty with the respondent nurse on the night shift when a patient fell. The patient was a frail, small woman with dementia, who was in her eighties. She was able to feed herself and walk holding on to a hand rail.

At 3am she said she had heard shouts for help so she went with the nurse to investigate. They found the patient on the floor where she had fallen and the patient told them that she was in pain.

They lifted the patient onto the bed where she continued to complain of pain in her leg. The care assistant said the nurse examined the patient and at this point the care assistant had to leave the room to attend to another patient. When she returned she said the nurse had covered up the patient and said that she would be back later. The patient was still expressing pain. She said the practitioner had been very well at the beginning of the shift, but now the patient's face looked grey.

The committee heard from a second care assistant who had worked at the home for six years, and also from house manager, an RGN and RMN. They had both checked the patient at different times and the house manager noticed that her right foot was rotated and shortened, and when she touched her little toe, the patient screamed in agony. She believed the patient was in deep shock and she phoned an ambulance straightaway.

The hospital diagnosed a fractured femur. The house manager said the patient suffered a heart attack a few days after the fracture but then made a full recovery and was now back at the home.

The committee heard from the operations manager for the nursing agency which had employed the respondent who had interviewed the nurse following the incident. The nurse had been suspended from the agency then subsequently removed from their books.

Decision on facts

The committee felt that the witnesses had been consistent and credible and that the facts of the allegation were proved.

Decision on misconduct

The committee was given the notes of the disciplinary interview. It found that the respondent was guilty of misconduct.

Judgement

The committee decided to remove the nurse's name from the register because it was in the interests of public protection. The committee had received no substantive evidence in mitigation to convince it that the public would be safe if this practitioner were free to practise as a registered nurse.

Case study three: Elderly patient suffered in fall

The Professional Conduct Committee considered the case of a registered nurse who had been employed at a nursing and residential home since April 2000. She faced allegations that she failed to call for medical attention when a resident fell and complained of pain, made inaccurate entries relating to the fall in the records, and failed to document observations in the resident's nursing notes. The nurse was present at the hearing and represented by a lawyer. She was also accompanied by a representative from the Nurses' Welfare Service.

The respondent admitted failing to call for medical attention and failing to document her observations but denied making inaccurate entries in the nursing records.

Background

The respondent worked at a home for 68 elderly mentally ill residents who were housed on two floors. The respondent was nurse in charge on the ground floor with two care assistants, with another registered nurse and two care assistants on the first floor.

Circumstances of the charges

Evidence was given by the manager of the nursing home, an RGN, who had been informed by a care assistant of an incident concerning a fall by a resident who was mobile but deaf, and who suffered from dementia.

She had contacted the nurse concerned and interviewed her. The nurse had found the resident on the floor and had got him back to bed with a care assistant's help. She had carried out observations on him on numerous occasions throughout the night but hadn't documented this. She had felt it unnecessary to get medical attention because she felt it was only a muscular injury.

The committee heard from a care assistant who had worked at the nursing home for five years and had been on duty with the nurse. She said she had discovered a resident on the floor sometime after 10.30pm and had pressed the emergency call buzzer. The nurse arrived, checked the resident and then they walked him to his bed. He was limping and seemed to be in a lot of pain. The care assistant said she had stayed with him at all times except for when she was needed for other duties. On three occasions she said she had asked the nurse to come and check him as he was pale and seemed in pain. The nurse did check him but said he wasn't prescribed any medication for pain.

She was asked about an entry in the records which stated that the resident was found on the floor at about 35 minutes after midnight. The care assistant insisted that she had found him just after 10.30pm.

An RGN on duty the following morning saw the patient and immediately phoned for an ambulance because she suspected he had a fracture. An x-ray confirmed that he had a fractured femur.

Another nurse, however, who had been on duty on the top floor of the nursing home had carried out neurological observations, but had not checked his limbs because the respondent had said she had done so. She said he had not complained of pain and she had not felt it necessary to call for medical assistance on the basis of what she had seen.

The committee then heard from the nurse herself who had qualified as a registered nurse in Zimbabwe and had undertaken an adaptation programme in January 2000.

She said that she had found the resident on the floor, had checked for any injury and saw that he was able to move his leg. She rotated his legs when he was undressed and said he was not in any distress. She continued observing him throughout the night and believed he was comfortable.

When he complained of pain at 2am the respondent said she assumed the pain might be muscular, and gave him two prescribed Paracetamol tablets. She had not called the doctor because she had not considered that he had a fracture.

She denied that it was the care assistant who had found him on the floor and that she had been repeatedly asked to come and see the resident. She further denied hearing him moaning with pain as she went off duty and said that she had not at any stage observed a shortening or rotation of his leg.

The respondent also denied making false entries in her notes when dealing with the incident, but she did accept that she should have called for an ambulance when the resident was clearly making a cry for help.

Decision on facts

The committee found it proved that the nurse had failed to call for medical attention for the resident when he complained of pain, and that she had failed to document her observations. However, the committee did not find it proved that she had made inaccurate entries in the nursing notes as the evidence was not conclusive as to the timing of the discovery of the patient.

Decision on misconduct

The respondent denied that the charges amounted to misconduct and her representative argued that the nurse had made a misjudgement

The committee found the nurse guilty of misconduct for failing to call for medical assistance and for failing to record observations. It felt that by 2.30am the nurse should have realised the resident needed medical attention.

By failing to record observations she had failed to safeguard the interests of the resident. The committee observed that record keeping is an integral part of nursing, midwifery and health visiting practice.

Mitigation

The manager of the home confirmed that the nurse had had no previous complaints about the care she provided and had undergone an induction programme. The respondent's representative asked the committee to take into account that the nurse had arrived recently from a different country where there are differences in the way care is provided, that there were no previous disciplinary matters recorded against her and that she was currently working for an agency in a nursing home.

Judgement

The committee decided to remove the nurse's name from the register in order to protect the public because she had failed to act so as to promote and safeguard the interests and well-being of the resident.

Case study 4: Drug administration error and false note

The Professional Conduct Committee considered the case of a registered general nurse who was employed first as the lead nurse in an ophthalmology department, then on a care of the elderly ward. She was present at the hearing and was represented by the RCN.

The nurse faced allegations that she put an instruction to 'dilate both eyes' on a patient's notes without medical authorisation, that she administered a drug via the wrong route, and while she was not competent to do so, and made a false entry on a patient's fluid balance chart relating to that drug error. The nurse admitted all the charges except for making the false entry.

Background

The committee heard that the nurse had been employed at the hospital for more than 20 years and had been in the ophthalmology department for about nine months in a specialist role.

The circumstances of the incident were that a staff nurse had administered eye drops to a patient who had an adverse reaction. The patient concerned was found to have had a number of

contraindications to the use of the drops and it was subsequently discovered that the drops had not been authorised by a medical practitioner, as they should have been, but by the respondent.

The line manager said the nurse had admitted stamping the notes and had said it was common practice for nurses to do so, but the line manager did not find any evidence of this. The respondent said she had not considered that the patient had any contraindications.

The respondent nurse was downgraded and moved to a care of the elderly ward. A staff nurse on this ward gave evidence that the respondent had not been assessed as competent to administer drugs, and that she was the only person on duty able to administer intravenous drugs. Despite this, however, in her absence the respondent had administered an intravenous drug subcutaneously.

An entry in the fluid balance chart was followed by the initials SC for subcutaneous. The staff nurse confirmed that the initials were not in her handwriting and that the drug pack clearly stated that it was for intravenous use only. Another staff nurse and the ward manager also confirmed that they did not recall the initials SC being on the chart when they had first seen it.

The respondent's representative argued that because there was no direct evidence that the nurse had altered the fluid chart there was no case to answer concerning the addition of the initials SC. Advice was given by the legal assessor about direct and circumstantial evidence and he advised that the issue of motive was relevant.

Decision on facts

The committee found the facts proved and said that they were convinced by the evidence that the letters SC had been added at a later date.

The respondent nurse gave evidence about the first three charges. She said she had believed it was the practice for nurses to stamp 'dilate both eyes' on the patient's notes but she now accepted she had been wrong.

In relation to the charges concerning the intravenous administration of a drug, the respondent said she had checked with the pharmacist to see whether it was classed as a fluid or as a drug. Because he had said it was a fluid she thought she could administer it.

Decision on misconduct

The respondent nurse did not admit misconduct on the first three charges, but had admitted misconduct in relation to inserting SC on the chart and the committee found that the proved facts of all the charges amounted to misconduct.

Background information

The committee heard from the assistant director of human resources who gave evidence about the disciplinary proceedings the respondent had faced.

Judgement

The committee decided to remove the nurse's name from the register.

The chair said that after one mistake she had been given additional support but despite this a further mistake had occurred, compounded by the falsification of a patient's fluid chart. The committee noted the respondent had not initially informed her new employer of the circumstances of her dismissal. The committee had taken into account the mitigation but said that the purpose of the register is to protect the vulnerable public and therefore removal was appropriate.

Conclusion

Many cases of this type are referred to the NMC for consideration. Not all result in removal from the register as in these instances. Others may not have sufficient evidence to progress to a full hearing or the circumstances are not sufficient to warrant referral on.

Further information

Copies of all NMC publications are available from our Publications Department at 23 Portland Place, London W1B 1PZ, by e-mail at publications@nmc-uk.org or from our website at www.nmc-uk.org.

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