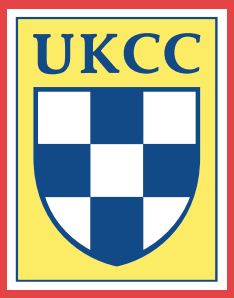

Professional conduct annual report 2000-2001

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Protecting the public through professional standards

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Contents

Foreword

Professional conduct is at the heart of the Council's public protection work. Ensuring that appropriate measures are taken to safeguard patients and clients from practitioners who are unfit to practise is one of the most important ways in which the regulatory body discharges its public responsibilities. It is certainly the area of the Council's work that generates the greatest public interest.

This second professional conduct annual report covers the Council's activity during 2000-2001. It sets out statistics and documents trends in conduct affairs during the year. The report also includes a series of themed case studies, based upon actual hearings held during the year. The purpose is not simply to disseminate raw data. The Council has consistently sought to use the information deriving from its professional conduct work to inform its standard setting and guidance work. By helping registered nurses, midwives and health visitors, and their employers and managers, learn the lessons from professional conduct work, the Council can make a major contribution to improving standards of patient and client care.

In almost all aspects of the Council's professional conduct work during the year, record levels of activity have been recorded. The fact that the Council has been able to deal with an increasing level of complaints is due to the hard work and expertise of Council members, panellists and staff. During the remainder of the Council's term of office, we will ensure that efforts are redoubled to enable the new Nursing and Midwifery Council to inherit a professional conduct workload in the best possible order.

Alison Norman
UKCC President
Chair of the
Professional Conduct Committee

Mary Hanratty
Vice President
Chair of the
Preliminary Proceedings Committee

November 2001

Trends and issues

New allegations of misconduct

The number of allegations of misconduct against registered nurses, midwives and health visitors continued to rise in 2000-2001. The UKCC received 1240 complaints during the year. This continues a long term rise in complaints over the last five years.

1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
893	1032	1077	1142	1240

Who makes the complaints?

The majority of complaints still come from employers, with those from the public now the second largest category. Police authorities are under an obligation to report to the UKCC any nurse, midwife or health visitor who is convicted of a criminal offence. The 230 convictions reported by the police during 2000-2001 range from minor charges such as motoring offences, which may not lead to further action by the UKCC, to serious offences including the assault of patients and offences taking place outside the workplace, including rape and murder. During 2000-2001, the categories of complainant were as follows, with the equivalent figures for 1999-2000 shown for comparison.

	1999-2000	2000-2001
Employers	539 (47%)	592 (48%)
Public	249 (22%)	276 (22%)
Police	250 (22%)	230 (18.5%)
Miscellaneous	104 (9%)	142 (11.5%)
Total	1142	1240

Where do the complaints come from?

Whilst complaints derive from all four countries of the United Kingdom, the majority come from England. The percentage of practitioners resident in each country during the year is indicated in parentheses in the third column.

England	1015	82% (76%)
Wales	81	6.5% (5%)
Scotland	81	6.5% (10%)
Northern Ireland	49	4% (3%)
Outside the United Kingdom	14	1% (4%)
Total	1240	

What happens to new complaints?

When a complaint is received, it is considered by the UKCC's Preliminary Proceedings Committee [PPC]. The PPC has to decide 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 UKCC's 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.

However, if the allegations are serious and the PPC believes they could lead to removal from the register, solicitors appointed by the UKCC will investigate and report on the strength of the evidence available to support the charges. The UKCC works to the criminal standard of proof and its committees must therefore be certain beyond reasonable doubt that the alleged incident(s) happened. This is a higher standard of proof than is required in, for example, employers' disciplinary hearings.

During 2000-2001, the PPC considered 1627 cases and made the following decisions. The comparative figures for 1999-2000 are shown in the second column.

	1999-2000	2000-2001
Case closed	642	869
Further investigation required	295	399
Referred to professional screeners (see page 8)	82	105
Cautioned	30	33
Referred to the Professional Conduct Committee	164	221
Total	1213	1627

The above figures include some cases that will have been considered twice. It is worth noting the 34% increase in the number of cases considered by the PPC. This reflects the Council's success in increasing the number of PPC meetings in order to manage the growing number of complaints and its determination to reduce the length of time between a complaint being received and referral to the PPC.

Cautions

A caution may be issued by the Preliminary Proceedings Committee if three criteria are satisfied:

- the offences must be serious enough to lead to removal from the register
- the practitioner must admit the facts of the charges and admits that those facts constitute misconduct
- the practitioner must provide mitigation which persuades the committee that she or he is not a risk to the public and that therefore 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 UKCC's confirmation service during that period is informed of the caution. If the practitioner is referred again to the Preliminary Proceedings Committee 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. The press are usually present, as are those who wish to attend as observers. This is a reflection of the Council's commitment to the transparency and accountability of its professional conduct work. Some respondents, and some employers of respondents, occasionally protest about this. However, the only reason whereby the PCC may agree to hold all or part of the hearing in private is to protect the identity of the 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 2000-2001, the committee met at the UKCC's offices and at other locations in London, in Nottingham, Sheffield, Bradford, Leeds, Preston and Liverpool. It also met in Belfast, Edinburgh and Cardiff. The committee meets most frequently in England, simply because that is where most of the cases originate. During the year, the PCC sat on 201 days and considered 187 cases of alleged misconduct and 11 applications for restoration to the register. Again, this represents a significant overall increase in the committee's workload during the year. The PCC sat on 172 days during 1999-2000 and considered 135 cases of alleged misconduct and 20 applications for restoration.

Categories of misconduct

The largest category of offence during 2000-2001 was the physical or verbal abuse of patients. This accounted for 28.5% of all charges considered by the PCC. The next largest category was failing to keep accurate records or report incidents and this accounted for 8.7% of the charges. Physical or verbal abuse of patients has consistently been the largest category

of offence considered by the UKCC, accounting for 31% of charges the previous year and 30% during 1998-1999. Poor record keeping had, at 6%, been the third largest category during 1999-2000.

The committee heard 10 cases arising from criminal convictions. A registrant may be called to account by the UKCC for convictions related to offences outside work, where such offences might undermine public trust and confidence in the professions. Failing to declare a criminal conviction when seeking employment is regarded by the UKCC as a serious offence and can lead to removal from the register.

Professional Conduct Committee decisions

Judgement	1999-2000	2000-2001
Removed from the register	96	104
Cautioned	27	39
Misconduct proven but no further action	2	1
Facts or misconduct not proven	8	9

Applications for restoration to the register

During 2000-2001, the committee considered 11 applications for restoration to the register and accepted three. This compares with nine successful applications from a total of 20 the previous year.

Anyone who has been removed from the register can apply to have her or his name restored to the register. In practice, the UKCC recommends that no application should be made within twelve months of removal. It also discourages applications from those who have clearly made little or no effort to address the issues that led to their removal in the first place. Finally, the UKCC has a policy that no practitioner who has been removed from the register after having committed a serious criminal offence should be re-admitted to the register if this is likely to undermine public trust and confidence in the professions.

All applications for restoration are considered by the Professional Conduct Committee. The applicant must attend so that she or he can be questioned by the committee. Restoration cases are heard on a designated day and the committee is always chaired by the President of the Council. 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, she or he is 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 were 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 procedures. The main reasons for referral to the Health Committee were as follows.

	1999-2000	2000-2001
Alcohol dependence	56	58
Mental illness	56	75
Drug dependence	27	26
Physical illness	7	5
Total	146	164

A person may be referred to the Health Committee in one of two ways. It may be by a direct referral, for example by an employer. There were 70 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. A total of 105 such referrals were made by the PPC to the professional screeners during the year.

If the screeners feel there may be a current health problem, the practitioner is invited to be examined by two of the UKCC's medical examiners. The medical evidence enables the screeners to decide whether to refer a practitioner to the Health Committee. During the year, the screeners met on 29 occasions and considered 375 cases. Eleven cases were closed and 122 were referred to the Health Committee. The remaining cases are still in progress.

Health Committee

The Health Committee meets in private because of the confidential nature of the medical evidence involved. During 2000-2001, the committee met on 32 days and considered 156 cases. Again, this represents an increased workload from the previous year, during which it met on 25 days and considered 119 cases. The Health Committee 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 but this power is much more commonly used by the Health Committee. A practitioner may, for example, have a history of drug addiction problems. She or he 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 of the UKCC's medical examiners would also be required.

Health Committee decisions

	1999-2000	2000-2001
Fitness not impaired – case closed	31	47
Fitness impaired – suspended	51	55
Fitness impaired – removed	7	0
Judgement postponed	28	30
Adjourned for further medical reports	2	13

In addition, one case was referred back to the PPC. The Health Committee also considered ten applications to terminate suspension, of which eight were accepted.

Interim suspension

The UKCC has the power to order the suspension of registration whilst an investigation is under way. The committee uses this power if it appears that there is a serious risk to the public in allowing the individual to practise pending the outcome of the UKCC's investigation. A practitioner under police investigation for a serious criminal offence against patients would almost certainly be subject to interim suspension. Alternatively, it may be imposed if is considered to be in the practitioner's own interest. This includes, for example, practitioners who 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 October 2000, a nurse appealed against a decision of the Professional Conduct Committee to remove her name from the register. The PCC hearing had taken place in her absence, even though she had asked for the hearing to be postponed. She had written to the UKCC, stating that she wanted to attend and present her case but was unable to do so due to ill health. A letter from her GP confirmed her inability to attend the hearing at that time. The court ruled that the PCC had been wrong to proceed with the hearing in these circumstances. It ordered that the nurse's name should be put back on the register and the case re-heard.

In December 2000, a nurse applied to the Court of Session for judicial review of a decision of the Preliminary Proceedings Committee to refer her case for a hearing before the PCC. The nurse argued that the decision was unlawful because the PCC did not meet the Human Rights Act requirement to be an independent and impartial tribunal. She argued that, because

members of the PCC also served as members of the PPC (although not in relation to the same cases), the PCC could not be an independent and impartial tribunal. Although there would be a right of appeal to the court if the PCC removed her name from the register, she asserted that this right was irrelevant in deciding whether there had been a breach of the Human Rights Act.

The Court of Session gave judgement in January 2001. It ruled that, because there is the right of appeal, the PCC was not in breach of the Human Rights Act. The judge observed that, although it is permitted in the legislation governing the committees, the practice of members serving on both the PPC and the PCC could give cause for concern about their independence and impartiality. As a result of this, the Council immediately changed its practices to separate membership of the two committees.

Case studies

The cases considered by the PPC and the PCC provide a rich source of information that can be used by the Council to provide professional advice to registered nurses, midwives and health visitors. In this way, negative issues can produce positive outcomes in helping to improve standards of professional practice and conduct.

An example of this is the Council's guidance on the prevention of abuse. The number of cases involving the physical and / or verbal abuse of patients has remained consistently high over the last few years. During 2000-2001, these cases represented 41% of all charges. Following the publication of a new UKCC guidance booklet entitled *Practitioner-client relationships and the prevention of abuse* in September 1999, work continued throughout 2000-2001 in producing and then distributing a teaching pack to explore these issues in greater depth.

This year's report features a selection of cases involving poor practice, abusive behaviour and lack of competence. They all highlight the need to maintain professional knowledge and competence through continuing professional development. In one case, a practitioner received a caution as the committee was reassured by the evidence presented of her efforts to maintain professional knowledge and competence. However, whilst considering an application for restoration to the register, the committee was not convinced that the individual had made adequate preparation for his return to practice.

Failure to keep accurate records or to report incidents was the second largest category of charges during the year. The third case involves a number of charges involving poor record keeping and sleeping on duty, the latter also featuring in 13 cases considered during 2000-2001.

The final case concerns a registered nurse who was training to become a midwife. Her attitude and behaviour gave cause for concern and she assumed responsibilities for which she was not competent.

Case study 1: Verbal abuse and inappropriate restraint of patients

The Professional Conduct Committee considered the case of a registered mental nurse who worked full-time on nights at a nursing home for the elderly mentally ill. She had been employed permanently on nights since 1998 and had previously worked at the home as a bank nurse.

Background

The nurse faced allegations of inappropriately using an elevating bed table as a form of restraint, giving unprescribed enemas, shouting at patients and restricting patients' choice by insisting they went back to bed when they got up in the night, and by instructing staff not to get patients up before the day staff started work at 7.30am.

The nurse was present and represented by a barrister. She was also accompanied by her husband and a representative of the Nurses' Welfare Service. She admitted the facts of each charge but denied that her action in sending patients back to bed and not getting them up before 7.30am had restricted their choice.

The committee first heard evidence from the home manager, who was a registered mental health nurse. He described how the patients were severely mentally ill, many with profound dementia and many unable to move independently. Some were also hard of hearing. They were highly dependent and required intensive nursing care. The manager said that there were no specific times at which patients should go to bed or get up. Some of the residents would wander during the night. Under cross-examination, he said that there would be instances whereby patients with severe dementia and mobility problems might have their freedom of choice restricted for their own safety. If patients were getting up every hour throughout the night, it would be appropriate for nursing staff to encourage them to go back to bed, he claimed. The manager also stated that it was in the best interests of patients to refrain from getting up until after 7.30am when there would be more staff to help them.

The committee then heard evidence from a care assistant at the nursing home. She had worked one night each week with the nurse over a period of two years. She said that the nurse shouted at patients in an unpleasant manner, particularly those who were walking up and down late at night. Other nurses would give patients drinks to settle them down; if they would not go back to bed, the nurses would dress them. When asked whether any of the patients were hard of hearing, the care assistant said that two were deaf. Under cross-examination, she accepted that the nurse had a loud voice but still maintained that she was shouting at the patients.

The care assistant also said that the day staff would complain to the night staff because they had not got enough patients up before they came on duty. She confirmed that the nurse discouraged them from getting the patients up just for the convenience of the day staff. The care assistant was adamant that the nurse's shouting was intimidating. She also said that when the nurse shouted at the patients, she was usually sitting in the lounge watching television.

The committee then heard evidence from another night care assistant who had worked about half a dozen times with the nurse. She confirmed that the nurse would shout at patients and force them to go back to bed. She said the shouting was excessively loud and that the tone

was angry and without compassion. The care assistant said that other nurses she had worked with would talk to patients and persuade them to go back to bed. If they did not want to do so, they would be allowed to sit in the lounge.

The nurse's account

The nurse was present and represented at the hearing. She admitted the facts of each charge but did not accept she had restricted the patients' choice by putting them back to bed and by not allowing them to get up before 7.30am.

She said that most of the patients suffered from dementia and that one had a learning disability and had been in care since he was very young. As he was being prescribed a significant amount of medication, the nurse had concerns for his safety and felt that he needed to be observed very closely in case he fell. In addition, she described one female patient as being very aggressive and who pinched, spat at, kicked and bit people. The home policy was that two members of staff should attend to her. The nurse confirmed that all the patients needed a considerable amount of nursing care.

She disputed that she shouted at the patients and claimed that she spoke in a firm but reasonable manner. She denied shouting at patients in order to force them to go back to bed and denied ever displaying anger towards them.

The committee heard that, between 1998 and 1999, the nurse had experienced difficulties in her personal life. Her youngest son had been diagnosed with attention deficit disorder and hyperactivity and her niece had died from leukaemia. The nurse said that she tended to speak in a jovial manner to those with dementia, as they responded better to someone who was pleasant and caring towards them. She said she had a naturally loud voice and would raise it when speaking to patients who were hard of hearing or to prevent an untoward incident. The nurse said that one of the male patients who tended to wander at night suffered from dementia and was very unsteady on his feet. In his own interests, she would try to make him go back to bed as quickly as possible after he had taken his night sedation. The nurse had raised concerns about staffing levels in the home but was told by the health authority that the levels were acceptable.

Decision on facts

The committee withdrew in private to consider the case. It then announced that the facts were proven.

Misconduct

The nurse admitted misconduct in relation to all the allegations except that concerning sending patients back to bed and not allowing them to get up until 7.30am.

She then gave further evidence. The nurse stated that she had insisted patients should go back to bed and that staff should not get them up before the day shift started for safety reasons. She felt that, because staffing levels were low, it was unsafe for patients to get up and be wandering around the unit, disturbing others. She said that two or three staff would be on duty at night but that six more staff would be on duty during the day shift. The nurse's representative said that patients were washed and changed at 6.00am and were then put back to bed for their own safety; there was no question of the nurse simply being lazy.

Decision on misconduct

The committee found misconduct proven in relation to using an elevating bed table as a form of restraint, giving an unprescribed enema and shouting at patients. However, it accepted the nurse's explanation that she was attempting to act in the best interests of the patients when she sent them back to bed during the night and did not get them up before the day staff were on duty.

History and mitigation

There was no relevant history. The nurse had incurred no previous disciplinary action and no significant ill health. Her previous employer confirmed that the nurse had discussed staffing levels and staffing issues with him.

Mitigation

In relation to the allegation of restraining a patient with an elevating bed table, the nurse said she had not viewed it as restraint at the time. She said the bed table had made patients feel more secure when it was over the bed. It could, she claimed, have been moved out of the way at any time because it was on wheels. However, she now accepted that restraint should only be used for the safety of a patient and that the use of any form of restraint should be discussed within the multi-disciplinary team and with the family. It should also be recorded in the patient's care plan.

In respect of giving an unprescribed enema, the nurse said that it had been the policy when she had worked in a hospital to train staff to assess the patient for the use of enemas, which were kept as stock items. She had not realised that there was a different policy in the private sector. With the incident in question, she had given the enema to a lady who was unable to sleep because of severe impaction. It had been around 4.00am and the nurse administered a phosphate enema, following which the patient had been able to sleep. She had documented the administration and informed the day staff. The nurse admitted that she raised her voice with patients but did not feel that she did so aggressively. In future, she vowed to lower her tone and her voice.

She had found it upsetting to be the subject of UKCC misconduct proceedings but had the support of her husband and her current employer, who was fully aware of the UKCC's investigation and hearing. The nurse had undertaken courses on manual handling, drug administration, wound healing and resuscitation. Her employer was intending to send her on an assessor's course. She was enjoying her current role as a sister in charge of a 15 bedded unit for the elderly mentally infirm. Her current employer gave evidence that she was a caring professional whose standard of work was high; she felt that the nurse was a safe practitioner.

Evidence was then heard from one of the directors of the nursing home where the nurse was employed. She said she knew about the UKCC hearing and had contacted the health authority to discuss it. It had been agreed that a series of study days would be set up to facilitate the continuing professional development of nursing staff. The nurse would not be left alone in charge of the unit. The director had worked alongside the nurse in a clinical environment and also felt that the nurse was a safe practitioner.

Decision

The committee decided that it would not remove the nurse's name from the register but would issue a caution as to her future conduct. The caution would be kept on her record for five years and disclosed to anyone enquiring about her registration. This is standard UKCC policy.

The chairman said that it was a serious matter to be found guilty of misconduct and that the nurse's actions were neither excused nor condoned. The committee had listened to the evidence and, together with the references and a report from the Nurses' Welfare Service, it had been persuaded that the nurse had learned from the events and did not present a risk to the public.

Case study 2: Application for restoration to the register

The Professional Conduct Committee considered an application for restoration to the register from a nurse who had been removed in May 1998 on three charges of misconduct related to the verbal abuse and inappropriate restraint of patients.

Circumstances of removal

The nurse had been working as the manager of two homes forming part of an acute assessment unit for patients with learning disabilities and challenging behaviour. The allegations related to incidents occurring between 1994 and 1996. Evidence had been given about the restraint of an elderly male patient with a mild learning disability and chronic depressive illness who had been admitted for assessment following a deterioration in his condition. On one occasion, he became upset when the nurse told him off for coming back late from a trip out of the unit. The nurse had then held him in an arm lock. On another occasion, the nurse had been found by a care assistant with his foot on the chest of a young patient with severe epilepsy and severe challenging behaviour. When asked what he was doing, the nurse had sworn and said that the patient had threatened to put his head through the window. Evidence had also been given in relation to a third charge that he frequently used highly abusive language to patients. The nurse had denied the charges.

Current employment

The committee heard that the nurse had returned to work as a care manager in the private sector after being removed from the register. He had been managing a unit for adults with learning disabilities. Two months later, the local social services department discovered that the nurse had been removed from the register and withdrew his registration as a home manager. Since then, he had not worked in clinical practice, instead doing casual work for an insurance company for a few months. The nurse later worked in an administrative capacity for an agency supplying specialist learning disabilities and psychiatric nurses.

Factors supporting the application

The nurse informed the committee that he had thought very carefully about what had happened. He now accepted that his actions were inappropriate and that removal from the register was justified. Although he had not worked in a clinical capacity with people with

learning disabilities, he said that his partner, a registered mental health nurse, had discussed with him new initiatives in professional practice. The nurse also claimed to have been reading relevant professional journals in order to keep himself up to date. With his employer, he had been involved in devising guidelines for managing violence and aggression.

The nurse said that he had discussed with his employer the incidents that had led to his removal from the register and that he had been seeing a counsellor because of two family bereavements. He accepted that he needed to listen more to patients and colleagues and to learn to work more effectively as part of a team. In his previous employment, he had not received sufficient training in the use of control and restraint and felt he should be more proactive about his own continuing professional development.

The committee asked him whether he was familiar with the UKCC's publications, *Guidelines for mental health and learning disabilities nursing* and *Practitioner-client relationships and the prevention of abuse*. The nurse stated that he was not. He said he now recognised that it was completely inappropriate to swear at patients and acknowledged that his professional standards had fallen to an unacceptable level. He said he was truly sorry for his behaviour during that time and would like to have another chance to work as a nurse.

In response to a question from the committee about how he would prepare himself to return to the register, he said that he would take a planned and gradual approach. He would receive supervision from his colleagues at the agency and would plan his own professional development. When asked whether he had undertaken any voluntary work with people with learning disabilities, he replied that he had not. Evidence was then heard from a family friend who was a registered general nurse and a registered mental health nurse. He expressed the view that the nurse had learned from what had happened and should be restored to the register.

Decision

The committee withdrew to consider the case in private. It then announced in open session that it had rejected his application for restoration to the register. Whilst the committee accepted there had been a change in the nurse's attitude and personal behaviour, there was no evidence of any improvement that could be relevant to working with people with learning disabilities. The committee was also not convinced that the nurse had made adequate preparation for his return to the profession.

Case study 3: Sleeping on duty and neglect of patients

The Professional Conduct Committee considered the case of a registered general nurse who had been employed on night duty at a nursing home between January and June 1998. He faced allegations concerning failure to examine a patient who had fallen, failure to document the accident, sleeping on duty and failing to take appropriate action when temazepam was administered to the wrong patient.

The respondent was present at the hearing but was not represented. He admitted sleeping on duty and failing to take appropriate action after the drug error. He denied failing to examine the patient who had fallen. The committee found the admitted facts to be proven and then heard evidence relating to the remaining allegations.

Facts

The first witness was the matron of the nursing home. She had interviewed the nurse for the post and organised two induction sessions for him. There were 46 patients in the nursing home, all of whom were high dependency. Some had suffered strokes whilst others suffered from Parkinson's disease and Alzheimer's disease. The matron said that recruiting the right numbers and skill mix of staff was difficult.

She stated that she had told the nurse quite clearly that sleeping on duty was not permitted. She had spoken to him twice about doing so following written complaints from other staff. The matter was dealt with, along with other allegations, at an internal disciplinary hearing. The issue of the patient who had fallen was raised at this hearing. The matron had been informed that a care assistant had pressed the emergency buzzer when the patient fell but the nurse, who was asleep on the settee, did not come immediately. When he did arrive, he did not examine the patient and simply put her back to bed. The matron also gave evidence that she had been informed that a patient had been given 20 milligrams of temazepam in error. The nurse did not record the error and informed neither the doctor nor the matron. When asked about the incident, the nurse admitted it and apologised but gave no explanation for his actions.

The committee then heard from the deputy matron who had worked on night duty with the nurse during his induction. She gave evidence that staff were not entitled to sleep during their break period. She also explained the protocol for handling drug errors. This involved informing the nurse in charge and the GP, informing the matron as soon as possible, keeping the patient under observation, documenting the incident and, if necessary, informing the next of kin. The deputy matron said that, at the disciplinary hearing, the nurse admitted sleeping on duty but not after 5.00am. He also admitted to having given the wrong drug and to not having followed the protocol.

Evidence was then taken from a care assistant who had worked frequently with the nurse. She said that he would occasionally sleep for up to 1½ hours and occasionally longer. He would sleep on the settee in the lounge with a pillow and blanket. On one occasion, she said, he was still asleep at the time of the 5.00am patients' rounds. Whilst he slept, other staff would answer call bells and do the laundry.

The care assistant spoke about the patient's fall. She had been checking the patients and heard one woman screaming and crying. When the care assistant went to her, she found her on the floor and rang the emergency buzzer. The nurse then arrived, picked up the patient, sat her on the edge of the bed and then left the room. The two care assistants changed the bed and settled the patient. This took about 30 minutes. She said that the nurse did not examine the patient. When the care assistant went back downstairs, the nurse was asleep on the settee.

The care assistant was shown an entry in the nursing notes, by which the nurse had written that the patient had been found on the floor by the care assistant, and that he had examined her, found no injury and put her back to bed. The care assistant said that no examination had been carried out in her presence.

The nurse's account

The nurse was conducting his own defence and said he did not dispute that the drug error had been made. However, he claimed that he subsequently checked on the patient every thirty minutes. He claimed that he had not reported the error because she had come to no

harm. He now realised that this was wrong. The nurse admitted sleeping on duty but claimed that he was not the only member of staff to do so.

He explained that, when he was putting the patient back to bed after her fall, he examined her in a cursory way to make sure that she had not broken any bones. He claimed that he had returned between five and seven minutes later when the care assistant was out of the room. He admitted having given a false account of the incident in the accident book.

Decision on facts

The committee considered the case in private and then announced that it found the facts in the remaining charges to be proven. The nurse did not admit misconduct in relation to those proven facts. The committee found that he was guilty of misconduct.

History

The committee heard from the former matron of the nursing home. She gave evidence that she had only been able to obtain one reference supporting his application for employment. This was a reasonable reference but it had expressed concern at his levels of sickness absence.

Mitigation

When asked if he had anything to say in mitigation, the nurse produced a number of testimonials. The committee considered these and retired to consider its decision in private.

Decision

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

Case study 4: Failure to practise within the limits of competence

The Professional Conduct Committee considered the case of a registered general nurse who was studying to qualify as a midwife. She faced allegations concerning failure to work collaboratively with her colleagues and mentors, speaking inappropriately to clients, failing to acknowledge the limitations in her knowledge and competence when advising clients, and causing distress to a mother when explaining the risks of epidural anaesthesia. The nurse was neither present nor represented at the hearing.

Background

The nurse had been suspended by her employer in February 1999 following a disciplinary hearing arising from the allegations. Her mentor and preceptor had expressed concerns about her behaviour and attitude. It was felt that she appeared to believe that, as a registered nurse, she had a much higher knowledge base than those who were trying to mentor and supervise her. She was unwilling to accept constructive criticism or guidance and she often spoke inappropriately to clients.

The committee heard that the nurse had been admitted to the course at short notice because of a cancellation by another student. She had trained as a nurse during the 1970s and then

had a fifteen year break from nursing while she worked as a legal secretary, before completing a return to nursing course.

Facts

The committee heard evidence from several witnesses. The first witness was the nurse's preceptor, who spoke of the difficulties she had encountered working with the nurse. For example, the nurse had insisted, inaccurately, that there was a 49% mortality rate associated with caesarean sections. When challenged, her manner was felt to be aggressive and confrontational. The committee heard that she took a day off without prior notice and that she had failed to follow the agreed protocol for a dural tap. When the preceptor raised her concerns about this with the nurse, she refused to talk to her.

A sister from the delivery suite described how the nurse asked a woman to move during an epidural. The client had been in pain during a contraction and the nurse told her to put her arms around her partner's neck, just at the point at which the anaesthetist was about to insert the needle. The sister also said that the nurse had explained the potential complications of an epidural in an inappropriate way.

On another occasion, when being taught about the physiology of labour, the nurse had said that she did not need to learn this. The sister also expressed concerns about her inappropriate manner with clients and described how she would often preface her actions by saying to women: "It is my legal duty to inform you …".

The committee then heard from the anaesthetist involved in giving the epidural. He confirmed that the client had been frightened when the nurse told her of the risks of becoming paralysed from the procedure. Whilst conducting the epidural, the anaesthetist needed to reposition the catheter, at which the nurse had said: "OK, now I know what a failed epidural looks like".

Evidence was taken from another midwifery sister, who spoke of what she considered to be inappropriate comments made by the nurse. The sister found it difficult to give the nurse any advice or information, as she would simply reply: "I know". The nurse's manner was felt to be confrontational, dismissive and threatening.

Finally, the committee heard evidence from the quality assurance manager who had interviewed the nurse with her personal tutor when a letter of complaint had been received about her.

Decision on facts and misconduct

The nurse had made no admissions of misconduct in her letter to the UKCC. The committee found the facts proven in all the charges and found her guilty of misconduct in all the charges.

Reasons

The committee chair stated that, although the nurse had been a student midwife, her conduct must be judged against the standard required of her as a registered nurse. The committee felt that the nurse had assumed responsibility for matters in which she had neither the knowledge nor the experience to make appropriate clinical judgements.

History

Evidence was then taken from the head of emergency services nursing, who had chaired the hearing at which the nurse was dismissed from her student midwife contract. Amongst the papers that had accompanied the nurse's application to become a student midwife was a reference that mentioned her difficulty in forming good working relationships with her colleagues.

Decision

No mitigation had been put forward by the nurse and the committee decided to remove her name from the register. The chair said that the nurse had demonstrated that she was unsafe to practise by failing to acknowledge limitations in her knowledge and competence, thus endangering the safety of patients and clients. In addition, she had failed to work in a collaborative manner with her colleagues.

Further information

Details of the UKCC's procedures for considering allegations of misconduct or unfitness to practise on health grounds are published in *Complaints about professional conduct. Reporting misconduct – a guide for employers and managers* and *Reporting unfitness to practise – a guide for employers and managers* specify the types of information that the UKCC needs in order to investigate a complaint.

Have you been mistreated by a nurse, midwife or health visitor? is written explicitly for members of the public. It provides a brief guide to other organisations that may be able to help a complainant address the issue in the first instance at a local level. The leaflet explains the types of complaints that the UKCC is able to consider and explains in simple terms the processes for doing so. It includes a detachable form by which a complaint can be submitted to the UKCC. Separate versions of the leaflet are available for England, Northern Ireland, Scotland and Wales, the latter being available in the English and Welsh languages.

Issues arising from professional conduct complaints, although published in 1996, still provides a useful guide to the trends and issues deriving from the UKCC's work in this area. It contains advice for employers and managers on addressing these issues at a local level in the interests of patients and clients.

Information about how to obtain these and other UKCC publications is set out below.

Selected UKCC publications at November 2001

**Code of professional conduct * ** **	June 1992
**The scope of professional practice * ** **	June 1992
Guidelines for professional practice *	June 1996
Reporting misconduct – information for employers and managers	August 1996
Reporting unfitness to practise – information for employers and managers	August 1996
Issues arising from professional conduct complaints	November 1996
Complaints about professional conduct	March 1998
Midwives rules and code of practice **	December 1998
Protecting the public – an employer's guide to the UKCC registration confirmation service for nurses, midwives and health visitors *	March 1999
Practitioner-client relationships and the prevention of abuse **	September 1999
Guidelines for the administration of medicines **	October 2000
Professional conduct annual report, 1999-2000	October 2000
Have you been mistreated by a nurse, midwife or health visitor? ** *(available in separate editions for England, Northern Ireland, Scotland and Wales)*	October 2000
Professional self-regulation and clinical governance **	June 2001
Professional conduct annual report, 2000-2001	November 2001

* currently under review

** also available in Welsh

All UKCC publications are free of charge and most are available in unlimited quantities. They can be accessed and downloaded through our website at www.ukcc.org.uk. Alternatively, please write to the Distribution Department at 23 Portland Place, London W1B 1PZ, by e-mail at publications@ukcc.org.uk or by fax on 020 7436 2924.

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