# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 27 November 2023 – Friday, 8 December 2023,**
**Tuesday, 12 December 2023,**
**Monday, 18 March 2024 and Tuesday 19 March 2024**

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

| | |
|---|---|
| **Name of Registrant:** | Melfort Makhosonke Khumalo |
| **NMC PIN** | 11E1092E |
| **Part(s) of the register:** | Registered Nurse, Sub Part 1<br>Adult Nurse, Level 1 – May 2011 |
| **Relevant Location:** | Leicester |
| **Type of case:** | Misconduct & Lack of competence |
| **Panel members:** | Mark Gower (Chair, lay member)<br>Allwin Mercer (Registrant member)<br>Hannah Harvey (Registrant member) |
| **Legal Assessor:** | George Alliott (27 November 2023 – 28 November 2023, 12 December 2023 and 18-19 March 2024)<br>Angus Macpherson (29 November 2023 – 7 - 8 December 2023) |
| **Hearings Coordinator:** | Jessie Miller<br>Sophie Cubillo-Barsi (18 and 19 March 2024) |
| **Nursing and Midwifery Council:** | Represented by Aoife Kennedy, Case Presenter |
| **Mr Khumalo:** | Present and represented by Emily Mattin |
| **Facts found proved by admission** | Lack of competence charges 1, 2, 3, 5, 9, 11, 13(a), 13(b)<br>Misconduct charges: 1(b), 1(d) |
| **Facts proved:** | Lack of competence charges: 6, 8, 12, 13(c), 14 |

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| | Misconduct charges: 3(f) |
| **Facts not proved:** | Lack of competence charges: 4, 7(a), 7(b), 10<br>Misconduct charges: 1(a), 1(c), 2, 3(a)(b)(c)(d)(e)(g), 4, 5, 6 |
| **Fitness to practise:** | Lack of competence: Impaired<br>Misconduct: Impaired |
| **Sanction:** | **Conditions of practice order – 12 months** |
| **Interim order:** | **Interim conditions of practice order – 18 months** |

**Details of charge as amended**

*'That you, between 9 April 2018 and 28 February 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 staff nurse in that:*

*Whilst working at Spire Healthcare;*

1. *On 26 May 2018 having checked the wrong patient's drug chart, incorrectly administered Paracetamol and Ibuprofen to a patient.*

2. *On 26 July 2018 failed to administer the following drugs whilst completing the 18.00 drugs round:*

   *(a) Dalteparin.*

   *(b) Metformin.*

   *(c) Zomorph.*

3. *On 22 September 2018;*

   *(a) Failed to administer Dalteparin to a patient.*

   *(b) Administered a non-steroid medication too early to a patient.*

4. *On 19 January 2019;*

   *(a) Failed to check whether Patient F had been administered 50mg of Tramadol at 14.00 hours.*

   *(b) Incorrectly signed Patient F MAR chart indicating that 50mg of Tramadol had been administered to Patient F at 14.00 hours when it had not.*

5. *On 11 May 2019 administered the incorrect eye drops to a patient.*

6. *On 15 May 2019 failed to check and/or ensure that a patient's intravenous cannula had been removed prior to the patient being discharged.*

7. *On 30 May 2019 failed to:*

*(a) Provide a handover of patients to colleagues on one or more occasions, and/or*

*(b) Provide an effective handover to Colleague A by;*

*i. Incorrectly stating that the patient had received all their medication, and/or*

*ii. Incorrectly stating that the patient just required hourly visual checks.*

8. *On 14 June 2019 had to be prompted on one or more occasions to check a patient's blood sugar level before insulin could be administered safely.*

9. *On 14 June 2019 failed to immediately dispose of a controlled medication device containing morphine upon removal from the patient.*

*Whilst working at University Hospital Coventry & Warwickshire*

10. *On 1 June 2019 failed to administer Clexane to Patient E at 18.00.*

*Whilst working at Burton Park Hospital*

11. *On 6 January 2021 incorrectly potted 12.5mg of Diazepam instead of the prescribed amount of 12.5mls.*

12. *On or around 29 January 2021 failed to complete a health clinic in respect of one or more patients.*

*13. On 5 February 2021 failed to;*

*(a) Complete mattress audits.*

*(b) Complete first aid box checks.*

*(c) Review and/or adequately evaluate one or more patients' care plan.*

*14. On 9 February 2021 on one or more occasions failed to complete waterlow assessments for patients.*

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

*That you a registered nurse;*

*1. Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient A's notes in that:*

*(a) On one or more occasions documented, 'has been noted to have fluctuated in mood and manner'.*

*(b) On one or more occasions documented, 'utilised section 17 to the cake sale and came back without any issues'.*

*(c) On one or more occasions documented, 'with episodes of presenting as relaxed and other episodes of pacing up and down'.*

*(d) On one or more occasions documented, 'Tried to contact his family on the phone without any success, received a parcel from the family and this was headphones which was opened in front of him'.*

*2. Between 21 February 2021 and 7 April 2021 provided inaccurate information in Patient B's notes in that:*

*(a) On one or more occasions documented, 'has been pacing a lot today in the corridors'.*

*(b) On one or more occasions documented, 'has also been in the lounge at times chewing his toy and watching the television'.*

*(c) On one or more occasions documented, 'episodes of rolling on the floor in the lounge'.*

*3. Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient C's notes in that:*

*a) On one or more occasions documented, 'at the start of the shift declined personal care and has throughout the day today'.*

*b) On one or more occasions documented, 'has spent most of the morning in the lounge then went to his bed area for the rest of the day'.*

*c) On one or more occasions documented, 'he has been pleasant on interaction'.*

*d) On one or more occasions documented, 'there was minimal interaction with staff but no aggressive behaviour'.*

*e) On one or more occasions documented, 'has had 1600mls of fluid today via his PEG'.*

*f) On one or more occasions documented, 'has had 1725 mls of fluid today via his PEG'.*

*g) On one or more occasions documented, 'has spent most of the day in his bed area'.*

*4. Between 21 March 2021 and 6 April 2021 provided inaccurate information in Patient D's notes in that:*

*a) On one or more occasions documented, 'some episodes of swearing at staff when prompted to engage in interventions'.*

*b) On one or more occasions documented, 'other occasions noted to have been pleasant and was taken out to access hospital grounds in a wheelchair'.*

*c) On one or more occasions documented, 'has also spent some time on the crash mat stating he loves the crush mat and getting up from the wheelchair to lay on the crash mat'.*

*d) On one or more occasions documented, 'has had poor fluid and dietary intake despite several prompts from staff which he has declined and had only accepted forticreme within his medication'.*

*e) On one or more occasions documented, 'has eaten his breakfast and dinner today, and had had yoghurts in between'.*

*5. Your actions in charge 1 and/or 2 and/or 3 and/or 4 were dishonest in that you were attempting to mislead others into believing that you had completed accurate documentation when you knew that you had not.*

*6. On 9 April 2021 incorrectly declared to Colleague B that you had only copied and pasted entries in Patient A's notes.*

*Your declaration in charge 6 was dishonest in that you were attempting to mislead Colleague A and/or others into believing the declaration was true when you knew that it was not.*

*And in light of the above your fitness to practise is impaired by reason of your misconduct.'*

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

The panel heard an application made by Ms Kennedy, on behalf of the Nursing and Midwifery Council (NMC) to amend the wording of charges number 3, 4a, 4b and 10 relating to lack of competence.

The proposed amendments were to amend an incorrect date and change *'a patient' to 'Patient F'* and *'Patient E' as appropriate*. Ms Mattin, on your behalf, supported the proposed amendments as they would provide clarity and more accurately reflect the evidence.

On Day 7 of the hearing, Ms Kennedy on behalf of the NMC made a further application to amend the wording of three paragraphs of the charge insofar as they related to the NMC's case against you in respect of misconduct. The purpose of the proposed amendments, which followed further disclosure of Patient A, B, C and D's notes at your request, was to reflect the extent of the alleged inaccuracy on your part in providing information concerning Patient A, C and D. Ms Mattin opposed the application on the basis that this may have the effect of extending a burden on you to justify the information which you set out in the patients notes, and thereby unfairly reverse the burden of proof.

The charges as proposed following both amendments are as follows:

> *'That you, between 9 April 2018 and 28 February 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 staff nurse in that:*
>
> *Whilst working at Spire Healthcare;*
>
> *15. On 26 May 2018 having checked the wrong patient's drug chart, incorrectly administered Paracetamol and Ibuprofen to a patient.*

*16. On 26 July 2018 failed to administer the following drugs whilst completing the 18.00 drugs round:*

*(d) Dalteparin.*

*(e) Metformin.*

*(f) Zomorph.*

*17. On ~~23~~* ***22*** *September 2018;*

*(c) Failed to administer Dalteparin to a patient.*

*(d) Administered a non-steroid medication too early to a patient.*

*18. On 19 January 2019;*

*(c) Failed to check whether* ***Patient F*** *~~the patient~~ had been administered 50mg of Tramadol at 14.00 hours.*

*(d) Incorrectly signed* ***Patient F*** *~~the patient's~~ MAR chart indicating that 50mg of Tramadol had been administered to* ***Patient F*** *~~the patient~~ at 14.00 hours when it had not.*

*19. On 11 May 2019 administered the incorrect eye drops to a patient.*

*20. On 15 May 2019 failed to check and/or ensure that a patient's intravenous cannula had been removed prior to the patient being discharged.*

*21. On 30 May 2019 failed to:*

*(c) Provide a handover of patients to colleagues on one or more occasions, and/or*

*(d) Provide an effective handover to Colleague A by;*

*iii. Incorrectly stating that the patient had received all their medication, and/or*

*iv. Incorrectly stating that the patient just required hourly visual checks.*

22. *On 14 June 2019 had to be prompted on one or more occasions to check a patient's blood sugar level before insulin could be administered safely.*

23. *On 14 June 2019 failed to immediately dispose of a controlled medication device containing morphine upon removal from the patient.*

*Whilst working at University Hospital Coventry & Warwickshire*

24. *On 1 June 2019 failed to administer Clexane to* ***Patient E*** *~~a patient~~ at 18.00.*

*Whilst working at Burton Park Hospital*

25. *On 6 January 2021 incorrectly potted 12.5mg of Diazepam instead of the prescribed amount of 12.5mls.*

26. *On or around 29 January 2021 failed to complete a health clinic in respect of one or more patients.*

27. *On 5 February 2021 failed to;*

*(d) Complete mattress audits.*

*(e) Complete first aid box checks.*

*(f) Review and/or adequately evaluate one or more patients' care plan.*

28. *On 9 February 2021 on one or more occasions failed to complete waterlow assessments for patients.*

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

*That you a registered nurse;*

7. *Between **22 February 2021** and 7 April 2021 provided inaccurate information in Patient A's notes in that:*

(e) *On one or more occasions documented, 'has been noted to have fluctuated in mood and manner'.*

(f) *On one or more occasions documented, 'utilised section 17 to the cake sale and came back without any issues'.*

(g) *On one or more occasions documented, 'with episodes of presenting as relaxed and other episodes of pacing up and down'.*

***(h) On one or more occasions documented, 'Tried to contact his family on the phone without any success, received a parcel from the family and this was headphones which was opened in front of him'.***

8. *Between 21 February 2021 and 7 April 2021 provided inaccurate information in Patient B's notes in that:*

(d) *On one or more occasions documented, 'has been pacing a lot today in the corridors'.*

(e) *On one or more occasions documented, 'has also been in the lounge at times chewing his toy and watching the television'.*

(f) *On one or more occasions documented, 'episodes of rolling on the floor in the lounge'.*

9. *Between **22** February 2021 and 7 April 2021 provided inaccurate information in Patient C's notes in that:*

h) *On one or more occasions documented, 'at the start of the shift declined personal care and has throughout the day today'.*

i) *On one or more occasions documented, 'has spent most of the morning in the lounge then went to his bed area for the rest of the day'.*

*j) On one or more occasions documented, 'he has been pleasant on interaction'.*

*k) On one or more occasions documented, 'there was minimal interaction with staff but no aggressive behaviour'.*

***l) On one or more occasions documented, 'has had 1600mls of fluid today via his PEG'.***

***m) On one or more occasions documented, 'has had 1725 mls of fluid today via his PEG'.***

***n) On one or more occasions documented, 'has spent most of the day in his bed area'.***

*10. Between 21 March 2021 and 6 April 2021 provided inaccurate information in Patient D's notes in that:*

*f) On one or more occasions documented, 'some episodes of swearing at staff when prompted to engage in interventions'.*

*g) On one or more occasions documented, 'other occasions noted to have been pleasant and was taken out to access hospital grounds in a wheelchair'.*

*h) On one or more occasions documented, 'has also spent some time on the crash mat stating he loves the crush mat and getting up from the wheelchair to lay on the crash mat'.*

*i) On one or more occasions documented, 'has had poor fluid and dietary intake despite several prompts from staff which he has declined and had only accepted forticreme within his medication'.*

***j) On one or more occasions documented, 'has eaten his breakfast and dinner today, and had had yoghurts in between'.***

*11. Your actions in charge 1 and/or 2 and/or 3 and/or 4 were dishonest in that you were attempting to mislead others into believing that you had completed accurate documentation when you knew that you had not.*

12. *On 9 April 2021 incorrectly declared to Colleague B that you had only copied and pasted entries in Patient A's notes.*

*Your declaration in charge 6 was dishonest in that you were attempting to mislead Colleague A and/or others into believing the declaration was true when you knew that it was not.*

*And in light of the above your fitness to practise is impaired by reason of your misconduct.'*

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

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

In respect of the second application for amendment, the panel noted that Ms Mattin's position in effect applied to the unamended misconduct charges in respect of Patients A, B, C and D and that no argument had been advanced to date that it would be unfair to you for the panel to hear those charges. The panel took into account the case of PSA and NMC and Joze 2015, EWHC 764 *admin* and determined to allow the application on the basis that it ought not to allow any undercharging of the case against you and because your position was not compromised further if it allowed the application. In those circumstances it was satisfied that no unfairness would be caused to you, and that it was in the interests of justice to allow the amendment.

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

At the outset of the hearing, Ms Kennedy made a request that parts of this case be held in private on the basis that proper exploration of your case involves reference to personal details identifying details of witnesses. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Mattin indicated that she supported the application.

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

The panel determined to hold parts of the hearing in private and go into private session when reference to personal and identifying details of witnesses is made to protect their privacy.

**Decision and reasons on further disclosure**

**Section 17 documents**

The panel noted that several of the reports completed by you made reference to Section 17 *Mental Health Act* 1983. It understood that there may be documentation in support of the Section 17 orders and indicated that it would be interested in having sight of these. Ms Kennedy submitted that the NMC did not require further evidence relating to these documents to make their case; however she understood the panel's position in wanting sight of them and undertook to make the appropriate requests to obtain these documents.

Ms Mattin indicated that she was in agreement with Ms Kennedy.

Nevertheless, the panel determined to seek disclosure of this documentation in the interests of fairness to you.

**Further clinical notes**

Ms Mattin indicated that in respect of the charges relating to misconduct, the documents disclosed did not appear to be complete as you will have worked further shifts than those in respect of which there has been disclosure and that, in consequence, patient notes which you will have completed are not before the panel.

Ms Mattin submitted that these are serious charges relating to dishonesty and inaccurate record entries; the panel is being asked to draw an inference that your notes were inaccurate, when that proposition cannot be tested against other entries which you made in respect of the patients on other days. She submitted that the NMC’s selection of entries may suggest that they are similar, however the panel should have sight of the full clinical notes of each patient to confirm whether your notes simply reflect what happened with the relevant patient on a daily basis.

Ms Mattin submitted that the NMC have not submitted a full picture of the facts and by not exploring the further documentation, the burden of proof is placed on you to disprove this allegation, rather than the NMC to prove it.

Ms Kennedy submitted that a request has been made to the case officer within the NMC to obtain these missing documents. She went on to state that if this was an issue, particularly one that speaks to the heart of any of the charges, this should have been raised at an earlier time. Ms Kennedy further submitted that out of fairness to you, an adequate time should be allowed to the NMC to produce these documents, however she noted that this evidence is unlikely to make a difference to the outcome, particularly given that this issue was not raised until the hearing was underway.

The panel took into account the legal advice and submissions before it and in the interests of fairness to you, requested that these documents be obtained.

**Background**

On 1 August 2019, the NMC received a referral from Spire Hospital, Leicester (the Ward) where you were employed as a registered nurse, relating to concerns around your fitness to practice.

During your employment with them, it is alleged that:

- You made numerous medication errors
- There were concerns raised around effective communication
- There were concerns raised regarding appropriate patient escalation
- You failed to remove a cannula before discharging a patient
- There were concerns raised around your time management and prioritisation

You were subsequently placed on an improvement plan; however you were dismissed from post on 31 July 2019 following further concerns of a similar nature.

You had also been working as an agency nurse with VIP Nursing (the Agency). Concerns regarding medication errors and patient escalation were also raised to the Agency. You were subsequently suspended from working with them in September 2019 due to these allegations and the interim conditions of practice order imposed on your practice.

In May 2020, you began working as a healthcare assistant for Priory Group as you were, at that time, suspended from practising as a nurse. In October 2020, after the suspension was replaced with a conditions of practice order, you were successful in gaining employment with them as a nurse. A further set of concerns regarding medication errors were raised, as well as allegations that you had copied and pasted patient notes.

You have not worked as a nurse since May 2021.

**Admissions**

At the outset of the hearing, the panel heard from Ms Mattin who informed the panel that you made full admissions to several charges brought against you.

The panel therefore finds the below charges proved by way of your admissions:

Lack of competence: Charges 1, 2a, 2b, 2c, 3a, 3b, 5, 9, 11, 13a, 13b
Misconduct: Charge 1b

Following the amendments in respect of paragraphs 1, 3 and 4 of the Misconduct charges, you maintained your admission in respect of charge 1(b) and admitted charge 1(d).

**Evidence**

Ms Kennedy highlighted that there have been some issues concerning the attendance of Witness 6. Witness 6 had stated that due to personal circumstances, they do not feel they will be able to provide much information of value and do not wish to attend to provide evidence. Ms Kennedy submitted that as a registered nurse, it is their professional obligation to make themself available to regulatory hearings as set out in the Code. Ms Kennedy therefore made a request that the panel make a direction for Witness 6 to attend to provide oral evidence.

Ms Mattin supported the submission and stated that it is right and fair that Witness 6 attend and submitted that all attempts should be made to secure the attendance of Witness 6.

The panel directed that Witness 6 do attend the hearing, albeit remotely and took steps to

ensure that all measures were taken to make her attendance as easy as possible. Witness 6 attended to provide oral evidence.

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

- Witness 1: Staff nurse who worked for the Ward as Deputy Ward Manager.
- Witness 2: Registered nurse who worked at University Hospital Coventry and Warwickshire Trust in a managerial position.
- Witness 3: Registered nurse who worked at the Ward in a managerial position. Was a direct manager and supervised your performance during your time working there.
- Witness 4: Registered nurse who supervised you after your commencement at Burton Park at the beginning of your employment there as a nurse.
- Witness 5: Registered nurse who worked for the Ward. Worked in managerial position. Chaired your internal Disciplinary Hearing.

- Witness 6: Registered nurse who worked with your at the Ward at the time of the allegations.

The panel also heard evidence from you under oath.

In order to allow a period of time to enable the NMC to obtain the further documentation relating to the patients the subject of paragraphs 1 to 4 of the misconduct charges, the panel heard your evidence in two parts. The first related to the lack of competence charges; the second related to the misconduct charges. The latter evidence was heard after such time as that documentation was to hand, and after it had completed its deliberations in relation to the lack of competence charges. It did not announce its findings in relation to the disputed lack of competence charges before you gave evidence in relation to the misconduct charges.

**Decision and reasons on facts**

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered all witness and documentary evidence provided by both the NMC and yourself.

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 Kennedy and by Ms Mattin.

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

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

In relation to lack of competence:

**Charge 4a**

> ***On 19 January 2019;***
>
> ***(a) Failed to check whether Patient F had been administered 50mg of Tramadol at 14.00 hours.***

**The panel finds this charge NOT proved.**

In reaching this decision, the panel noted that, according to the Medication Administration Record (MAR), Patient F was due to receive a 50mg dose of Tramadol at 14.00 hours on 19 January 2019. You had come on duty at 15.30 hours on that day. Notwithstanding that the relevant box on the MAR was initialled, the panel accepted that Tramadol was not administered at 14.00 hours or thereafter until 21.30 hours as the Controlled Drugs book showed that no Tramadol had been withdrawn for Patient F at that time.

The proposition that you failed to check whether Patient F had been administered 50 mg of Tramadol at 14.00 hours depended upon you becoming aware there had been an error of omission whilst you were caring for Patient F, something which depends on the box not being initialled at that time. The reason why you might have become aware of the omission at that time is if the box was not then initialled. The NMC alleges that you inserted your initials into the box at a time when you did not administer Tramadol, thereby confirming that you must have known that the Tramadol was not administered.

The proposition that you had signed the drug chart stemmed from an assertion by Witness 3 that the relevant box was initialled by you as she recognised your initials, and because of an account given by Witness 5 in a BESS Error Reporting Form that you could offer no

explanation as to why you signed the box and why you hadn't given patient (the pain relief). It was not, however, clear that Witness 5 had spoken to you about the incident as you did not countersign the form (in contrast to your practice in respect of some other BESS Error Reporting forms). Further, although there was a Datix report in respect of the incident included in the documents, it was not complete and did not assist as to what had happened so far as you were concerned.

You told the panel in evidence that you did not put the initials in the relevant box on the MAR, and that you had no recollection of being interviewed by Witness 5 in relation to the incident.

The panel was concerned not to assume the role of an expert in expressing an opinion as to whether the initials in the box were in your hand. It took the view that Witness 3 was in no better position to judge whether those initials were in your hand than it was. It reflected that there was no reason why you would seek to enter initials in the relevant box on the MAR following the apparent mistake of the nurse caring for Patient F at 1400. Further it was not satisfied that you had made any admissions in respect of this incident to Witness 5.

It therefore reached the conclusion that it should reject the proposition that the box was empty when you took over the care of Patient F. Accordingly, there was no reason for you to comprehend that Tramadol had not been administered when you took over Patient F's care. Paragraph 4(a) is therefore found not proved.

**Charge 4b**

> ***On 19 January 2019;***
>
> ***(b) Incorrectly signed Patient F's MAR chart indicating that 50mg of Tramadol had been administered to Patient F at 14.00 hours when it had not.***

**The panel finds this charge NOT proved.**

In reaching this decision, the panel relied upon its reasoning in respect of charge 4(a).

**Charge 6**

> ***On 15 May 2019 failed to check and/or ensure that a patient's intravenous cannula had been removed prior to the patient being discharged.***

During oral evidence, Witness 5 confirmed that before discharging a patient, standard practice is to review the cannulation site for any visual signs for infection, as well as referring to patient notes to ensure that all other aspects of patient discharge have been completed. Witness 5 also stated that the family member of this patient called to report that the cannula remained in situ.

During your oral evidence, you accepted that you did not examine the patient for signs of infection, nor check patient notes to ensure that the cannula had been removed. You further stated that you had made an assumption that this had been done, based on the patient having been dressed. When asked if you had checked this, you responded with *'no I did not check'* and accepted responsibility for this error.

**The panel finds this charge proved.**

**Charge 7a**

> ***On 30 May 2019 failed to:***
>
> ***(a) Provide a handover of patients to colleagues on one or more occasions, and/or***

**The panel finds this charge NOT proved.**

The panel noted that paragraph 7(a) alleges that on 30 May 2019, you failed to provide any handover at all of patients on one or more occasions. This is in contrast to paragraph 7(b) which alleges you failed to provide *an effective handover* to Colleague A. There is no particularity as to the patients or colleagues concerned or as to the number of occasions.

This allegation concerns an occasion when Witness 3 sent you home early as the ward was not busy. The oral evidence given by Witness 3 did not support the proposition that you provided no handover at all. In the disciplinary hearing outcome letter to you from Witness 5 dated 1 August 2019, it was asserted:

> *'It is alleged that on 30.5.19 you did not effectively deliver handover to 3 separate colleagues who were taking over from your patients due to you being sent home early as staffing levels were over and above patient ration's. Details included 3 patients receiving late medication as colleagues were unaware that they were due medications and a colleague having no knowledge of important post-operative information.*
>
> *You could not recall how many patients you handed over but you thought it might be 3 and that you handed over to (Witness 3) and they thought you left at 18.00. We investigated this further at the hearing and the timesheet that you competed clearly states 17.30. Witness 3 is clear in the investigation that you handed over 1 patient to her and that there were no instructions that medication needed completing and she also stated that she witnessed you handover to another colleague your other patients.'*

There was no evidence from any other source in relation to this incident. It reached the conclusion that the evidence in support of it was inadequate and confused.

**Charge 7b**

***On 30 May 2019 failed to:***

***(b) Provide an effective handover to Colleague A by;***

***v. Incorrectly stating that the patient had received all their medication, and/or***

***vi. Incorrectly stating that the patient just required hourly visual checks.***

In reaching this decision, the panel took into account the passage from Disciplinary Hearing Outcome letter recited above. It noted the reference to your timesheet being completed on 30 May 2019 at 17.30, although the timesheet itself was not in evidence. In her evidence, Witness 3 gave inconsistent timings for when you handed over the patient to her, namely at 18.00 and 18.30 hours. In your oral evidence, you stated that the handover was at 17.30, although you may have stayed in the ward completing paperwork until 18.00 hours. The panel preferred your evidence to that of Witness 3 in this regard.

The panel noted that the evening medication round for patients on the ward was at 18.00. Whilst there was no direct evidence from Witness 3 that you said the patient in question had received all their medication, the panel did note that in the Disciplinary Hearing Outcome letter, Witness 7 stated that:

> *'Witness 3 received handover for one of the patients being re-allocated and the handover received included the following details that all care had been completed and the patient will just need the standard hourly visual checks and answering the call bell.'*

Whether or not you stated to Witness that the patient had received all their medication when you gave handover of the patient to Witness 3 (as alleged), and the panel recognised that you denied that you did, the panel did not accept that the statement, if

made, would have applied to the medication round at 18.00 which had not yet happened as opposed to the preceding medication round. Witness 3 would or should have understood that, if she took handover of the patient *before* 18.00, the medication round at that time would not have been given. In their oral evidence, Witness 3 agreed that there could have been a communication error during the handover.

The panel recognised that Witness 7 set out in the letter that you had stated that all the patient needed was the standard hourly visual checks. In evidence, you denied that you said that, explaining that there was no such thing as standard hourly checks, as opposed to checks every 15 minutes or every half an hour. The panel accepted your evidence in this regard.

**The panel therefore finds this charge not proved in its entirety.**

**Charge 8**

> ***On 14 June 2019 had to be prompted on one or more occasions to check a patient's blood sugar level before insulin could be administered safely.***

**The panel finds this charge proved.**

This charge related to an occasion when Colleague C had allegedly prompted you to check a patient's blood sugar level on several occasions in order to enable Colleagues C to administer insulin. At the material time, you were not permitted to administer medication; in consequence this had to be done by another member of staff. The medication was due at 8.00 hours, but was not in the end administered until 10.00 hours. Colleague C did not give evidence. The account of the incident came from Witness 6 who was in charge of the ward at the material time. Colleague C made representations to her as to what had happened. Witness 6's account was therefore hearsay which could not be challenged by you.

In the statement provided by Witness 6, it is stated that:

> *'Colleague C* [sic] *had offered to do the morning drug round for the team which included one of Melfort's patients who was diabetic. She has asked Melfort to check the patient's blood sugar before giving diabetic medication. I do not remember the exact conversation, but I do recall that the conversation was escalated to me because there was a repeated issue in Melfort not checking the blood sugar. I remember that Melfort had to be prompted a number of times (more than twice) to check the patient's blood sugar.'*

The panel noted that Witness 6 had made a handwritten record of this matter on the day of the incident at 18.30. The panel considered the evidence in support of this allegation to be contemporaneous hearsay of a compelling nature. The account of the incident was made to the nurse in charge, and it was one of a number of observations made to Witness 6 about your performance on the ward on that day, really in the form of a report. When the panel looked to you for a response, you initially stated that the check wasn't necessary as previous checks had been done at 6.00AM and 6.45AM; however you later expressed the view that, if you had been approached by Colleague C, you were not made properly aware of the facts. You further stated that in any event even if you were approached, there is no reason why Colleague C should not have carried out these checks rather than you; you stated that you must have been doing something else with other patients which caused a delay. You had the responsibility for looking after both Colleagues C's patients as well as your own.

The panel considered that your responses to this allegation were inconsistent. It had no reason to doubt the hearsay evidence as to what had happened in this regard. It noted moreover that Colleagues C's account included that in the end you did check the patient's blood sugar level. As to whether you had a responsibility to comply with Colleagues C's several requests, it found that this was the case. Colleague C was administering

medication on your behalf. She was not engaged to carry out other albeit closely associated tasks. That responsibility remained with you. Moreover she made the requests, it was therefore your duty to assist since she was doing something on your behalf.

**Charge 10**

***Whilst working at University Hospital Coventry & Warwickshire:***

***On 1 June 2019 failed to administer Clexane to Patient E at 18.00.***

**The panel finds this charge NOT proved.**

In the statement of Witness 2, they acknowledged that they were not on shift at the time of the allegation. However, in oral evidence, they stated that the care of Patient E on this shift at 18.00 hours was your responsibility.

When reviewing the MAR concerning this charge, the panel noted that the initials confirming administration of medication against six other medication at 18.00, suggested that a different nurse was responsible for the medications administration of Clexane to Patient E at that time . When presented with this information and questions, Witness 2 accepted that the records indicate that this did not appear to be your signature.

In your evidence, you denied administering medication to Patient E at this time; you did not initial having administered medication to that patient at all, at that time on 1 June 2019. You accepted you had administered medication at 8.00 am but not later.

The panel also had sight of your reflection regarding this charge in which you stated:

*'If that could be the case it would make me feel sorry for the error.'*

The panel noted that this statement was made by you when you had not examined or seen the MAR, and did not know that you were not on duty at the material time. The panel heard no evidence to support that you had failed to administer medication to the Patient E at 18.00 hours on 1 June 2019.

**Charge 12**

> ***Whilst working at Burton Park Hospital:***
>
> ***On or around 29 January 2021 failed to complete a health clinic in respect of one or more patients.***

***Charge* 13c**

> ***On 5 February 2021 failed to;***
>
> ***Review and/or adequately evaluate one or more patients' care plan***

**Charge 14**

> ***On 9 February 2021 on one or more occasions failed to complete waterlow assessments for patients.***

**The panel finds these charges proved.**

The panel considered these three charges together as the evidence in support of them all came from Witness 4; moreover Witness 4 stated in evidence that you had admitted all these matters when they were considered internally. All of the matters were the subject of action plans which had been instituted at Burton Park Hospital. The action plan was either not completed or marked not completed in respect of these matters.

In your evidence, you acknowledged that you did not carry out the tasks allotted to you. You sought to explain this as follows:

- The care plan evaluations were not due on 5 February 2021, but on 7 February 2021;
- Although you did not complete a waterlow assessment, you completed a MUST nutritional assessment;
- Your ability to complete these tasks was compromised by an incident in which you were assaulted and your spectacles were broken so that you could not make appropriate entries on the computer.

The panel determined to reject your explanations. The action plans were clear as to the obligations which you had to complete. The incident in respect of your spectacles could not possibly have provided an explanation for failure to carry out what would be routine nursing procedures for a period as long as between 29 January 2021 to 9 February 2021. In any event, it appeared from the action plans that you were entering information on them via a computer.

The panel therefore finds charges 12, 13(c) and 14 proved.

In relation to misconduct:

**Charge 1a**

> ***Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient A's notes in that:***
>
> ***a) On one or more occasions documented, 'has been noted to have fluctuated in mood and manner'.***

**Charge 1c**

***Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient A's notes in that:***

*c) **On one or more occasions documented, 'with episodes of presenting as relaxed and other episodes of pacing up and down'.***

**Charge 2**

***Between 21 February 2021 and 7 April 2021 provided inaccurate information in Patient B's notes in that:***

***a) On one or more occasions documented, 'has been pacing a lot today in the corridors'.***

***b) On one or more occasions documented, 'has also been in the lounge at times chewing his toy and watching the television'.***

***c) On one or more occasions documented, 'episodes of rolling on the floor in the lounge'.***

**Charge 3a, b, c, d, e, g**

***Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient C's notes in that:***

***a) On one or more occasions documented, 'at the start of the shift declined personal care and has throughout the day today'.***

***b) On one or more occasions documented, 'has spent most of the morning in the lounge then went to his bed area for the rest of the day'.***

***c) On one or more occasions documented, 'he has been pleasant on interaction'.***

***d) On one or more occasions documented, 'there was minimal interaction with staff but no aggressive behaviour'.***

*e) On one or more occasions documented, ‘has had 1600mls of fluid today via his PEG.’*

*g) On one or more occasions documented, ‘has spent most of the day in his bed area.’*

**Charge 4**

***Between 21 March 2021 and 6 April 2021 provided inaccurate information in Patient D’s notes in that:***

***a) On one or more occasions documented, ‘some episodes of swearing at staff when prompted to engage in interventions’.***

***b) On one or more occasions documented, ‘other occasions noted to have been pleasant and was taken out to access hospital grounds in a wheelchair’.***

***c) On one or more occasions documented, ‘has also spent some time on the crash mat stating he loves the crush mat and getting up from the wheelchair to lay on the crash mat’.***

***d) On one or more occasions documented, ‘has had poor fluid and dietary intake despite several prompts from staff which he has declined and had only accepted forticreme within his medication’.***

***e) On one or more occasions documented, ‘has eaten his breakfast and dinner today, and has had yoghurts in between.’***

**The panel finds these charges NOT proved.**

The panel considered these charges on both an individual basis as well as looking at them from a holistic perspective. It noted that there is a difference between ‘similarity’ and ‘inaccuracy’ when determining the facts.

You submitted that your purpose in copying and pasting entries was to introduce a template which you could amend and that you were subject to time constraint when

completing the patient notes. You explained that the patients were all long stay neurological patients who exhibited repeat behaviours, actions and interactions with staff and that these can be seen in not only your entries, but also in the entries of your colleagues. You gave an example of this regarding Patient B: the toy that they ‘chew on’. Several entries which use the same or similar wording can be seen throughout the records disclosed. You also stated that the notes recorded in the entries come from a number of places including direct observations, notes made elsewhere by other staff, fluid chart entries, etc.

In Witness 4’s oral evidence, when asked about the records, they did not state or raise any concerns as to inaccuracy, but rather just noted similarities between entries.

The panel considered that there was no specific evidence to support the charges of ‘inaccuracy’. It was cautious about drawing conclusions that might be considered speculative, and concluded that in the absence of such evidence, it cannot find these charges proved.

**Charge 3f**

> ***Between 22 February 2021 and 7 April 2021 provided inaccurate information in Patient C’s notes in that:***
>
> ***k) On one or more occasions documented, ‘has had 1725mls of fluid today via his PEG.’***

**The panel finds this charge proved.**

The panel closely scrutinised the entries concerning fluid intake amounts. It noted that there were 153 entries within this disclosure. There are only two occasions where entries feature the same number consecutively. The five fluid entries of 1725mls of Patient C between 22 March 2021 to 6 April 2021 recorded in the patient notes by you were

consecutive entries. When questioned about this during your oral evidence, you accepted that this is *‘unusual’* but maintained that these reflected the records of others.
The panel reviewed the fluid intake levels recorded for the other patients identified in the other charges, namely Patients A, B and D on the dates in question. The panel identified that there was a reliance on cut and paste throughout many of your entries, however some, with quite detailed amendments and others completely identical. The panel shared the view that it is improbable for Patient C to have the same fluid intake readings on five consecutive dates and determined that, on balance, it is unlikely that this patient would have had an intake of the same amount, so many times in a row.

The panel noted that reviewing these charges was a difficult task, due to the lack of evidence supplied by the NMC. However, based on the evidence before it, particularly noting the unlikeliness of having the same fluid intake repeatedly, as well as an already identified pattern of error made through copying and pasting, it finds this charge proved.

**Charge 5**

> ***Your actions in charge 1 and/or 2 and/or 3 and/or 4 were dishonest in that you were attempting to mislead others into believing that you had completed accurate documentation when you knew that you had not.***

**The panel finds this charge NOT proved.**

The panel considered this charge solely in relation to paragraph 1(b) and 1(d), those being the charges which were found proved on your admission. The panel was of the view that whilst your actions reflected poor practice and highlighted some issues regarding your time management, it did not find that, at the time, you believed that the information you were recording was inaccurate. It therefore did not find that your behaviour was dishonest or that you intended to mislead your colleagues.

The panel acknowledged that you appear to have some formed bad habits, including the copying and pasting clinical notes, and a failure to edit those notes adequately or at all. However, it also observed, from the same records, that this appears to be common practice amongst other clinicians working with you.

The panel determined that the errors made as admitted in charges 1b and 1d were genuine mistakes where you failed to edit the notes due to time pressures and whilst this amounts to poor practice, it was not dishonest.

**Charge 6**

> ***On 9 April 2021 incorrectly declared to Colleague B that you had only copied and pasted entries in Patient A's notes.***

**The panel finds this charge NOT proved.**

In a supervision record completed on 9 April 2021 by Witness 4 (also known as Colleague B), it is stated that:

> *'In relation to documentation Melfort openly admitted to copying and pasting previous notes onto his most recent entries stating he did not have time and so was his reasoning behind this.'*

The panel considered that this statement did not confine your admission to copying and pasting Patient A's notes on one occasion only. It went wider than that. In your oral evidence, you maintained that you did not discuss the other patients with Witness 4. When shown these inaccuracies, you responded with:

> *'I can only say I never meant to mislead the ward manager and deputy ward manager, being Witness 4* [sic]. *I recall very well talking about patient A but talking about other patients we did not discuss anything*

*about that. I was not trying to mislead or acting in dishonesty to make her believe I had"*

The panel took the view that you remained largely consistent in your answers. Although you were being questioned concerning your recording of matters to do with Patient A, it does not accept that you declared that your habit of copying and pasting was confined to your recording matters solely in respect of Patient A.

**Charge 7**

***Your declaration in charge 6 was dishonest in that you were attempting to mislead Colleague A and/or others into believing the declaration was true when you knew that it was not.***

**The panel finds this charge NOT proved.**

Having found charge 6 not proved, the panel therefore finds this charge also not proved.

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence and/or misconduct. 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 and/or misconduct.

**Submissions on lack of competence, misconduct and impairment**

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

The NMC has defined a lack of competence as:

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

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

Ms Kennedy submitted that your actions demonstrate a pattern of copy and pasting, which on balance would mean that some entries are inaccurate and as such, clearly puts patients at risk of harm. She went on to state that risk was particularly relevant in relation to Charge 3f when it would not have been possible to correctly monitor deterioration or insufficient fluid intake due to the repetition of inaccuracies.

Ms Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need

to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen* v. General Medical Council [2008] EWHC 581 (Admin).

Ms Kennedy submitted that there is a clear lack of competence demonstrated through your actions in which patients were placed at a risk of harm. She submitted that whilst you have demonstrated some level of insight, it is not fully developed at this stage. She went on to note that you have accepted that you will require supervision and monitoring to allow you to return to safe practice, however at this time, you remain impaired on both public protection and public interest grounds.

Ms Mattin submitted that in relation to misconduct, the panel have found limited parts of the NMC's case proved. She noted that the panel also found that your bad habits were part of common practice amongst colleagues working on the same ward. Ms Mattin went on to state that these errors, which have been found to be genuine mistakes due to time pressures and poor practice, did not result in actual patient harm. She further noted that you have shown deep remorse for your actions which has been reflected well within your reflection.

Ms Mattin quoted various witnesses attesting to your character:

Witness 5 as stating that you are:

> *'the loveliest most caring genuine human being'*

Witness 1:

‘*Melfort was lovely person and caring nurse. Patients loved him. He just couldn’t cope with the pace of the ward. I do think that in the right setting, Melfort would be fine. Perhaps in a less fast spaced ward where there was not as must activity’* [sic]

Witness 3:

‘*I did not think Melfort was lacking in clinical skills. I think if Melfort was working in an environment where there isn’t a huge amount of pressure, he might be able to cope. When he wasn’t under pressure, he was able to demonstrate to us that he could administer medication safely. I think the ward environment was too fast faced and dynamic for him to handle. We’ve had people come and work with us for three months and then leave saying they couldn’t cope with the pace so it wasn’t unusual.’* [sic]

Ms Mattin stated that you have no previous history of disciplinary action, nor any evidence of deep-seated attitudinal issues. She stated that since your suspension, you have continued working in a healthcare setting and have managed to keep your skills and knowledge up to date.

Ms Mattin submitted that you have demonstrated insight and understanding into your errors and that your conduct has already to a degree been remedied. She concluded by stating that there is no risk that you would repeat your actions and that you are not currently impaired.

The panel accepted the advice of the legal assessor which included reference to NMC Guidance and a number of relevant judgments, including *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *CHRE v NMC and Grant.*

**Decision and reasons on lack of competence, misconduct and impairment**

When determining whether the facts found proved amount to lack of competence and/or misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code.

In relation to lack of competence, specifically:

***1. Treat people as individuals and uphold their dignity. To achieve this, you must:***
***1.2 make sure you deliver the fundamentals of care effectively***

***2. Listen to people and respond to their preferences and concerns. To achieve this, you must:***
***2.1 work in partnership with people to make sure you deliver care effectively***

***8. Work cooperatively. To achieve this, you must:***

***8.1 work in partnership with people to make sure you deliver care effectively***

***8.2 maintain effective communication with colleagues***

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

***8.4 work with colleagues to evaluate the quality of your work and that of the team***

***8.5 work with colleagues to preserve the safety of those receiving care***

***8.6 share information to identify and reduce risk***

***9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues. To achieve this, you must:***

***9.1 provide honest, accurate and constructive feedback to colleagues***

***13 Recognise and work within the limits of your competence. To achieve this, you must, as appropriate:***

***13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care***

In relation to misconduct, specifically:

***10. Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:***

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

***10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements***

***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice. To achieve this, you must:***

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

***20 Uphold the reputation of your profession at all times. To achieve this, you must:***

***20.1 keep to and uphold the standards and values set out in the Code***

The panel appreciated that breaches of the Code do not automatically result in a finding of lack of competence and/or misconduct. The panel noted that the charges found proved relate to failings in basic fundamental nursing skills including medication administration, record keeping and amongst others, communications skills. It further noted that these failings were not an isolated incident but rather occurred over a prolonged period of time, namely May 2018 until April 2021. The panel acknowledged that it was common practice amongst colleagues to cut and paste entries where there was a level of repetition. Whilst this may provide an explanation for your behaviour, this could not be used as an excuse and should not be considered safe practice.

Additionally, some of the charges found proved occurred whilst you were under a high level of supervision and receiving support from your employers. You were made aware of concerns surrounding your practice and consequently action plans were put in place in September 2018, November 2020 until February 2021 and 11 – 29 January 2021. Despite this you continued to evidence poor practice whilst working as a registered nurse.

The panel was of the view that, when considered both individually and collectively, your failings placed patients at an unwarranted risk of harm. It therefore determined that your actions did fall far short of conduct and standards expected of a nurse. It was of the view that these actions amounted to lack of competence and misconduct.

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

*If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

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

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

*a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

*c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

*d) …'*

The panel finds that whilst no actual harm occurred, your actions had the potential to do so and patients and colleagues were put at unnecessary risk. The panel was of the view that your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that you demonstrated some insight, however this was not fully developed at this stage. It noted that you admitted your failings early on and have continuously demonstrated a keen passion for the nursing profession. However, during the course of this hearing you were unable to explain to the panel how you would effectively manage a similar situation should it arise again, focusing on delegation rather than your own practice. In your oral evidence you told the panel that you would 'utilise' your team member to help you with your workload.

The panel was satisfied that the misconduct in this case is capable of being addressed by the strengthening of your practice. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you have addressed some issues whilst working in a Health Care Assistant role, however you are yet to work in a registered nursing space. The panel noted some concerns around how you would manage in such a role given that the concerns have not been fully remediated. It noted that these errors are of a serious nature and include poor practice by cutting and pasting information which could have resulted in actual harm caused by inaccurate records.

However, the panel is of the view that there is a risk of repetition and as such, the panel determined that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment was 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 conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

**Submissions on sanction**

Ms Kennedy invited the panel to impose a conditions of practice order. She outlined what, in the NMC’s view, were aggravating and mitigating factors in your case. Ms Kennedy

acknowledged that the concerns found proved are capable of remediation and that you have indicated a willingness to engage with any conditions which may be imposed, with the support of your employer. She suggested conditions that the panel may be minded imposing. Ms Kennedy submitted that a conditions of practice order would protect the public and address the public interest concerns in your case.

Ms Mattin invited the panel to impose a conditions of practice order. She reminded the panel that you have been subject to an interim suspension order since 2021. In this regard, she referred the panel to the case of Selvarajan v General Medical Council *[2008] EWHC 182 (Admin)* in which Blake J stated that

> *"It is common sense that the longer the threat of erasure has been hanging over the head of a professional person terminating their ability to practice their vocation, and with it the extinction of their means of earning a living and the deprivation of their practice, the more severe the sanction will be and the more punitive it will appear to be to the recipient, even if in disciplinary proceedings the purpose of the sanction is not intended to be punitive."*

She told the panel that you have worked as a healthcare assistant throughout your suspension and have demonstrated a continuing commitment to healthcare and personal development. Ms Mattin stated that your employers are willing to support you should the panel impose a conditions of practice order.

Ms Mattin highlighted the fact that you have no history of other disciplinary action or regulatory proceedings and that there is no evidence of harmful deep-seated personality or attitudinal problems. She submitted that a suspension order is not the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards and that the consequences of a suspension would be significant.

Ms Mattin submitted that you would now benefit from close supervision and support in the nursing space which can be carefully managed by appropriate conditions. She suggested

conditions limiting your employment to a single employer, clinical supervision, training and progress reports.

**Decision and reasons on sanction**

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your failings were repeated over a period of three years;
- Some of your failings occurred whilst you were under a high level of supervision; and
- Some of your failings placed patients at an unwarranted risk of harm.

The panel also took into account the following mitigating features:

- You have demonstrated developing insight which is evidenced within both your reflective statement and oral evidence;
- You made early admissions to some charges; and
- You have been working as Health Care Assistant in a clinical setting since 2022.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the wide-ranging allegations found proved. 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 your failings, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. During the course of this hearing, the panel did not receive any evidence to suggest a harmful deep-seated personality or attitudinal problem. To the contrary, the panel had before it a number of positive comments from witnesses attesting to your character and your patient centred approach to nursing. It noted that you have been working as a Health Care Assistant since you were made subject to an interim suspension order and that, during this time, no

further concerns have been raised regarding your employment in this role. The panel accepted that you would be willing to comply with a conditions of practice order and that your employer would be supportive of any conditions imposed. It determined that you should now be allowed the opportunity to demonstrate a strengthening of your practice as a registered nurse. The panel determined that conditions could be formulated that would protect patients during the period they are in force and that it was in the public interest, with appropriate safeguards, that you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order at this time would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must limit your employment to one substantive employer. This cannot include agency work.

2. You must ensure that you are working at all times on the same shift as, but not always directly observed by, a registered nurse of band 6 or above and/or equivalent.

3. You must be directly supervised by another registered nurse of band 6 or above and/or equivalent when administering medication until signed off as competent by your clinical line manager, mentor and/or supervisor.

4. You must work with your line manager, mentor and/or supervisor to create a personal development plan (PDP). Your PDP must address the regulatory concerns about:

    a) Medication administration
    b) Prioritisation
    c) Record keeping
    d) Time management

You must send your case officer a copy of your PDP before any review hearing.

5. You must meet with your line manager, mentor and/or supervisor, every two weeks for the first three months of this order and once a month thereafter, to discuss your progress towards aims set in your personal development plan (PDP).

6. Send your case officer a report from your line manager, mentor and/or supervisor before any review hearing. This report must show your progress towards achieving the aims set out in your PDP.

7. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your case officer your employer's contact details.

8. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

9. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

10. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

11. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the hearing;
- Any up to date testimonials from your current employment; and
- Evidence of your compliance with the order.

This will be confirmed to you in writing.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Kennedy who invited the panel to impose an interim conditions of practice order for 18 months, with conditions mirroring those in the substantive order. She reminded the panel that the substantive order will not come into effect until after the 28-day appeal period. Ms Kennedy submitted that an

interim order is necessary for the protection of the public and is otherwise in the public interest in order to cover any potential appeal period.

Ms Mattin did not oppose the application.

**Decision and reasons on interim order**

The panel was satisfied that an interim order is necessary for the protection of the public, is otherwise in the public interest and is also in your own interests. The panel had regard to the facts found proved and its reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any potential appeal period.

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

That concludes this determination.