Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 8 April 2024 – Tuesday 16 April 2024

Virtual Hearing

Name of Registrant:	**Tracey Anne Lawrence**
NMC PIN	00C0560E
Part(s) of the register:	Adult Nurse, Sub Part 1, Level 1
Relevant Location:	Chesterfield
Type of case:	Misconduct
Panel members:	Paul O'Connor (Chair, Lay member) Jane Jones (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Caroline Hartley
Hearings Coordinator:	Zahra Khan
Nursing and Midwifery Council:	Represented by Holly Girven, Case Presenter
Mrs Lawrence:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e (in its entirety), 1g, 2a and 3c
Facts not proved:	Charge 1f (in its entirety), 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 3a and 3b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months) with review**

Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Lawrence was not in attendance and that the Notice of Hearing letter had been sent to Mrs Lawrence's registered email address by secure email on 7 March 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Lawrence

The panel next considered whether it should proceed in the absence of Mrs Lawrence. It had regard to Rule 21 and heard the submissions of Ms Girven who invited the panel to continue in the absence of Mrs Lawrence. She submitted that Mrs Lawrence had voluntarily absented herself.

Ms Girven referred the panel to an email from Mrs Lawrence to the NMC, dated 26 March 2024, which stated:

'I won't be attending the hearing as I've sent you the document to be voluntary [sic] removed from the register a while back…'.

The panel noted the correspondence in which the NMC say they have not received the voluntary removal request and that they have sent a further application form to Mrs Lawrence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Mrs Lawrence. In reaching this decision, the panel has considered the submissions of Ms Girven and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Lawrence;
- Mrs Lawrence informed the NMC that she will not be attending the hearing as she wishes to be removed from the register;
- There is no reason to suppose that adjourning would secure Mrs Lawrence's attendance at some future date;
- Four witnesses will be attending over the course of the hearing to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020, 2021 and 2022;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Lawrence in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

Furthermore, the limited disadvantage is the consequence of Mrs Lawrence's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Mrs Lawrence. The panel will draw no adverse inference from Mrs Lawrence's absence in its findings of fact.

Details of charge

That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

    (a) Administered 1mg of Lorazepam to Patient A which was not clinically justified.

(b) Failed to record on the MAR chart, the rationale for the administration of the additional 1mg of Lorazepam to Patient A.

(c) Failed to record on the MAR chart, the time of the administration of the additional 1mg of Lorazepam.

(d) Failed to record on the MAR chart, the effect the administration of the additional 1mg of Lorazepam had on Patient A.

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(i) unsettled,
(ii) agitated,
(iii) entering the rooms of other patients,
(iv)taking items belonging to other patients,
(v) raised their hand,
(vi) attempting to exit the building,
(vii) stating they were going home.

(f) Failed to record Failed to record in Patient A' progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was a

(i) distressed,
(ii) agitated,
(iii) entering the rooms of other patients,
(iv) tried to take another resident's frame from them,
(iv) attempting to exit the building,
(v) did not respond to distraction techniques,
(vii) remained unsettled for the rest of the night.

(g) Failed to follow Resident A's prescription of administrating additional Lorazepam, in incremental 0.5mg doses to a maximum of 2mg daily.

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident B

(a) On or around 11 May 2022 incorrectly recorded on Resident B's medication administration chart, 4 x 20ml of Paracetamol oral suspension, as opposed to 3 x 20ml.

(b) On 12 May 2022 gave Resident B an additional 20ml dose of Paracetamol, that was not clinically justified.

(c) On an unknown date in May 2022 failed to administer to Resident B the prescribed paracetamol.

(d) Failed to order in a timely manner or at all Paracetamol for Resident B, resulting in Resident B's paracetamol running out.

Resident C

(e) On 12 May 2022 failed to ensure there was sufficient patches in stock for Resident C, resulting in there being none stock

(f) Incorrectly recorded [in the drug book] 4 patches when there was none

Resident D

(g) On 12 May 2022 failed to ensure there was sufficient stock of Lansoprazole for Resident D, resulting in there being none in stock

Resident F

(h) On or around 4 May 2022 altered the dosage of Resident F's metformin, from 1g/10mls to 500mg/5mls, when not qualified to do so.
(i) Between 12 May and 21 May 2022 administered 500mg/5mls of Metformin as opposed to the 1g/10mls prescribed

Resident G

(j) On the 14 July 2021 whilst working night shift, failed to administer to Resident G the prescribed Atorvastatin 80mg tablet orally

3. Failed to keep proper and accurate records at Care Home 2 in that:

(a) Signed for controlled drugs without a colleague to witness the administration of controlled drugs.

(b) Signed in controlled drugs to the controlled drugs book without a colleague witnessing this.

(c) Incorrectly recorded in the controlled drug book 30 Pregablin tablets for Resident E, when there were only 28 tablets.

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 Girven, on behalf of the NMC, to amend the wording of charges 1f, 1g, 2c, 2d, 2e, 2f, 2j, 3c and the stem of charge 3.

The proposed amendments were all to correct typographical errors. It was submitted by Ms Girven that the proposed amendments would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record ~~Failed to record~~ in Patient A'**s** progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was ~~a~~

(i) distressed,
(ii) agitated,
(iii) entering the rooms of other patients,
(iv) tried to take another resident's frame from them,
(iv) attempting to exit the building,
(v) did not respond to distraction techniques,
(vi) remained unsettled for the rest of the night.

(g) Failed to follow Resident A's prescription **to administer** ~~of administrating~~ additional Lorazepam, in incremental 0.5mg doses to a maximum of 2mg daily.

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident B

(c) On an unknown date in May 2022 failed to administer to Resident B the prescribed ~~paracetamol~~ **Paracetamol**.

(d) Failed to order in a timely manner or at all Paracetamol for Resident B, resulting in Resident B's ~~paracetamol~~ **Paracetamol** running out.

Resident C

(e) On 12 May 2022 failed to ensure there was sufficient patches in stock for Resident C, resulting in there being none **in** stock

(f) Incorrectly recorded [in the drug book] 4 patches when there ~~was~~ **were** none

Resident F

(h) On or around 4 May 2022 altered the dosage of Resident F's ~~metformin~~ **Metformin**, from 1g/10mls to 500mg/5mls, when not qualified to do so.

Resident G

(j) On the 14 July 2021 whilst working **on a** night shift, failed to administer to Resident G the prescribed Atorvastatin 80mg tablet orally

3. Failed to keep proper and accurate records at Care Home 2 in that **you**:

(c) Incorrectly recorded in the controlled drug book 30 ~~Pregablin~~ **Pregabalin** tablets for Resident E, when there were only 28 tablets."

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).

The panel was of the view that such amendments as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Mrs Lawrence and no injustice would be caused to either party by the remaining proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy as there were typographical errors.

Ms Girven made a further application to amend charge 2h from '4 May 2022' to '12 May 2022'. In regard to that amendment, the panel found that it would amount to material change which would be unfair to Mrs Lawrence at this stage. The panel noted that when this matter had been investigated locally, Mrs Lawrence had not been referred to 12 May 2022 and so had not provided any answer she may have wished to give. Mrs Lawrence would therefore be prejudiced by this change to the charge being permitted at this late stage, particularly as she is not present.

Background

Mrs Lawrence was referred to the NMC on 21 July 2020 by Witness 1, the Deputy Manager of The Willows Care Home ("Care Home 1").

The alleged facts are:

On 1 February 2013, Mrs Lawrence began working as a nurse for the Local Care Force Agency ("the Agency"). On 6 and 7 June 2020, she worked night shifts at Care Home 1, via the Agency. Care Home 1 had 42 beds on two floors. The upper floor had keypad

entry and was for those with dementia. At night there was a nurse per floor with two support workers.

Patient A was in Care Home 1 on the upper floor, for respite care. He was prescribed a regular dose of 1mg of Lorazepam to be taken at 17:00. This was to settle him for the evening. Patient A was also prescribed an additional 1mg PRN (prescribe as needed) if clinically justified. The PRN protocol confirmed that it should be given as two separate doses of 0.5mg. Lorazepam could make Patient A unsteady on his feet.

Patient A was to receive no more than 2mg of Lorazepam over a 24-hour period. Mrs Lawrence was required to complete the reverse of the medication chart to specify the time given and the reason for the administration if a PRN medication was necessary. Mrs Lawrence was also required to record, on the progress notes and the reverse of the MAR chart, the effect of the medication. Allegedly, she reported that the medication was given, but with no explanation for it, or the dosage level, nor did she record the impact on Patient A. She had only noted that they were calm earlier in the shift.

Mrs Lawrence noted that Patient A had a fall on 7 June 2020 at 23:10. On 8 June 2020 Patient A attended hospital following the fall with a suspected fracture. He returned to Care Home 1 the same day, with no fracture identified. Care Home 1's Home Manager submitted a safeguarding referral on 10 June 2020 regarding Patient A. As a result, Mrs Lawrence and another nurse were asked for statements.

Witness 1 received Mrs Lawrence's statement around 9 June 2020. She found this to be completely different from the progress notes that Mrs Lawrence made on Patient A at the time. Witness 1 asked for another statement thinking that Mrs Lawrence had made a mistake. However, Mrs Lawrence's second statement was similar in nature.

As a result of this incident, the Priory Group advised the Agency on 8 July 2020 that Mrs Lawrence was not to work at any of their care homes again. Mrs Lawrence was referred to the NMC. Witness 3, the Senior Regional Clinical Lead for the Agency, carried out a

clinical supervision with Mrs Lawrence by phone on 28 July 2020, reminding Mrs Lawrence of the need for assessing a patient herself when administering medication.

As requested by Witness 2, on 29 July 2020 Mrs Lawrence completed a reflection on the incident at Care Home 1 and admitted errors. Mrs Lawrence allegedly said that she had allowed herself to be distracted when making notes on Patient A.

From 8 April 2021, Mrs Lawrence was employed as a general nurse at St Michael's Care Home ('Care Home 2'). Care Home 2 is a dementia nursing and residential home registered to 39 individuals, usually with around 33 residents.

There was usually one registered nurse on shift at Care Home 2, unless there was an individual in their supernumerary period. Allegedly, Mrs Lawrence made a series of errors.

On 5 August 2021, Mrs Lawrence was moved to day shifts and provided with training. At some point in 2021, Mrs Lawrence became Clinical Lead at Care Home 2. However, it is alleged that she then made further errors in relation to medicines management.

On 21 May 2022, a medication audit at Care Home 2 identified some of these errors. Mrs Lawrence was suspended on 22 May 2022 pending an investigation. She resigned on the same date. Care Home 2 did not pursue the disciplinary process.

The NMC understand that Mrs Lawrence is not currently working in a nursing role.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Girven.

The panel has drawn no adverse inference from the non-attendance of Mrs Lawrence.

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

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

- Witness 1: Deputy Manager of The Willows Care Home ("Care Home 1")
- Witness 2: Service Manager for Derbyshire County Council ("the Council")
- Witness 3: Senior Regional Clinical Lead Nurse at the Local Care Force ("the Agency")
- Witness 4: Home Manager of St Michaels Nursing and Residential Home ("Care Home 2")

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

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

Charge 1a

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(a) Administered 1mg of Lorazepam to Patient A which was not clinically justified."

This charge is found proved.

In reaching this decision, the panel took into account Patient A's Progress Notes dated 6 and 7 June 2020; Mrs Lawrence's two written statements provided by the Agency; one undated and the second dated 22 June 2020; Care Home 1's PRN Protocol (which had been provided to the panel following its request); Patient A's MAR chart dated May to June 2020; and Patient A's medication notes (trained staff or carers medication notes) which is to be completed if a PRN medication is given to resident.

The panel noted, when looking at Patient A's MAR chart, that an untimed 1mg of PRN Lorazepam was administered to Patient A by Mrs Lawrence during the night shifts of 6 and 7 June 2020. It had regard to Care Home 1's PRN Protocol which stated that 0.5mg of Lorazepam should be administered to Patient A, up to twice, with an interval of 6-12 hours between the doses. The reasons for the administration of this PRN medication to Patient A, as set out in the PRN Protocol were:

- Agitation and distressed behaviours.
- Verbal aggression.
- Threatening behaviour.

The panel noted that Mrs Lawrence's statements as to Patient A's presentation during the nightshifts of 6 and 7 June 2020 set out that Patient A was demonstrating the above behaviours and could not be settled by other means.

The panel paid particular attention to the PRN protocol which clearly set out that the PRN Lorazepam was to be administered in incremental doses of 0.5mg and that the effect of the medication was to be monitored. Witness 1 stated that this protocol was attached to the MAR chart and so was readily available. Mrs Lawrence failed to follow the protocol.

Mrs Lawrence has accepted, in her statement and reflective piece, that she provided Patient A with a 1mg dose stating that: *'… I gave 1mg PRN Lorazepam at 9:50pm as advised by the homes nurse as 0.5mg had no effect'*. She had also failed to document on the back of the MAR chart's sheet the time, reason and impact of the PRN medication as was required.

Further, the entry in the progress notes at 05:00 on 7 June 2020 by Mrs Lawrence did not correlate with her later statements, stating that Patient A: *'… was walking around at start of shift. Sat in lounge for supper. Meds taken. Assisted to bed around 11pm. Settled in mood up. x3 overnight for toilet. Slept long periods on checks. No issues to report'.* Mrs Lawrence said the difference was due to her being distracted and forgetting to include these details. Whilst that may have been the case the panel did not consider that Patient A's presentation, as described in the progress notes, justified Mrs Lawrence's decision to not follow the PRN protocol without providing clear and cogent reasons at the time of administration.

The panel was of the view that Mrs Lawrence had not recorded clinically justifiable reasons in the progress notes or MAR chart as to why she administered Lorazepam, particularly of a 1mg dose to Patient A.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence administered 1mg of Lorazepam to Patient A which was not clinically justified.

The panel therefore found charge 1a proved.

Charge 1b

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(b) Failed to record on the MAR chart, the rationale for the administration of the additional 1mg of Lorazepam to Patient A."

This charge is found proved.

In reaching this decision, the panel took into account Mrs Lawrence's reflective piece dated 29 July 2020, Care Home 1's PRN Protocol, Patient A's MAR chart dated May to June 2020, and Patient A's medication notes (trained staff or carers medication notes) which is to be completed if a PRN medication is given to resident.

The panel noted that the back of Patient A's MAR chart showed that nothing had been recorded by Mrs Lawrence. There is an absence of justification as to the rationale behind administering Patient A the additional 1mg of Lorazepam.

Further, the panel noted that the PRN protocol states that rationale must be given. As such, it was of the view that Mrs Lawrence had a duty to record this on the MAR chart which she failed to do.

The panel also had regard to Mrs Lawrence's reflective piece, whereby she recognised that it was her responsibility to record the rationale for the administration of the additional 1mg of Lorazepam to Patient A. The reflective piece stated:

‘Night shift. 6th June 2020 on a busy emi unit. I failed to document the complete events of the night regarding a client and the administering of a prn medication’.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence failed to record on the MAR chart, the rationale for the administration of the additional 1mg of Lorazepam to Patient A.

The panel therefore found charge 1b proved.

Charge 1c

“That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(c) Failed to record on the MAR chart, the time of the administration of the additional 1mg of Lorazepam.”

This charge is found proved.

In reaching this decision, the panel took into account Mrs Lawrence’s reflective piece dated 29 July 2020, Care Home 1’s PRN Protocol, Patient A’s MAR chart dated May to June 2020, and Patient A's medication notes (trained staff or carers medication notes) which is to be completed if a PRN medication is given to a patient or resident.

The panel noted, when looking at Patient A’s MAR chart, that the time of administration is not recorded on the front or back of the MAR chart. The PRN protocol states that this

should be recorded as the timing of the drug being administered to Patient A is important when judging when the next dosage is due.

The panel had regard to Mrs Lawrence's reflective piece which stated:

> *'… It was the end of a busy shift, as I was writing the daily notes I was also answering buzzers due to the carers on duty attending to other clients… when I returned to complete my notes I didn't read through what I had already written and continued to write them…*
>
> *When informed by my agency that I had not documented events, dose and time of administering the medication i was deeply upset that I hadn't documented this as i know is not a standard required by the nmcs. code of conduct in record keeping and administering medication….'.*

The panel noted that it is clear that Mrs Lawrence recognised that she did not record the time of the administration of the PRN 1mg Lorazepam to Patient A. As such, the panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence failed to record on the MAR chart, the time of the administration of the additional 1mg of Lorazepam.

The panel therefore found charge 1c proved.

Charge 1d

> "That you, a registered nurse
>
> **Care Home 1**
>
> 1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(d) Failed to record on the MAR chart, the effect the administration of the additional 1mg of Lorazepam had on Patient A."

This charge is found proved.

In reaching this decision, the panel took into account Mrs Lawrence's reflective piece dated 29 July 2020, Care Home 1's PRN Protocol, Patient A's MAR chart dated May to June 2020, and Patient A's medication notes (trained staff or carers medication notes) which is to be completed if a PRN medication is given to resident.

The panel noted, when looking at Patient A's MAR chart, that the effect of administration of the additional 1mg of Lorazepam on Patient A is not recorded on the front or back of the MAR chart. The PRN protocol states why this is important and that the following observations are required:

- Monitor effectiveness of medication following administration.
- Monitor for any side effects and report any to GP.
- Report to GP if dosage required regularly to enable him to amend prescription.

The panel had regard to Mrs Lawrence's reflective piece which stated:

'… When informed by my agency that I had not documented events, dose and time of administering the medication i was deeply upset that I hadn't documented this as i know is not a standard required by the nmcs. code of conduct in record keeping and administering medication….'.

Similarly to charge 1a, 1b and 1c, Mrs Lawrence recognised her failure.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence failed to record on the MAR chart, the effect the administration of the additional 1mg of Lorazepam had on Patient A.

The panel therefore found charge 1d proved.

Charge 1e (i)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(i) unsettled."

This charge is found proved.

Charge 1e (ii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(ii) agitated."

This charge is found proved.

Charge 1e (iii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(iii) entering the rooms of other patients."

This charge is found proved.

Charge 1e (iv)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(iv) taking items belonging to other patients."

This charge is found proved.

Charge 1e (v)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(v) raised their hand."

This charge is found proved.

Charge 1e (vi)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(vi) attempting to exit the building."

This charge is found proved.

Charge 1e (vii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(e) Failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of Lorazepam that Patient A was

(vii) stating they were going home."

This charge is found proved.

The panel looked at charge 1e collectively.

In reaching this decision, the panel took into account Patient A's Progress Notes dated 6 and 7 June 2020, and Mrs Lawrence's two statements, one undated and the second dated 22 June 2020.

Before making its decision on charges 1e and 1f, the panel assessed Mrs Lawrence's statements and their credibility in the context of how they were prepared. Witness 2 told the panel that the Agency did not have any clinical documentation at the time and no evidence to suggest that Mrs Lawrence was given access to any medical records for the purposing of preparing her own.

The panel therefore determined that Mrs Lawrence's statements provided to the Agency are questionable.

The panel has interpreted this charge to be the night shift of 6 June 2020 going into 7 June 2020. This is in keeping with the stem of the charge.

The panel noted an entry made by Mrs Lawrence on 7 June 2020 at 23:10 which recorded Patient A's fall.

The panel noted an entry made by Mrs Lawrence on 7 June 2020 at 05:00, which stated:

> *'[Patient A] was walking around at start of shift. Sat in lounge for supper. Meds taken. Assisted to bed around 11pm. Settled in mood up. x3 overnight for toilet. Slept long periods on checks. No issues to report'.*

The panel considered that this record clearly shows no mention of Patient A requiring or receiving PRN Lorazepam.

The panel determined that Mrs Lawrence failed to record in Patient A's progress notes, on 6 June 2020 prior to the administration of PRN Lorazepam that Patient A was:

- Unsettled.
- Agitated.
- Entering the rooms of other patients.
- Taking items belonging to other patients.
- Raised their hand.
- Attempting to exit the building.
- Stating they were going home.

The panel therefore found charge 1e proved in its entirety.

Charge 1f (i)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(i) distressed."

This charge is found NOT proved.

Charge 1f (ii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(ii) agitated."

This charge is found NOT proved.

Charge 1f (iii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(iii) entering the rooms of other patients."

This charge is found NOT proved.

Charge 1f (iv)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(iv) tried to take another resident's frame from them."

This charge is found NOT proved.

Charge 1f (v)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(v) attempting to exit the building."

This charge is found NOT proved.

Charge 1f (vi)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(vi) did not respond to distraction techniques."

This charge is found NOT proved.

Charge 1f (vii)

"That you, a registered nurse

Care Home 1

1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –

(f) Failed to record in Patient A's progress notes on 7 June 2020 prior to the administration of Lorazepam that Patient A was

(vii) remained unsettled for the rest of the night."

This charge is found NOT proved.

The panel looked at charge 1f collectively.

In reaching this decision, the panel took into account Patient A's Progress Notes dated 7 and 8 June 2020, and Mrs Lawrence's two statements, one undated and the second dated 22 June 2020.

The panel interpreted this charge to be the night shift of 7 June 2020 going into 8 June 2020.

The panel further noted an entry made by Mrs Lawrence on 8 June 2020 at 05:10 which stated:

'[Patient A] has been awake all night'.

However, the panel noted that this entry is incomplete as there appears to be an additional page that has not been provided. This is shown by the ‘page 2/3’ printed on the bottom right hand corner and as Mrs Lawrence’s entry is unsigned by her which appeared to be her usual practice. The following page exhibited starts at an entry at 21:30 and has ‘page 1/2’ printed again in the bottom right hand corner and therefore does not appear to follow on from Mrs Lawrence’s entry.

The panel noted that the requirement is that Mrs Lawrence should write her progress notes by the end of her night shift.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 1f not proved in its entirety.

Charge 1g

> “That you, a registered nurse
>
> **Care Home 1**
>
> 1. Whilst working at the Willows Care Home on the night shifts of the 6 and 7 June 2020 –
>
> > (g) Failed to follow Resident A’s prescription to administer additional Lorazepam, in incremental 0.5mg doses to a maximum of 2mg daily.”

This charge is found proved.

In reaching this decision, the panel took into account Mrs Lawrence’s reflective piece dated 29 July 2020 and Care Home 1’s PRN Protocol.

The panel noted that Mrs Lawrence was an agency nurse and it was her first time caring for Patient A. She was advised by Care Home 1's nurse and followed that advice.

The panel noted that Mrs Lawrence, in her reflective piece regarding 6 June 2020, stated:

> *'… As all other methods had failed in calming the client I gave 1mg prn lorazepam at 9.50pm as advised by the homes nurse as 0.5mg had no effect…'.*

The panel was of the view that Mrs Lawrence had a duty to aware of the correct dose of Lorazepam for Patient A, namely being incremental 0.5mg doses to a maximum of 2mg daily as set out in the PRN protocol. The panel noted that there were two other signatures that appeared to have given the same 1mg PRN dose in the two weeks preceding the incident.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence failed to follow Patient A's prescription to administer PRN Lorazepam, in incremental 0.5mg doses to a maximum of 2mg daily.

The panel therefore found charge 1g proved.

Charge 2a

> "That you, a registered nurse
>
> **Care Home 2**
>
> 2. Whilst working at St Michael's Care Home (Care Home 2)
>
> **Resident B**

(a) On or around 11 May 2022 incorrectly recorded on Resident B's medication administration chart, 4 x 20ml of Paracetamol oral suspension, as opposed to 3 x 20ml."

This charge is found proved.

In reaching this decision, the panel took into account Resident B's MAR chart from May 2022, the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022, and Witness 4's oral evidence.

The panel noted that Mrs Lawrence, in the interview on 22 May 2022, made an admission in relation to incorrectly recording, on Resident B's MAR chart, 4 x 20ml of Paracetamol oral suspension, as opposed to 3 x 20ml. Witness 4 had asked Mrs Lawrence why she did not follow the MAR chart and gave extra doses to Resident B when she was the registered nurse on duty and Mrs Lawrence responded:

'I followed the previous dose and copied it from the old MAR chart. I was not aware the dosage had changed… I had to write 4x dose on in case she did not take other doses'.

The panel was of the view that this shows that Mrs Lawrence did make an inaccurate record and did not follow what was on Resident B's prescription.

Witness 4, in his oral evidence, stated that the record of '20ml' in Resident B's MAR chart was Mrs Lawrence's handwriting. Further, Witness 4 also confirmed that at the time of the interview, they had the MAR chart in front of them although that was not documented in the meeting minutes.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence incorrectly recorded on Resident B's medication administration chart, 4 x 20ml of Paracetamol oral suspension, as opposed to 3 x 20ml, on or around 11 May 2022.

The panel therefore found charge 2a proved.

Charge 2b

"That you, a registered nurse

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident B

(b) On 12 May 2022 gave Resident B an additional 20ml dose of Paracetamol, that was not clinically justified."

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident B's MAR chart from May 2022, the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022, and Witness 4's oral evidence.

The panel had no confirmation as to whether Mrs Lawrence was on duty on 12 May 2022 and therefore there was insufficient evidence to say that she gave Resident B, on 12 May 2022, an additional 20ml dose of Paracetamol that was not clinically justified.

The panel considered Witness 4's written and oral evidence. However, it concluded that it could not place much weight on his evidence as he appeared somewhat defensive as to the failings in the Home at the time. His recollection of events some two years ago he acknowledged were poor and the copy of records were poor quality. He couldn't be sure himself of whose initials were recorded on the records. It noted that Witness 4 no longer works at Care Home 2, nor does he have access to a number of the key documents.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2b not proved.

Charge 2c

"That you, a registered nurse

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident B

(c) On an unknown date in May 2022 failed to administer to Resident B the prescribed Paracetamol."

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident B's MAR chart from May 2022.

The NMC did not provide the panel with any specificity or clarity as to this charge.

The panel noted that the photocopy of Resident B's MAR chart is of such poor quality that it is almost illegible and did not contain the dates for the whole month of May 2022.

Further, the panel was not provided with any evidence to demonstrate that Mrs Lawrence was on duty or the person in charge of medication administration to Resident B, in particular, nor was it provided with a rota.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2c not proved.

Charge 2d

> "That you, a registered nurse
>
> **Care Home 2**
>
> 2. Whilst working at St Michael's Care Home (Care Home 2)
>
> **Resident B**
>
> (d) Failed to order in a timely manner or at all Paracetamol for Resident B, resulting in Resident B's Paracetamol running out."

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident B's MAR chart from May 2022, the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022, Care Home 2's Medication Policy (version date October 2021), and Witness 4's oral evidence.

The panel noted that Care Home 2's Medication Policy states that it is the manager's responsibility to order medication. There was no evidence to suggest that Mrs Lawrence was responsible for the ordering of Resident B's Paracetamol at that time. Although the panel was aware that Mrs Lawrence was the Clinical Lead, it could not be sure whether she was on duty at the time that the ordering should have taken place as no evidence in respect of her work pattern has been adduced.

The panel, when looking at the interview on 22 May 2022, noted that the Operations Manager stated:

> *'…I would now like to discuss the following Medications being ordered late leading to issues trying to obtain them and at times almost running out. run out of Paracetamol for 1x day… Stating we have enough and then we don't. Could you explain this to me'.*

Mrs Lawrence responded:

> *'There was plenty of Paracetamol for [Resident B] can't understand why she run out. She had little bottles she came in with'.*

The panel noted that Mrs Lawrence maintained that she did order the Paracetamol.

The panel did not have sufficient evidence before it to make this charge out and, as in charge 2c.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2d not proved.

Charge 2e

> "That you, a registered nurse
>
> **Care Home 2**
>
> 2. Whilst working at St Michael's Care Home (Care Home 2)
>
> **Resident C**

(e) On 12 May 2022 failed to ensure there was sufficient patches in stock for Resident C, resulting in there being none in stock."

This charge is found NOT proved.

In reaching this decision, the panel took into account the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022, and Witness 4's written and oral evidence.

The panel had regard to the interview on 22 May 2022 where Mrs Lawrence was informed that Witness 4 had to go to Nottingham to get patches for Resident C. Mrs Lawrence stated:

> *'I did not know why [Resident C] would have run out of patches. She was not registered… I had confused her patches with someone else's was residential and was not my responsibility'.*

The panel noted that Mrs Lawrence did not admit to this allegation in the interview.

The panel was not provided with a copy of Resident C's MAR chart. Witness 4 acknowledged, in his oral evidence, that he had difficulty in recalling these events and could not establish it was Mrs Lawrence's responsibility for this. Witness 4 implied that the investigation was superficial and truncated due to Mrs Lawrence resigning from her position.

The panel determined that there was insufficient evidence from the NMC to find this charge proved.

The panel therefore found charge 2e not proved.

Charge 2f

“That you, a registered nurse

Care Home 2

2. Whilst working at St Michael’s Care Home (Care Home 2)

Resident C

(f) Incorrectly recorded [in the drug book] 4 patches when there were none.”

This charge is found NOT proved.

In reaching this decision, the panel took into account the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022.

The panel had not been provided with the drug book. Nor could it find any reference to this matter within the interview notes (22 May 2022) to evidence that Mrs Lawrence made an incorrect recording in the drug book.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2f not proved.

Charge 2g

“That you, a registered nurse

Care Home 2

2. Whilst working at St Michael’s Care Home (Care Home 2)

Resident D

(g) On 12 May 2022 failed to ensure there was sufficient stock of Lansoprazole for Resident D, resulting in there being none in stock."

This charge is found NOT proved.

In reaching this decision, the panel took into account the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022.

The panel noted that Mrs Lawrence does not make any comment on this. It also noted that Resident D is residential, and so this resident may not have been her responsibility. Witness 4 recalled that Resident D had been residential at that time, although changed to nursing, but he did not know when.

The panel did not have sight of Resident D's MAR chart, nor was it informed of anything related to this charge, other than the fact Witness 4 had to go to Nottingham to collect the Lansoprazole. It was of the view that just because someone went to get the medication for Resident B does not mean that it was Mrs Lawrence's fault that it had not been in stock.

The panel was also aware that Mrs Lawrence resigned that same day by text message. However, it has not seen this text message.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2g not proved.

Charge 2h

"That you, a registered nurse

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident F

(h) On or around 4 May 2022 altered the dosage of Resident F's Metformin, from 1g/10mls to 500mg/5mls, when not qualified to do so."

This charge is found NOT proved.

In reaching this decision, the panel took into account the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022.

The panel noted that during the interview on 22 May 2022, Mrs Lawrence was informed that:

'[Resident F] was on 500mg Metformin suspension. On 4.5.22 stated to go on to 1g which commenced on new cycle. 10mls crossed out and hand written 5mls making under dose'.

Mrs Lawrence stated:

'She has always been on 500mg. I carried on with what she had… I didn't know the medication dosage had changed. I have not done the ward round in a while with me being on nights. She has always been on this dose. It's 5mls and I didn't know about the change…'.

The panel noted that Mrs Lawrence maintained that she did not know that there was a change to the prescription. It found the local investigation to be confusing as when

referring to Resident F's MAR chart, the dosage of Metformin was 500mg/5mls on or around 4 May 2022 and so it appeared that no error had been made.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2h not proved.

Charge 2i

> "That you, a registered nurse
>
> **Care Home 2**
>
> 2. Whilst working at St Michael's Care Home (Care Home 2)
>
> **Resident F**
>
> (i) Between 12 May and 21 May 2022 administered 500mg/5mls of Metformin as opposed to the 1g/10mls prescribed."

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident F's MAR chart with a start date of 12 May 2022, the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022, and Witness 4's written and oral evidence.

The panel noted that Mrs Lawrence stated, in the interview on 22 May 2022, that she *'had not done the ward round for a while with me being on nights'*. Mrs Lawrence also admitted that she gave Resident F the same dosage, but this was on 4 May 2022 rather than 12 May 2022 to 21 May 2022.

The panel had no evidence to confirm that Mrs Lawrence had administered Resident F 500mg/5mls of Metformin as opposed to 1g/10mls prescribed. It noted that Mrs Lawrence was not asked about this matter in relation to 12 – 21 May 2022 at the investigation interview and so there was no opportunity for her to respond.

Further, the panel cannot be sure which, if any, signatures belong to Mrs Lawrence. Witness 4 also confirmed that he cannot be sure as to which signatures are Mrs Lawrence's.

In these circumstances, the NMC failed to prove that Mrs Lawrence did administer 500mg/5mls of Metformin.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2i not proved.

Charge 2j

"That you, a registered nurse

Care Home 2

2. Whilst working at St Michael's Care Home (Care Home 2)

Resident G

(j) On the 14 July 2021 whilst working night shift, failed to administer to Resident G the prescribed Atorvastatin 80mg tablet orally."

This charge is found NOT proved.

In reaching this decision, the panel took into account the findings of the investigation into Mrs Lawrence's conduct dated 14 July 2021.

The panel noted that, within the findings of the investigation dated 14 July 2021, under the title ‘Missing giving a medication’, it stated:

> *‘Given to [Resident G] 14/07/21 missed given a night time tablet for a new resident … This medication is to be given at night and the MAR sheet is blank… [Mrs Lawrence] stated this was given in the morning and someone had changed it to night time, and she had noticed this had not been given in the morning, I asked if she had passed this over as it was never mentioned to me, she said no, we advised moving forward to check every MAR chart to see if anything had changed with the times medication is given’.*

The panel was not provided with Resident G’s MAR chart. It had regard to Witness 4’s statement, however, as it was not his investigation nor did he work for Care Home 2 when the incident took place, the panel gave the investigation report little evidential weight. It also noted that the investigation notes are not minutes, neither did Mrs Lawrence admit this error and she has not agreed the accuracy of the notes.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 2j not proved.

Charge 3a

> “That you, a registered nurse
>
> 3. Failed to keep proper and accurate records at Care Home 2 in that you:

(a) Signed for controlled drugs without a colleague to witness the administration of controlled drugs."

This charge is found NOT proved.

In reaching this decision, the panel took into account the findings of the investigation into Mrs Lawrence's conduct dated 14 July 2021.

The panel noted that, within the findings of the investigation dated 14 July 2021, under the title 'Signing in medication', it stated:

> *'Please see enclosed photo. Only being signed in by [Mrs Lawrence]. Even thought I spoke with her and said the guidelines are two members of staff to check in all of the medication for any resident to ensure the correct numbers are in the boxes being delivered. [Mrs Lawrence] stated she thought it was only one staff to sign medication in…'.*

The panel was not provided with the photograph of the controlled book, and it noted that this charge was not put to Mrs Lawrence in the investigation. As the author of the investigation notes was not called as a witness by the NMC, the panel was unable to judge the integrity of the notes and as such gave very little weight to the document.

The panel determined that there was insufficient evidence to find this charge proved.

The panel therefore found charge 3a not proved.

Charge 3b

"That you, a registered nurse

3. Failed to keep proper and accurate records at Care Home 2 in that you:

(b) Signed in controlled drugs to the controlled drugs book without a colleague witnessing this."

This charge is found NOT proved.

In reaching this decision, the panel took into account the findings of the investigation into Mrs Lawrence's conduct dated 14 July 2021.

The panel adopted the same views as those it had in charge 3a. It was not provided with the controlled book and found the note in the investigation report to be vague. Whilst the notes of the investigation reported that Mrs Lawrence said *'… She thought it was only one staff to sign medication in…',* the panel recognised that Mrs Lawrence did not agree these notes as accurate minutes and the author of the investigation notes has not been called as a witness by the NMC to be questioned.

The panel determined that there is insufficient evidence to find this charge proved.

The panel therefore found charge 3b not proved.

Charge 3c

"That you, a registered nurse

3. Failed to keep proper and accurate records at Care Home 2 in that you:

(c) Incorrectly recorded in the controlled drug book 30 Pregabalin tablets for Resident E, when there were only 28 tablets."

This charge is found proved.

In reaching this decision, the panel took into account the meeting notes from an investigation interview between Mrs Lawrence and Care Home 2 / Witness 4 dated 22 May 2022.

The panel noted that Mrs Lawrence admitted to recording in the controlled drug book 30 Pregabalin tablets for Resident E. In the interview on 22 May 2022, she stated:

> *'I signed it in incorrectly. There was 28 but there was not just me. Another carer was also present. I should have noticed. I admit that I wrote it wrong'.*

The panel did not have the controlled book but took into account Mrs Lawrence's admission in the investigation notes.

The panel determined that, on the balance of probabilities, it is more likely than not that Mrs Lawrence did incorrectly record in the controlled drug book 30 Pregabalin tablets for Resident E, when there were only 28 tablets.

The panel therefore found charge 3c proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Lawrence's 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 ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Ms Girven 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 Girven identified the specific, relevant standards where Mrs Lawrence's actions amounted to misconduct. She referred to paragraphs 1.2, 3.1, 8.6, 10.1, 10.2, 10.3, 10.4, and 18.2 of the Code.

In relation to charge 1a, Ms Girven submitted that Mrs Lawrence gave medication to Patient A when this was not clinically justified. She submitted that this is a serious concern and drew the panel's attention to the reported impact of Patient A, specifically Patient A becoming lethargic and the increase in his falls.

In relation to charges 1b to 1d, Ms Girven submitted that Mrs Lawrence failed to record medication on the MAR chart which put Patient A at risk of harm. She submitted that record-keeping is a fundamental tenet of nursing.

In relation to charge 1e, Ms Girven submitted that Mrs Lawrence failed to make accurate records within Patient A's progress notes. She submitted that this failure had an adverse impact as the staff at the Care Home 1 were unaware that Patient A was behaving in the way he was.

In relation to charge 1g, Ms Girven submitted that, as a registered nurse, it is important to follow protocols provided when administering medications to a patient.

In relation to charge 2a, Ms Girven submitted that Resident B's dose of Paracetamol had changed due to her weight loss. As such, she submitted that it is important for a registered nurse to record the correct medication, which Mrs Lawrence failed to do as she made an incorrect record on Resident B's MAR chart.

In relation to charge 3c, Ms Girven submitted that by Mrs Lawrence incorrectly counting and recording the stock of Resident E's medication, Resident E could have been deprived of her medication.

Ms Girven therefore submitted that the charges found proved collectively and individually amount to misconduct.

Submissions on impairment

Ms Girven 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).

Ms Girven submitted that Mrs Lawrence's fitness to practise is impaired on both grounds of public protection and public interest.

Ms Girven first referred to the NMC's guidance on impairment, in particular: *'Can the nurse practise kindly, safely and professionally?'*. She submitted that this is not the case for Mrs Lawrence. She then referred to *Cohen* and submitted that the concerns are remediable as they relate to clinical concerns and medication management.

However, Ms Girven submitted that there is lack of substantial insight from Mrs Lawrence at this stage. Ms Girven referred the panel to the Proceeding in Absence bundle which contains emails from Mrs Lawrence indicating that she does, informally, accept some concerns relating to charge 1. Ms Girven submitted that as Mrs Lawrence's insight does not go further than this, her insight is limited. Further, she submitted that Mrs Lawrence has lack of insight regarding charges 2 and 3.

In relation to strengthening practice, Ms Girven submitted that there are some training certificates in Mrs Lawrence's Response bundle. However, Ms Girven submitted that there is still a risk of repetition as these certificates were completed after the Care Home 1 incidents but prior to the Care Home 2 incidents.

Ms Girven submitted that the first three limbs of Dame Janet Smith's "test" are engaged. She submitted that Mrs Lawrence has put patients at risk of harm, that her actions brought the profession into disrepute, and that medication administration and record keeping are fundamental tenets of nursing, both of which she breached.

Ms Girven acknowledged that Mrs Lawrence makes it clear that she does not wish to return to nursing. However, she submitted that a finding of impairment is still required on both grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mrs Lawrence's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Lawrence's actions amounted to breaches of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *…*
>
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> *…*
>
> ***8 Work co-operatively***
>
> *To achieve this, you must:*
>
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> *8.5 work with colleagues to preserve the safety of those receiving care*

8.6 share information to identify and reduce risk

…

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:

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

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

10.3 complete records accurately … taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

…

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

To achieve this, you must:

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

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

In relation to charge 1a, the panel noted that Mrs Lawrence was an agency nurse who had worked at Care Home 1 from around 2014. As such, the panel determined that Mrs Lawrence should have been fully aware of the PRN protocol and yet gave 1mg of Lorazepam when it was not clinically justified. Her failure to follow the PRN protocol placed Patient A at risk of harm and indeed Patient A was noted as lethargic on the following days. It also noted that Mrs Lawrence admitted that she did not provide the expected standards of care to Patient A. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 1b, the panel determined that Mrs Lawrence's failure to record the reasoning behind administering an additional 1mg of Lorazepam to Patient A resulted in colleagues being unaware of Patient A's presentation at that time and the rationale for its use. This was important as it would not allow for ongoing reviews of Patient A's treatment plan. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 1c, the panel determined that Mrs Lawrence failed to record the timing of medication administration for Patient A which put him at risk. Accurate records of medication timing are crucial for colleagues to determine when the next dose is required and also for patient observation. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 1d, the panel determined that Patient A's PRN protocol clearly stated that the effects of administering Lorazepam should be recorded. However, Mrs Lawrence

failed to document this. Patient A did become lethargic later, and it would have been important to note this in order for other staff to be alert to the risk of falls. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 1e (in its entirety), Mrs Lawrence failed to record important information that would help those treating Patient A to know if the medication had been effective or needed altering in some way. The panel determined that this placed Patient A at risk, as his treatment was not reviewed or monitored properly due to Mrs Lawrence failing to update his progress notes or reporting this to staff in Care Home 1. Other patients were also placed at risk as Mrs Lawrence failed to note that Patient A was entering their rooms and taking their belongings. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 1g, the panel determined that Patient A's PRN protocol was clear, and that Mrs Lawrence failed to follow it. Mrs Lawrence ignored the instructions on the document without clear reasons for this and instead she took a colleague's advice to give 1mg of Lorazepam as opposed to 0.5mg as set out in the PRN protocol. The panel determined that Mrs Lawrence would have been aware of the PRN protocol being in place and the importance of following it. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 2a, the panel determined that, as a result of Mrs Lawrence's failure to follow Resident B's prescription, she made an inaccurate record in her MAR chart resulting in her being administered too much Paracetamol. Too much of this medication could have caused Resident B harm. Mrs Lawrence was a Clinical Lead at the time and should not of made such an entry on Resident B's MAR chart and this misled colleagues who went on to administer too much Paracetamol to Resident B over a number of days. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

In relation to charge 3c, the panel determined that Mrs Lawrence's recording of the incorrect quantity of Pregabalin tablets could have caused problems within Care Home 2

and created additional work for other staff members and a risk to Resident E. The panel determined that Mrs Lawrence should have understood the importance of being careful when counting controlled drugs and, as in charge 2a, particularly as a Clinical Lead. Therefore, Mrs Lawrence's actions in this charge amount to misconduct.

The panel therefore found that Mrs Lawrence's actions, in charges 1a, 1b, 1c, 1d, 1e (in its entirety), 1g, 2a and 3c, did individually and collectively fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Lawrence's 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) ...'*

The panel found that patients and residents were put at a risk of harm as a result of Mrs Lawrence's misconduct. Mrs Lawrence's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Lawrence made some admissions in relation to charge 1 and she acknowledged that she did not provide the expected level of care to Patient A. The panel had no evidence of insight or reflection in relation to charges 2a and 3c. As such, it considered that Mrs Lawrence's overall insight and understanding as to how her actions put Patient A, Resident B, and Resident E at risk of harm was very limited.

Further, Mrs Lawrence has not sufficiently demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession, nor has she demonstrated how she would handle the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed through training and supervision in a supportive environment. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Lawrence has taken steps to strengthen her practice. The panel took into account the training that Mrs Lawrence undertook in 2021 relating to the safe administration of medicines, record keeping, and safeguarding of vulnerable adults. However, it noted that this training was completed after the incidents in Care Home 1 occurred but prior to the incidents in Care Home 2. It was not provided with evidence of any further training from Mrs Lawrence since 2021 as she appears to have left nursing.

The panel was of the view that there is a real risk of repetition if Mrs Lawrence chose to return to nursing as she has not demonstrated sufficient insight having placed Patient A, Resident B and Resident E at risk of harm.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore decided that Mrs Lawrence's fitness to practise is impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Lawrence's fitness to practise is currently impaired.

Sanction

The panel decided to make a conditions of practice order for a period of 12 months with review. The effect of this order is that Mrs Lawrence's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

In reaching this decision, the panel 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 Girven informed the panel that in the Notice of Hearing, dated 7 March 2024, the NMC had advised Mrs Lawrence that it would seek the imposition of a suspension order for a period of 12 months if it found Mrs Lawrence's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a conditions of practice order is more appropriate in light of the panel's findings.

In relation to aggravating features, Ms Girven submitted that the following are engaged:

- There is a pattern of medications errors over a period of time between two care homes with a two-year gap.
- Mrs Lawrence's conduct put patients at risk of harm.
- Mrs Lawrence has very limited insight.

In relation to mitigating features, Ms Girven submitted that the following are engaged:

- Mrs Lawrence made some admissions regarding charge 1 and recognised failures regarding Patient A.
- Mrs Lawrence completed some training that predates Care Home 2's incidents.

Ms Girven submitted that the imposition of either no order or a caution order would be inappropriate in light of the panel's findings. She submitted that a suspension order or striking-off order would be wholly inappropriate.

Ms Girven submitted that there is no evidence of deep-seated attitudinal problems at this stage. She submitted that the concerns solely relate to medication management and record keeping. Despite the concerns raised over the two homes, Ms Girven submitted that there does not appear to be evidence of general incompetence.

Ms Girven submitted that Mrs Lawrence is not currently engaging with the NMC as she has made it clear that she does not wish to return to nursing. However, she said that it is still necessary to place restrictions on Mrs Lawrence's practice in order to protect the public and it was also in the public interest to do so.

Ms Girven said that despite Mrs Lawrence's limited insight, it is possible to formulate conditions to protect the public. She informed the panel that Mrs Lawrence has been under an interim conditions of practice order and provided it with the conditions that are currently in place.

Ms Girven submitted that is for the panel to decide on the length of order. However, she suggested that a period of 12 months would allow an opportunity for Mrs Lawrence to engage.

Additionally, Ms Girven submitted that the next panel would be assisted by confirmation from Mrs Lawrence as to whether she will return to nursing, evidence of training, and a reflective statement.

Decision and reasons on sanction

Having found Mrs Lawrence's 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:

- There has been a pattern of errors (relating to both medication and record keeping) which occurred in two different care homes over a two-year period.

- Mrs Lawrence's actions and omissions put three vulnerable patients/residents at risk of harm.
- There has been limited evidence of Mrs Lawrence's insight.

The panel also took into account the following mitigating features:

- Mrs Lawrence has demonstrated some insight in relation to charge 1.
- Mrs Lawrence undertook some training in 2021 after the Care Home 1 incident.
- The panel heard from Witness 4 that Mrs Lawrence had many positive attributes as a nurse including doing 'more than asked to' and that she was 'helpful'.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Lawrence's 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 Mrs Lawrence's 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 Mrs Lawrence's 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;*
- *No evidence of general incompetence;*
- *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 there was no evidence of harmful deep-seated personality or attitudinal problems nor of general incompetence. The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case and that would protect patients and the public. In relation to Mrs Lawrence's potential and willingness to respond to retraining, the panel noted communication from Mrs Lawrence to the NMC in March 2024 suggesting she may want to apply for voluntary removal. However, in October 2023, an email from Mrs Lawrence stated:

> *'I won't be returning to nursing anytime soon'.*

The panel was of the view that there is a possibility that Mrs Lawrence may engage with the NMC and want to return to nursing.

The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Lawrence should be able to return to practise as a nurse should she wish to.

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

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Lawrence's case in light of its earlier findings.

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) When employed as a registered nurse, you must ensure that this is with a single substantive employer, or alternatively for one nursing agency that will allocate you to a single place of work for a minimum period of three months to ensure consistency of supervision.

2) You must ensure that you are directly supervised by another registered nurse at all times that you are involved in the administration or management of medication until assessed as competent to do so without supervision. Evidence of this assessment must be sent to the NMC within 7 days of completion.

3) You must not be the nurse in charge of any shift.

4) You must meet monthly with your line manager/mentor/supervisor to discuss your practice, learning and progress in relation to:
    a) Medicines administration and management.
    b) Record keeping.

5) Prior to any review hearing you must provide a report from your manager/mentor/supervisor outlining your learning and progress in relation to:
    a) Medicines administration and management.
    b) Record keeping.

6) You must keep the NMC 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.

7) You must keep the NMC 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.

8) 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.

9) 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.

10) 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 to allow Mrs Lawrence time to decide whether she wants to return to nursing and if so, to secure employment.

Should Mrs Lawrence achieve all of the requirements listed above in a lesser period, she may apply to the NMC for review earlier than 12 months.

Before the order expires, a panel will hold a hearing to review Mrs Lawrence's progress and compliance 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:

- Confirmation of Mrs Lawrence's future plans.
- A reflective statement addressing the impact her actions, as described in the charges found proved, had on patients, colleagues, the profession, and public confidence; insight/reasons into why she did what she did; and how she would avoid repeating the same mistakes.
- Evidence of relevant training in medicines management and record-keeping.
- Testimonials from managers in either nursing or non-nursing roles.

This will be confirmed to Mrs Lawrence in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel 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 Mrs Lawrence's 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 Girven. She submitted that an interim conditions of practice order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest.

Ms Girven submitted that this was required to cover the 28-day appeal period and, if Mrs Lawrence does appeal the decision, the period for which it may take for that appeal to be heard.

Decision and reasons on interim order

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

The panel concluded that 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 the 28-day appeal period and any period which an appeal may be heard.

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 Mrs Lawrence is sent the decision of this hearing in writing.

That concludes this determination.