Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 September 2023 – Tuesday, 12 September 2023
Thursday, 2 November 2023
Thursday, 14 March 2024 – Friday, 22 March 2024

Virtual Hearing

Name of Registrant:	June Haines
NMC PIN	87Y0121W
Part(s) of the register:	Registered Nurse – Adult Nursing RN2 – December 1989 RN1 – July 1999
Relevant Location:	Merthyr Tydfil
Type of case:	Misconduct/Lack of Competence
Panel members:	David Evans (Chair, lay member) Mary Karasu (Registrant member) Richard Bayly (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Clara Federizo
Nursing and Midwifery Council:	Represented by Rebecca Paterson, Case Presenter
Ms Haines:	Present and represented by Sharmistha Michaels, of counsel
Facts admitted:	Charges 2a-c, 4c(ii), 4c(iii), 4d, 13b, 14a(i), 15a, 15b, 15c, 18a-18f and 20a-20c
No case to answer:	Charges 4c(i), 14b, 14c, 14d, 15d, 16 and 19f
Facts proved:	Charges 1a-c, 3a-c, 4a-b, 8a-b, 9a, 11a, 12a-b, 14a(ii), 14a(iii), 17a-b, 18g, 19a-e

Facts not proved:	Charges 5, 6, 7a(i), 7a(ii), 7b-c, 9b-c, 10a-d, 11b-c, 13a and 17c
Fitness to practise:	Impaired by reasons of misconduct, but not by reasons of lack of competence
Sanction:	**Caution order (24 months)**

Details of charge

That you, a Registered Nurse:

1) On one or more of the following dates incorrectly administered one furosemide tablet to Resident I, instead of 2 tablets as prescribed:

a) 29 June 2019 **[PROVED]**
b) 30 June 2019 **[PROVED]**
c) 4 July 2019 **[PROVED]**

2) On one or more of the following dates you incorrectly administered one tablet of spironolactone to Resident I, instead of half a tablet as prescribed:

a) 29 June 2019 **[ADMITTED]**
b) 30 June 2019 **[ADMITTED]**
c) 4 July 2019 **[ADMITTED]**

3) On one or more of the following dates while administering medication to Resident I did not review the relevant MAR Chart/Medication box:

a) 29 June 2019 **[PROVED]**
b) 30 June 2019 **[PROVED]**
c) 4 July 2019 **[PROVED]**

4) Between 1 June 2019 to 31 July 2019/On or around 6 June 2019;

a) Did not encourage Resident C to eat/complete their breakfast/carbohydrates. **[PROVED]**
b) Did not check on Resident C after they had failed to eat their breakfast. **[PROVED]**
c) Following Resident C suffering low blood sugar/a hypoglycaemic attack, did not;

i. Check Resident C's blood glucose levels; **[NO CASE TO ANSWER]**

ii. Provide orange juice/Lucozade to Resident C. **[ADMITTED]**

iii. Provide glucose tablets/jelly babies to Resident C. **[ADMITTED]**

d) Were unable to demonstrate knowledge of how to use a glucagon syringe. **[ADMITTED]**

Whilst subject to a performance improvement plan

5) On or before 23 September 2019 did not document that you had administered a PRN medication. **[NOT PROVED]**

6) On or before 23 September 2019 did not inform Colleague A that an unknown carer had left the home whilst on duty. **[NOT PROVED]**

i)

7) On or before 18 December 2019 you:

a) On one or more occasion omitted detailed/vital information from care plans in that you;

i. Failed to record that an unknown resident required a spoon/plate guard for assistance. **[NOT PROVED]**

ii. Failed to record consent from residents before undertaking personal care/tasks. **[NOT PROVED]**

b) Did not know where to order PEG feed from; **[NOT PROVED]**
c) Did not ask your colleagues about the origin of the PEG feed. **[NOT PROVED]**

8) On or before 14 January 2020 failed to record In Resident H's care plan that:

a) They could only use one hand to feed themselves; **[PROVED]**
b) Their weight had increased. **[PROVED]**

9) On or before 14 January 2020 failed to record within an unknown patient care plan that they;

a) Had a BMI of 13; **[PROVED]**
b) Were under the care of a dietician; **[NOT PROVED]**
c) How to promote a healthy weight gain. **[NOT PROVED]**

10) On or before 14 January 2020 did not record within an unknown patient care plan:

a) Details about oral care; **[NOT PROVED]**
b) Other preferences of the unknown patient; **[NOT PROVED]**
c) How their privacy and dignity was to be upheld; **[NOT PROVED]**

d) Patients consent. **[NOT PROVED]**

11) On or before 14 January 2020 did not provide the required detail within care plans as you:

a) Did not describe if there had been choking incidents; **[PROVED]**
b) Did not provide detail of any weight gain and / or weight loss; **[NOT PROVED]**
c) Did not record if an unknown resident was able to independently feed themselves. **[NOT PROVED]**

12) On or before 14 January 2020 you:

a) did not re catheterise Resident G; **[PROVED]**
b) did not order more catheters. **[PROVED]**

13) On or before 14 January 2020 you did not:

a) alter care plans when residents began and / or changed supplements; **[NOT PROVED]**
b) Complete wound assessments for new wounds. **[ADMITTED]**

14) On 8 February 2020 when caring for Resident D:

a) did not check and / or record;

i. temperature; **[ADMITTED]**
ii. blood pressure; **[PROVED]**
iii. pulse rate; **[PROVED]**

b) did not ask if Resident D was in pain; **[NO CASE TO ANSWER]**
c) did not document that they had contacted an out of hours General Practitioner; **[NO CASE TO ANSWER]**
d) Did not notify colleague A and / or Colleague B that Resident D needed antibiotics collected from the pharmacy. **[NO CASE TO ANSWER]**

15) Between 1 February 2020 to 29 February 2020 whilst caring for Resident E you:

a) Administered thickener in Resident E's drink without any clinical justification; **[ADMITTED]**

b) Did not document your reasoning/rationale for making the decision to administer thickener in their drink in Resident E's medical records; **[ADMITTED]**
c) Did not seek advice from a General Practitioner before administering the thickener in Resident E's drink; **[ADMITTED]**
d) Did not request a referral to a speech and language therapist for a swallowing evaluation. **[NO CASE TO ANSWER]**

16) Between 1 February 2020 to 29 February 2020 you did not check Resident G temperature. **[NO CASE TO ANSWER]**

17) On or before 17 February 2020, within one or more care plans, they:
ii)
a) Were not person centred; **[PROVED]**
b) Did not include detailed documentation and / or information **[PROVED]**
c) Were not accurate **[NOT PROVED]**

18) On or before 6 March 2020, after assessing Resident B skin tear :

a) Did not complete an incident report; **[ADMITTED]**
b) Did not document your rationale for not applying a dressing; **[ADMITTED]**
c) Did not notify their next of kin; **[ADMITTED]**
d) Did not complete a wound assessment chart; **[ADMITTED]**
e) Did not photograph the wound; **[ADMITTED]**
f) Did not complete a care plan; **[ADMITTED]**
g) Did not notify management that the injury occurred during moving and handling of Resident B. **[PROVED]**

19) Between 4 - 7 March 2020 after Resident A was found with the call bell around their neck you:

a) Did not check for/complete a risk assessment; **[PROVED]**
b) Did not check for/complete an incident form; **[PROVED]**
c) Did not check for/record the incident within a care plan; **[PROVED]**
d) Did not check for/record accurate details about the suspected self-harm and / or record comments about their mood and / or behaviour; **[PROVED]**
e) Did not record in their progress notes that you had instigated 15 minute checks and / or carried out 15 minute checks; **[PROVED]**
f) Did not contact a General Practitioner and / or a psychiatrist for Resident A. **[NO CASE TO ANSWER]**

20) On 24 December 2021 you messaged Colleague B, words to the effect of:

a) "*I don't know how you can sleep at night what you done to me"* **[ADMITTED]**
b) *"well you could of told the truth"* **[ADMITTED]**
c) *"you have ruined my career something I have worked hard for, but you did liar and it will be proven"* **[ADMITTED]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in respect of charges 1 – 19, and by reason of your misconduct in respect of charge 20.

Application for special measures in accordance with Rule 23

Ms Paterson, on behalf of the Nursing and Midwifery Council (NMC), invited the panel to provide for special measures when Witness 2 gave evidence. She referred the panel to the telephone note, dated 4 September 2023, which outlined Witness 2's request for breaks during her evidence [PRIVATE]. Witness 2 also requested for camera arrangements to enable her to give evidence without seeing you on screen, as she feels she would be under too much pressure.

Ms Paterson submitted that measures were required to enable Witness 2 to provide her best evidence as Witness 2 feels that seeing you on screen will impact the quality of her evidence. This application was made in accordance with Rule 23(1)(d) of the Fitness to Practice Rules (the Rules) in cases of a vulnerable witness.

Ms Michaels, on your behalf, opposed this application.

The panel accepted the advice of the legal assessor.

[PRIVATE]. The panel was satisfied that the use of special measures was required and accepted the NMC's application in relation to the first adjustment of breaks during evidence. However, the panel was not satisfied [PRIVATE] that it required your camera to be switched off during her evidence. The panel determined there may be an element of unfairness to you if it were to allow this without sufficient information to meet the criteria.

The panel accepted the application for the first measure request [PRIVATE]. It refused the application for the second measure of turning off your camera during Witness 2's evidence.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Paterson under Rule 31 to allow the written statement of Colleague B and relevant exhibits into evidence. Colleague B was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, she has not attended. Ms Paterson submitted that her evidence is highly relevant, and it would be fair to admit into evidence.

The panel was provided with documentation of all communication between the NMC and Colleague B, the Home Manager at the Beeches Care Home. The panel noted that Colleague B currently resides outside of the United Kingdom and considered the possible difficulties of being able to attend the hearing due to the significant time differences. It also noted that Colleague B's last communication with the NMC was on 24 January 2023 and had not responded since to subsequent communications (emails and telephone calls) from the NMC.

Ms Paterson outlined for the panel that the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) sets out that where sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the panel to make a careful assessment, weighing up the competing factors. She submitted that most of Colleague B's evidence is neither sole nor decisive and the panel can fairly admit the evidence as it is corroborative in nature. She referred the panel to the case of *Ogundele v Nursing and Midwifery Council* [2013] EWHC 248, no issue was found with the NMC relying on hearsay evidence where the case was demonstrating a pattern of conduct.

Ms Paterson asserted that there were only two charges where the evidence is sole or decisive and these are charges 15 and 20, both of these are largely admitted. Consequently, it would be entirely appropriate to admit the evidence in support of those admitted charges. She also submitted that the evidence of Colleague B is demonstrably reliable and there are means of testing its reliability, as the exhibited records of meeting have been signed by you and Colleague B, and Resident D's notes support these. The witness statement is also signed by Colleague B and includes a statement of truth.

Ms Paterson submitted that reliability can be tested against other evidence, such as, Colleague B's statement regarding a duty to make a referral was supported by Witness 4 in her oral evidence, and therefore can be admitted as it is not the sole or decisive evidence.

Ms Paterson highlighted that at this stage the panel is only deciding whether or not the evidence is admissible, and that doing so does not determine the weight to be attached. The panel will undertake this balancing exercise at a later stage.

Ms Paterson submitted that if the panel considers parts of the documentation sole or decisive, she invited it to consider that the evidence is still admissible because it is either demonstrably reliable or there is some means of testing its reliability. She submitted that should the panel find some evidence to be inadmissible, then she proposed it consider the alternative of redacting these specific parts.

In response, Ms Michaels opposed the application and submitted that Colleague B's evidence and exhibits should be excluded in its entirety. She submitted that this evidence is not only sole or decisive evidence in relation to some of the charges but also that it is not demonstrably reliable as there are clear conflicts in the evidence between her account and Witness 1, and if it were to be admitted, this would not be capable of being tested in cross-examination.

Ms Michaels explained the background to the case and submitted that Colleague B is relied upon for the bulk of the allegations. She explained that the exhibits include supervision records, statements on competencies relating to administering medication and progress, Performance Improvement Plan (PIP) and assessments on competency for care plans. She invited the panel to consider whether it would be fair to admit this hearsay evidence if it cannot be challenged. She referred the panel to the cases of *White v Nursing and Midwifery Council* [2014] EWCA 520 (Admin) and *R (on the application of SS (Sri Lanka)) v Secretary of State for the Home Department* [2018] EWCA Civ 1391.

Ms Michaels submitted that the evidence of Colleague B is the sole or decisive evidence of some of the regulatory concerns alleged. She outlined that the panel has not been provided with MAR charts, care plans or patient records. Further, she submitted that there are inconsistencies in Colleague B's statement, such as that you were 'suspended' when Witness 1 stated in her oral evidence that you were 'put on administrative duties'. Ms Michaels also outlined that the oral evidence of Witness 6 appears to acknowledge the targeting of you and the managers of the home were taking action to rectify the poor practise that developed generally under their leadership. She submitted that Colleague B's evidence is contradictory as opposed to corroborative of other evidence the panel has before it.

Ms Michaels submitted that there is no clear or cogent reason for Colleague B's non-attendance and that the duty to co-operate in these proceedings under the Code does still apply to former Registrants. Further, Ms Michaels submitted that the record of communications with Colleague B seem to suggest that she indicated that she was unlikely to give evidence in person as far back as June 2022. She outlined that there had been no response from Colleague B since January 2023.

Earlier this year there was a case management meeting in respect of this case. At that meeting there was no suggestion from the NMC that Colleague B might be a reluctant witness and until this week, Ms Michaels and you expected Colleague B to be attending to give evidence and be available for cross-examination.

Ms Michaels submitted that none of the evidence of Colleague B can be fairly admitted in the circumstances of this case and would prejudice you in these proceedings.

In response, Ms Paterson made it clear for the panel that Colleague B's evidence is not relied on for all of the charges, only from charges 5 to 13. She also urged the panel to approach the evidence of Witness 6 (that you were being targeted) with caution, she outlined that this is speculative, and he cannot conclusively tell the panel what Witness 1 and Colleague B were thinking at the time.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor referred the panel to relevant case law, namely, *Thorneycroft v NMC* [2014] EWHC 1565, *NMC v Ogbonna* [2010] EWCA Civ 1216 and *R (Bonhoeffer) v GMC* [2011] EWHC 1585 (Admin).

The panel gave the application in regard to Colleague B serious consideration. The panel noted that Colleague B's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by Colleague B. However, the panel noted the guidance that the admission of the statement of an absent witness should not be regarded as a routine matter and the rules require the consideration of fairness before admitting the evidence. Further, the fact that the absence of the witness can be reflected in the weight to be attached to their evidence it is a factor to weigh in the balance but will not always be a sufficient answer to the objection to admissibility.

The panel considered whether it would be fair to all parties to accept the change in the NMC's position of moving from reliance upon the live testimony of Colleague B to that of

allowing hearsay testimony into evidence. There was no dispute that Colleague B's evidence was relevant.

The panel concluded that it would not be fair to admit the hearsay evidence of Colleague B. This evidence would not be confirmed true under oath and cannot be tested in cross-examination and panel questions. The panel determined this to be key to the fairness in these proceedings, particularly as there are some inconsistencies in the evidence of Colleague B and that of other witness' oral and written evidence.

The panel noted that Colleague B was the care home manager and one of the main witnesses to many of the charges, and therefore, a key witness.

The panel concluded that although reliability may be tested against other evidence, it would be unfair to admit the evidence without the opportunity for further questioning. The panel would have asked a number of questions to test Colleague B's evidence, for example: competency and supervision documents, how staff were managed, how performance was managed, the training and induction provided, the internal investigation, the suggestion of bullying in the workplace or that you were being treated differently from other nurses.

Further, the panel noted that Colleague B is not present and there would appear to be no good or cogent reason for her non-attendance. The panel had particular regard to the email of 20 June 2022 from Colleague B, which highlighted to the NMC the difficulty that she would have in attending the hearing due to work commitments.

The panel also took into account that you and your counsel were only alerted to the fact that Colleague B might not attend earlier this week after the hearing had commenced. The panel also noted that no reference to Colleague B seeming reluctance to attend was made at the case management meeting.

The panel also took into account the seriousness of the charges to which this witness gives key evidence and the potential adverse impact on you should they be found proved. After careful assessment, weighing up all the competing factors the panel found that to allow this evidence to be admitted, without the opportunity for it to be tested under cross-examination, would be unfair.

In these circumstances the panel refused the application.

Submissions on application of no case to answer

The panel considered an application from Ms Michaels that there is no case to answer in respect of charges 1, 3, 4a, 4b, 4c(i), 5, 6, 7, 8, 9, 10, 11, 12, 13a, 14a(ii), 14a(iii), 14b, 14c, 14d, 15d, 16, 17, 18g and 19. This application was made under Rule 24(7) and 24(8).

In relation to this application, the panel had regard to Ms Michaels' submissions, which set out:

> *"1. This is an application under rule 24(7) and 24(8) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004. The Registrant argues that there is no case to answer on the factual charges that are not admitted under (rule 24(7)), or on the overarching allegation that her fitness to practice is impaired (rule 24(8)by reason of the statutory grounds of lack of competence (Charges 1-19) or misconduct (Charge 20).*
>
> *2. It is submitted that the NMC have failed to discharge the burden of proof in relation to the outstanding charges and as a consequence it is submitted on behalf of the Registrant that the case should not proceed further.*
>
> *3. The Panel is asked to consider the following documents:*
> *(a) Evidence Matrix (amended)*
> *(b) Exhibit 1 and Exhibit 2 (Witness bundle and Exhibits bundle).*

LEGAL PRINCIPLES

4. In the case of R v Galbraith [1981] 2 All ER 1060, Lord Lane CJ stated:

> *'How then should the judge approach a submission of 'no case'? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the Crown's evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. (b) Where however the Crown's evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. It follows that we think the second of the two schools of thought is to be preferred.'*

5. In R (on the application of Dr Tutin) v General Medical Council [2009] EWHC 553 (Admin), McCombe J (as he was then) considered the application of the Galbraith test to regulatory proceedings. McCombe J cited with approval the case of Shippey [1988] Crim LR 767. In the commentary on Shippey Professor JC Smith stated:

> *'It is quite clear that the case must not be withdrawn from the jury merely because the judge thinks that the principal prosecution witnesses are not telling the truth. That would be to usurp the function of the jury. It is arguably different, however, though the difference is one of degree, if the judge thinks that no reasonable jury could find that the prosecution witnesses are telling*

the truth. If that is truly the case, then there is no point in leaving the case to them, for (in the absence of damaging evidence appearing during the case for the defence) the jury, which we must assume to be a reasonable jury, would inevitably acquit.'

6. McCombe J approved of advice given to the panel in Tutin in the following terms:

a. *Was there any evidence before the Panel upon which it could find that matter proved? The Panel resolved that if there was no evidence of any particular fact, then it would allow [the submission of no case to answer].*
b. *Was there some evidence, but of such an unsatisfactory character that the Panel, properly directed as to the burden and standard of proof, could not find the matter proved? If so, the Panel would allow [the submission of no case to answer].*
c. *Was there some evidence, the relative strength or weakness of which was dependent upon the Panel's view of the reliability of a witness? In such circumstances the Panel determined that it would consider the issue of the strength or weakness of the evidence at this stage. Only where the Panel found that the witness' evidence is reliable in respect of the allegation in question has it concluded that that fact is capable of being proved to the criminal standard and only in such circumstances has the Panel allowed [the allegation to proceed past half time].*

7. So far as those parts of charges 1(a),(b),(c),3,4(a),(b),(c)(i),12,14,16,17,18,19 are concerned this application is made under limb (2) of the Galbraith test, namely that the evidence that has been called is of such a tenuous character [emphasis added] that a properly directed panel could not find the allegations proven.

8. So far as charges 5 and 6,7,8,9,10,11 and 13(a),15(d) are concerned, the application is made under limb (1) of Galbraith as there is no evidence [emphasis added] in relation to these matters. Further detail is provided below in relation to each of the charges. If the Panel were to find that there is some evidence in relation

to these charges then it is respectfully submitted that the Panel should go on to consider the evidence presented in relation to these charges under limb (2) of Galbraith namely, that any evidence that has been adduced is tenuous in character.

[Witness 1]'s credibility

9. The NMC's entire case is predicated on the Panel accepting the evidence of [Witness 1]. The NMC's their amended evidence matrix relies on the evidence of [Witness 1] for charges 1,2,3,4,5,6,7,8,9,10,11,12,13,14,16,17,18,19. I

10.It is accepted that witness credibility/reliability is generally a 'jury question' and therefore not normally a matter for a submission of no case. However, as Shippey and Tutin confirm, where a witness's evidence is shown to be intrinsically unreliable, a case can be dismissed on a submission of no case to answer.

11.It is submitted that [Witness 1]'s credibility and reliability are proper matters for consideration at this stage. [Witness 1] is the only person who can give evidence about the majority of the allegations, she states she was in charge of the Registrant's PIP, carried out the competency assessments with [Colleague B] although she failed Ms Haines. It is averred that [Witness 1]'s evidence was lacking in credibility:

a. *Before the NMC's FTPC [Witness 1] in April 2023 was found to be impaired in relation to her fitness to practise on relation to," Between 12 June 2020 and 22 June 2020 failed to amend Resident A's insulin dose on the MAR chart following a review by the GP and advanced nurse practitioner ." The allegation was from her time as Deputy Home manager at the Beeches home. She was referred by the Home Manager who had replaced [Colleague B]. Although she is retired, it is of note that the Panel in the knowledge of this said that, "[Witness 1] had not recognised her failings in respect of Resident A and continued to deflect blame. Furthermore, the panel noted that it had no evidence of reflection from [Witness 1]." [Witness*

1] is currently under a conditions of practise order. She is not a witness of good character.

b. *More than that, her character in relation to these specific events has been found lacking given the evidence you have heard from [Witness 3] who gave evidence in relation to Resident A and [Witness 1]'s behaviour towards her. [Witness 2] regarding [Witness 1]'s treatment of the Registrant and lack of support as well as the evidence of [Witness 6] in terms of focusing blame on the Registrant for Resident A and treating others involved differently. It may be averred that she held the Registrant to a higher standard than other members of staff,*

c. *[Witness 1] at times during her evidence which the Panel will recall was vague she said due to passage of time. She stated that the Registrant would have had an induction, but that was not her responsibility rather [Colleague B]. The Panel are aware from [Witness 4] there were issues around induction at the home generally.*

d. *[Witness 1]'s evidence was contradictory and inconsistent. The account she gave in her witness statement was inconsistent with her evidence to Panel particularly when taken to exhibits. She drafted her statement as did all witnesses without access to the MAR charts, patient care plans, Given the way in which [Witness 1]'s evidence evolved through the course of her cross-examination, it cannot be safely relied upon in any meaningful way. Absence of Key Documentary Evidence*

12.Given that this majority of the charges relate to lack of competence charges the Panel has not been provide with any care plans or all of the relevant resident notes. The audit of the care plans conducted by [Witness 4] is not available. None of the witnesses were provided with these care plans prior to the writing of their witness statements. The Panel has not been provided with any evidence of induction or

training at the Beeches Care Home. The Panel have quite properly excluded the witness statement and exhibits of [Colleague B] and therefore none of that documentation can be relied upon by the NMC this would include the PIP, various competency and supervision records.

Submissions on charges

Charges 1(a) (b) (c) and 3 (RESIDENT I)

13.In relation to Charges 1 and 3, the Panel will note that the Registrant has admitted Charge 2 on relation to spironolactone but not in relation to furosemide. The Panel will note that in her statement [Witness 1] refers to the medication lansoprazole, her statement dates back to 2021. Further that during her oral evidence she stated that at the time of making her statement she did not have sight of the MAR chart or patient records. In her evidence she suggested that she knew that the Registrant had not given the correct dose of Furosemide during the count of medication from the MAR chart, which she stated had shown the Registrant had only deducted one furosemide tablet. The Panel do not have the MAR chart for Patient I and cannot be certain that what is said by [Witness 1] is accurate. Certainly, [Witness 1] also got this wrong in her statement when she referred to the wrong medication. The Panel also do not have Resident I's progress notes or care plan.

14.The Panel will note that [Witness 1] exhibits a document at JL/03 from [Colleague B]. It is clear from this document that Ms Field formed her opinion on this incident from what she had been told by [Witness 1]. The Panel have not heard from [Colleague B] and this evidence can not therefore be tested and it is submitted that little weight can be given to this exhibit.

15.As with the majority of the NMC's case, this charge is predicated on the Panel accepting [Witness 1]'s version of events without seeing the MAR chart or patient care plans. For this and the reasons given previously [Witness 1]'s evidence cannot be relied upon as it is of such a tenuous nature.

Charge 4 (a) (b) (c)(i) (RESIDENT C)

16.It is submitted that the only evidence in support of this charge is comes from [Witness 1]. The Panel have also been referred in the evidence matrix for this charge to exhibits CM/01 and CM/04. The Panel will note that CM/01 is a patient record for Resident C. However, this record is not Ms Haine's record of the incident with Resident C but relates to a different incident on 6 June where [Witness 1] was involved and an ambulance had to be called for Resident C. This was confirmed by [Witness 1] in her evidence and her signature is at the bottom of the document. The Panel therefore have not been provided with the correct patient record for Resident C relating to the incident alleged in Charge 4. Therefore, save for those matters admitted, proving this allegation is once again predicated on the Panel accepting evidence from [Witness 1].

17.The Panel is invited to note that [Witness 1] did not see whether the Registrant had tried to encourage the Resident to have breakfast or that she left him with chocolate biscuits. Further that she accepted that Ms Haines could not have as alleged in Charge 4(c)(ii) and (iii), " Following Resident C suffering low blood sugar/ a hypoglycaemic attack" given orange juice/Lucozade or glucose tablets/jelly babies to Resident C, as she says he was fitting. The Panel will recall that when shown the Diabetic protocol (JL/01) [Witness 1] agreed that there was a risk of choking had the Registrant attempted to do so. Therefore, it is unclear where charge 4(c)(ii) and (iii) comes from given that it would not have been within the protocol to provide drinks or glucose when Resident C was fitting/unconscious.

18. Although Ms Haines admitted the fact that she did not give Resident C juice/Lucozade or glucose tablets/jelly babies she did so for those same reasons. The evidence suggests she went to get the glucagon syringe, which would be in line with the diabetic protocol. Whether she ran or not with the syringe is not relevant it is disputed by the Registrant that she was not timely in her response to Resident C's low blood sugar/hypoglycaemic attack. It is submitted that [Witness

1]'s evidence cannot safely be relied upon to support the outstanding part of Charge 4.

Charges 5,6,7,8,9,10,11,12 and 13a

19.As with the other charges these also rely on the Panel accepting [Witness 1]'s evidence. Her evidence cannot safely be relied upon for the reasons given above and in relation to these matters the absence of documentary evidence to support these. It is submitted that here is no evidence in relation to these matters or alternatively it is of such a tenuous nature that it can not be relied upon.

20.In relation to charges 5,6, 7,9, 10, these all relate to 'unknown patients' and no further detail could be provided by [Witness 1] in relation to these matters in her oral evidence. These charges are lacking in particulars. Some of these patients [Witness 1] notes in her evidence that she was made aware of from others for example in relation to PRN medication, unknown carer leaving the home. The NMC rely solely on her evidence in relation to these charges as set out in the evidence matrix (amended). There is no documentary evidence to support these charges, the supervision records provided are vague and provide limited or no detail about theses alleged concerns. It is impossible for the Registrant to respond to allegations properly where there is a failure to identify residents/patients and dates and a failure to provide care plans or patient records to substantiate it. In any event the burden is on the NMC to prove the allegation.

21.Similarly with charges 11,12, 13(a), 17 the Panel have not been provided with any care plans, MAR charts or any detail relating these unknown patients and again there is a failure to particularise these charges in any detail. Ms Haines admitted 13(b) on the as she presumed it referred to Resident B, but the Panel may think that 13(b) is an example of double charging given that there are no other residents mentioned or other examples provided where the Registrant failed to complete a wound chart, This failure to complete a wound chart has also been alleged at charge 18(d), which the Registrant has admitted in relation to Resident B.

22.In relation to Charge 12 it is the Registrant's case that she did catheterise Resident G that same day. This was put to [Witness 1] and not disputed although she noted it was after their discussion when that took place is unclear. Further it is not proved whose responsibility it would have been to order catheters and there is no evidence to suggest that the Registrant did not.

Charge 14

23.It is averred that this charge is misconceived. The progress notes for Resident D do not indicate that any call was made or that a call was required. Neither is there any evidence to suggest that any medication was required for collection given that a call had not been made based on the Registrant's clinical judgment. [Witness 2] in her evidence could not recall making the note in the progress notes regarding a call made to the GP by her, but [Witness 1] was clear that it was [Witness 2] who had told her of this incident and that the entry in the progress notes was signed by [Witness 2]. The Panel do not have Resident D's MAR chart so can not satisfy itself that there was medication for collection. The Panel are invited to find the evidence that has been called is of such a tenuous character that a properly directed panel could not find the allegations proven.

Charge 15 (d) (Resident E)

24.The Panel is reminded that the evidence that the NMC rely on is that of [Colleague B] which has been excluded by the Panel. Although the Registrant has admitted 15(a)(b)and (c) the Panel has heard no evidence in relation to the referral to the speech and language therapist. It is submitted that it does not follow that because Ms Haines has admitted 15(a)(b) and (c) that (d) should also be found proved. It is Ms Haines position that she did note this referral in the diary. For those reasons it is submitted that there is no evidence to support Charge 15(d).

Charge 16 (Resident G)

25.In relation to this matter the Panel heard from [Witness 1], who did not recall when this took place who notes (para 72 -73) she was on leave at the time and that [Colleague B] had reported it to her . The Panel do not have resident G's progress notes or further detail about this incident. The evidence is of a tenuous nature and can not be relied upon.

Charge 17 (unknown care plans)

26.In relation to this matter it is alleged that Ms Haines care plans were not detailed enough although it is accepted that the Panel has heard some evidence on this from [Witness 2] and [Witness 4] on this as well as [Witness 1], nonetheless none of this evidence is backed with the care plans, the audit of care plans and specific patient examples with relevant care notes. It is submitted that the evidence presented is tenuous in nature.

Charge 18(g) (Resident B)

27.The Panel can not be sure that the registrant did not notify senior management of this from the evidence heard from [Witness 1] alone. [Colleague B] is not providing evidence. [Witness 2] does not recall this incident despite [Witness 1] saying it was [Witness 2] who told her about it. The injury was documented in the progress notes and the Registrant accepts the majority of the charge. It is again submitted that the evidence for charge 18(g) is tenuous in nature and relies on [Witness 1]'s account

Charge 19 (Resident A)

28.The Panel heard evidence from [Witness 1] who was not present at the incident. The Registrant was also not there on the day of the day when Resident A was found with the call bell. [Witness 6] confirmed in his oral evidence that during the disciplinary telephone meeting he did not uphold this charge on the basis that the Registrant was being treated differently from others. There were two other nurses involved neither of them faced any consequences for failing to record the incident within the care plan (not that the Panel has seen the care plan). This charge is also

predicated on their being an obligation on the Registrant to do the incident form and risk assessment. The nurse on shift not complete any risk assessment or incident form, nor did they escalate the incident with the management. This was also the case for the night staff who handed over the Registrant. The evidence of [Witness 5] also indicates that she did not check if this had been done despite being present on the day, her response being that it not her responsibility what the nurses did. When [Witness 1] was asked why she had treated the Registrant differently from others her response was to blame it on being busy, lack of PPE, Corona virus and that she had spoken to the nurse who had handed over but did not do the paperwork. The evidence of [Witness 1] can not be relied upon and is tenuous for all the reasons given previously and in the absence of any corroborating evidence.

29.It is submitted that there is no case to answer on any of the remaining charges that are not admitted under (rule 24(7). There is insufficient evidence to substantiate the allegations, or the evidence is itself manifestly unreliable or discredited. The main evidence the panel has for the bulk of the charges is the unreliable evidence of [Witness 1]. [Witness 3] had noted [Witness 1] was difficult to work with and who [Witness 2] also noted that [Witness 1]'s " approach to things was a bit harsh sometimes. One occasions when she mentioned contacting the NMC I felt that more support was needed rather than that."

Rule 24(8) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004.

30.Finally, it is submitted that the remaining charges even if found proved could not lead to a finding of impairment on the grounds of lack of competence. It is submitted that the charges do not represent a fair sample of the Registrant's work, there was no patient harm. There was one isolated incident around medication in relation to spironolactone/

31.It is submitted that the Performance Improvement Plan was not run properly, and adequate support was not given by those running the PIP (See evidence of

[Witness 2]). [Witness 1] admitted to never having done one before but it being her responsibility. There was no action plan, no SMART targets were set for the Registrant to achieve, there was a lack of support, allegations of bullying, there were no induction and seemingly disagreements between [Witness 1] and [Colleague B] as to whether the Registrant was achieving any of the PIP. Further a disciplinary meeting that was linked to a grievance procedure for which the Panel have not been provided with the investigation report. It is unclear how much training Ms Haines or indeed any of the staff would have received in relation to these matters.

32.It is submitted that the Registrant was not provided with adequate support or guidance during the PIP and core issues around her competencies were disputed. For example, [Witness 1] states that despite the Registrant carrying out PEG training she failed her on this competency as she had been told by [Witness 2] that the Registrant did not know how to order PEG feed. [Witness 2] in her oral evidence denies having said this and notes that the Registrant did order PEG feed. [Witness 2] also stated when questioned by the Panel that any omissions or lack of detail in the care plan did not put patients at any risk of harm

33.It is submitted that not only do the allegations not represent a fair sample of the Registrant's work but also that the Panel do not have the documentary evidence which is required in order to support the statutory ground of lack of competence namely patient records and care plans. References are made to unknown residents and no detail has been provided. It is therefore submitted that impairment on the grounds of lack of competence could not be found proved.

34. The Registrant has no previous fitness to practise concerns and has been practising with no issues since she left the Home. It is submitted that the charges are not sufficiently serious to amount to the statutory ground of lack of competence.

35.In relation to the ground of misconduct (Charge 20) it is submitted that this charge was a single isolated incident in an otherwise unblemished career which was not repeated and is not sufficiently serious to amount to the statutory ground of misconduct.

36.In conclusion it is submitted that for all the reasons set out the burden of proof has not been discharged by the NMC and there is no case to answer in relation to the charges or any alleged impairment. It is submitted on behalf of the Registrant that the case should not proceed further."

In response, Ms Paterson submitted that NMC concede that in respect of charge 15d there is no evidence, and in respect of charge 16, the evidence is tenuous. She further submitted that there is sufficient evidence that the panel can look to and that there is a case to answer for the rest of the charges.

The panel had regard to Ms Paterson's submissions, which set out:

*"**SUBMISSIONS***

[Witness 1]' Credibility

6. Though it is acknowledged that a number of witnesses were critical of [Witness 1]' 'harsh' approach as Deputy Manager, this cannot be said to render her evidence 'intrinsically unreliable'. Additionally, it is submitted that the fitness to practise finding against [Witness 1], which amounts to a singular charge, is of limited relevance to her credibility as a witness as a whole.

7. In respect of paragraph 11c of the submissions on behalf of Ms Haines, the panel is reminded that at this stage it should not take into consideration matters which may form part of Ms Haines' case. There has been no positive evidence that Ms Haines herself did not undergo an induction and so this should not form part of the panel's consideration. It is not relevant to an assessment of [Witness 1]' credibility in any event.

8. The Panel has been referred to the case of R (on the application of Dr Tutin) v General Medical Council [2009] EWHC 553 (Admin). In this case, Ms A had made allegations of sexual misconduct against Dr Tutin. Ms A, 'had in many cases demonstrated an ability to report wide ranging sexual allegations against a number of people; she appeared to have her mind regularly on sexual matters and was fantasising in relation to these matters.' The complaints related back to incidents approximately 20 years prior. Ms A had also continued to take her own children to receive medical attention from the claimant, even after, as she alleged, acts of sexual misconduct had been committed towards her son and that she even took her daughter to see him when it was thought that she was a victim of sexual abuse by another person.

9. In his judgment, McCombe J, referring to the Tribunal's finding that there was a case to answer in relation to some of the charges:

> *[26] It seems clear to me that the Panel must have taken the view that, whatever the strength of the argument submitted, they did not at that stage go to undermine entirely Ms A's credibility. It is clearly open to a tribunal of fact to decide in respect of any witness whether it can accept all of its evidence, none of it or only some of it… It clearly took the view that the reliability of Ms A was not undermined in sufficient extent for it to be unsafe to leave it for final consideration on the facts in respect of some of the charges and to allow the matter to be assessed at the end of the day.*
> *[27]… I am unable to find that these points demonstrate that the panel was wrong in finding that there was a case to answer in respect of some of the allegations based on Ms A's evidence.*

10.It is submitted that it would be safe for the Panel to leave its assessment of [Witness 1]' credibility, and the weight to be attached to her evidence, for final consideration on the facts.

Charge 1

11.[Witness 1] exhibits a letter in which this matter is recorded in clear terms and signed by Ms Haines (JL/03). [Witness 1] spoke to this exhibit, confirmed that lansoprazole was the incorrect medication, and indicated that the medications listed within the letter were most likely to be correct.

12.JL/03 cannot be considered to be tenuous in nature. The weight to be attributed to JL/03 is therefore best considered after all the evidence has been heard [DMA-6].

13.The evidence is such that, taken at its highest, charge 1 is capable of being found proved.

Charge 2

14.This charge is admitted and found proved.

Charge 3

15.JL/03 includes a handwritten reflection from Ms Haines. It is written:

> *'…I wasn't concentrating on the mar chart and administered the medication without reading the instructions on the mar chart. I don't know why I didn't read the instructions but I then gave the wrong dose…'*

16.[Witness 1]' statement (WSJL) at paragraph 35 sets out:

> *'When I questioned the Registrant, she responded that she had obviously not read the MAR chart…'*

17.Taken at its highest, the evidence is such that charge 3 could properly be found proved.

Charge 4

> ***4) Between 1 June 2019 to 31 July 2019/On or around 6 June 2019;***

a) ***Did not encourage Resident C to eat/complete their breakfast/carbohydrates.***
b) ***Did not check on Resident C after they had failed to eat their breakfast.***
c) ***Following Resident C suffering low blood sugar/a hypoglycaemic attack, did not;***
    i. ***Check Resident C's blood glucose levels;***
d) ***Were unable to demonstrate knowledge of how to use a glucagon syringe.***

18.It is submitted that [Witness 1]' evidence, taken at its highest, is capable of proving these charges.

19.In oral evidence [Witness 1] confirmed that Ms Haines had told her she did not encourage Resident C to complete their breakfast/carbohydrates.

20.WSJL/24: 'The Registrant said she did not check on Resident C after breakfast, and when I asked her why not, she said that she felt she did not need to.' In oral evidence she stated that Ms Haines did not go to Resident C until midday and this was after being requested to observe Resident C by a carer.

c) Following Resident C suffering low blood sugar/a hypoglycaemic attack, did not;

ii) Provide orange juice/Lucozade to Resident C.

iii) Provide glucose tablets/jelly babies to Resident C.

21.These charged have been admitted and found proved.

22.It is submitted that the mischief in charge 4 is that Ms Haines did not take sufficient action in her care of Resident C. Resident C was left, having been administered insulin, without having eaten any food, and was not returned to by Ms Haines until called by a carer to go through and observe Resident C acting

strangely at around midday. Had Ms Haines acted in the manner expected of a registered nurse, i.e. checking on the resident every 20 minutes, she would most likely have identified that Resident C's blood sugar was low before Resident C became unconscious. Ms Haines would have been in a position to provide orange juice/Lucozade and glucose tablets/jelly babies at that stage.

<u>Charges 5 – 13a</u>

23. The panel has been invited to consider that these charges lack detail/particulars and that some of [Witness 1]' evidence demonstrates that she was 'made aware of from others'.

24. The panel is referred to the principles established in Ogundele. It is submitted that the particulars of the charges are appropriate in a 'pattern case' and that it would be disproportionate to call all witnesses in respect of all charges in a case of this kind.

25. The specific evidence for each of these charges is set out in [Witness 1]' witness statement. In relation to many of these charges, they are evidenced within supervision records, signed by Ms Haines herself. This, together with general concerns expressed by [Witness 2] and [Witness 4], taken at its highest, is such that a properly directed panel could find these charges proved.

<u>Charge 13b</u>

26. This charge has been admitted and found proved. The panel has been invited on behalf of Ms Haines to consider the basis upon which Ms Haines has made this admission. This was not put forward when the admission was made. This is therefore something which may form part of Ms Haines' own evidence and should not therefore be taken into account at this stage.

27. In any event, the panel will note that charge 13b and 18d cannot relate to the same incident in light of the dates. Charge 13 refers to 'on or before 14 January

2020'. The evidence demonstrates that the incident with Resident B occurred on (or much closer to) 6 March 2020.

Charge 12

28. The panel has been invited to consider Ms Haines' case that she catheterised Resident G 'that same day'. The panel should not consider evidence which might form part of Ms Haines' case at this stage.

29. The evidence in respect of whose responsibility it was to order catheters comes from [Witness 1]' witness statement at paragraph 66, exhibit JL/08, and [Witness 4]'s oral evidence, in which she confirmed that nurses are responsible for ensuring catheters are ordered.

30. The evidence demonstrating that Ms Haines did not order more catheters is set out at paragraph 66 of [Witness 1]' witness statement and JL/08.

31. The evidence, taken at its highest is capable of proving charge 12.

Charge 14

32. [Witness 1] and [Witness 2]' evidence demonstrate that Resident D's notes should have recorded observations including temperature, blood pressure and pulse rate following a positive UTI test. Resident D's notes record a positive UTI test result but no such observations. Taken at its highest, this evidence therefore proves charge 14a in its entirety. Further, there is no record in relation to whether Resident D was in pain.

33. The evidence suggests that charge 14c and 14d do not relate to the same incident as Resident D's patient notes.

34. The panel is respectfully referred to the principles established in Jozi at this stage. If the panel takes the view that there is evidence to support a case to answer

in respect of a failure to document contacting the out of hours general practitioner and a failure to notify Colleague A and B that Resident D needed antibiotics collected from the pharmacy but simply that this occurred on a different day, it is within the panel's gift to amend the allegation accordingly. The panel, and its role in protecting the public and the wider public interest, should not be bound by errors in the drafting of the charges. The relevant evidence to consider is at paragraph 29 to 33 of [Witness 1]' statement.

Charge 15d

35.It is accepted that there is no evidence to support this charge.

Charge 16

36.It is accepted that [Witness 1]' evidence in respect of charge 16 is hearsay. In a pattern case of this kind, it is submitted that the panel are entitled to rely on this hearsay evidence. However, [Witness 1]' evidence in respect of the charge focuses on Ms Haines' report to the doctor as to the presence of a thermometer as opposed to whether or not Resident G's temperature was taken. The panel may therefore find that this evidence is of such a tenuous nature that the facts could not be properly found proved.

Charge 17

37.It is submitted that [Witness 2], [Witness 4], and [Witness 1] have all spoken to charge 17a and 17b. Taken at its highest, this is sufficient to prove the charges.

Charge 18

38.Charge 18a to 18f have been admitted and found proved.

39.[Witness 1]' evidence at paragraph 99 of her statement and her oral evidence is sufficient to prove charge 18g when taken at its highest. As Deputy Manager, it is most likely that she would have discussed this matter with [Colleague B] after all of

the concerns had come to light. [Witness 1] is therefore in a proper position to confirm whether or not management had been made aware.

Charge 19

40.DW/04 demonstrates that Ms Haines was the nurse on shift the day after Resident A was found with the call bell next to/around her neck.

41.The handover notes (JL/11) and daily progress notes (JL/10) show that Ms Haines was most likely alerted to the call bell being 'around neck'.

42.The evidence demonstrates it is most likely that Ms Haines took a call with [Witness 5], exhibited as RM/02. WSJL/84: '…The Registrant admitted, when I discussed the incident with her, that she took a call from [Witness 5] regarding the incident which had, at that time, occurred the previous day.'

43.RM/02 shows that the risks involved in keeping the cord in Resident A's room were most likely discussed with Ms Haines. It also demonstrates that the nurse [Witness 5] spoke to was prompted to check whether an incident and risk assessment was completed and, if not, to do so.

44.It is submitted that it is entirely appropriate for a panel to make findings in respect of charges even where there is evidence that other nurses may similarly have failed. A failure to complete an incident form by the nurse on duty on the day of the incident does not absolve Ms Haines from all responsibility in the care of Resident A. The panel should bear this in mind when considering the evidence of [Witness 6] who notes at paragraph 12 of his statement that '…the Registrant should have escalated this.'. However, the panel will no doubt be mindful that it should not allow disciplinary findings to influence its own independent decision on the evidence presented before it, which may differ from that put before [Witness 6].

45.It is submitted that the evidence in respect of this charge, taken at its highest, is such that a panel could properly find charge 19 proved in its entirety.

Rule 24(8)

46.In respect of lack of competence, it is submitted that on the facts admitted and found proved alone, there is a case to answer on impairment. The panel should not consider any matters which might form part of Ms Haines' case at this stage. The panel's consideration of training certificates and testimonials are best reserved for final consideration of the facts and when assessing impairment following the facts stage. The proven charges present a fair sample of Ms Haines' work and a pattern of concerns in relation to her competence.

47.[Witness 1] has informed the panel that there was a PIP in place which set out objectives for Ms Haines and that this was kept under review. [Witness 6]'s evidence was that he remembers seeing an action plan and timeline by which to achieve targets. There is evidence that Ms Haines was given significant support in respect of care plans and that she attended training courses.

48.In respect of misconduct, it is submitted that charge 20 is very serious. It involves approaching a witness to the NMC's case through messages. It is not known what impact this may have had on [Colleague B], who has since disengaged with the process. This conduct certainly risks having an intimidating or harassing effect.

CONCLUSION

49.It is respectfully submitted that there is a case to answer on impairment in respect of charges 1 to 14, 15a, b, and c, and 17 to 20. The evidence as set out in the evidence matrix and as heard by the panel in oral testimony, when taken at its highest is such that the facts are capable of being found proved.

50.It is further submitted that [Witness 1]' evidence cannot be said to be intrinsically unreliable and that the weight to be attributed to her evidence can safely be left for the panel to consider upon final consideration of the facts.

51.The panel may reasonably consider that there is no evidence in support of charge 15d and that the evidence in respect of charge 16 is of such tenuous nature that the facts could not properly be found proved."

Decision and reasons on application of no case to answer

The panel took account of the submissions made and heard and accepted the advice of the legal assessor. The panel should consider whether there is sufficient evidence to find the facts proved on the balance of probabilities. The panel should consider whether it could find so, not whether it would do so.

In reaching its decision, the panel has made an assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

Charge 1 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had sight of the supervision meeting notes between you and Colleague B , followed by your written reflections. The meeting notes, dated 15 July 2019, stated:

"June made a medication error when administering a resident's medication to her on 3 occasions (29 June, 30 June and 4 July) On each occasion she administered 1 Furosemide tablet instead of 2 and 1 Spironolactone Tablet instead of ½"

The panel noted this document was signed by you and Colleague B . It also noted that there were admissions contained in your hand-written reflection in relation to the incident involving Resident I:

> *"…I don't know why I didn't read the instructions but I then gave the wrong dose…I was devastated at the time and couldn't believe that I had made this error. I also felt ashamed and concerned for Resident I…"*

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 1a, 1b and 1c, and therefore, there is a case to answer.

Charge 2 (in its entirety)

Charge 2 in its entirety was admitted.

Charge 3 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to the same evidence it considered for charge 1, however, it considered the allegations of this charge separately. The panel had sight of the supervision meeting notes between you and Colleague B , dated 15 July 2019, which stated:

> *"[Witness]1's explanation for the error occurring was that she did not read the directions properly on the MAR chart or the medication boxes and just assumed the dose was 1 tablet."*

The panel noted this document was signed by you and Colleague B . It also noted that there were admissions contained in your hand-written reflection, which supported what was stated on the meeting notes in relation to the incident involving Resident I:

> *"While I was doing the medication round, I came to Resident I…I had her MAR chart with written instructions on it, stating the dose of medication she should have. I wasn't concentrating on the MAR chart and administered the medication without reading the instructions on the MAR chart."*

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 3a, 3b and 3c, and therefore, there is a case to answer.

Charge 4a and 4b

The panel considered this charge and each sub charge separately.

The panel had regard to the oral evidence and the witness statement of Witness 1 in relation to the allegation in charge 4a, that you did not encourage Resident C to eat/complete their breakfast/carbohydrates. Witness 1 stated:

> *"The Registrant told me that she had left biscuits for Resident C after he refused to eat his breakfast and explained what had happened before I arrived. [Colleague B] and I asked why the Registrant did not use either orange juice or jelly babies, as per protocol, or something with carbohydrates, for the treatment if [sic] a hypoglycemic [sic] attack."*

In relation to charge 4b, the panel hard regard to the following section in Witness 1's statement:

"The Registrant said she did not check on Resident C after breakfast, and when I asked her why not, she said that she felt she did not need to, The Home did not have a specific policy for diabetic patients, but we followed the diabetic nurse's specialist policy…Additionally, under the policy, the Registrant should have checked on Resident C, as he had not eaten his breakfast, which would have affected his blood sugar levels. The Registrant did not do so."

The panel also considered Resident C's patient records, dated 3 June 2019, which stated that he had *"eaten very little breakfast and drank very little, gave 4-5 jelly babies some rich tea biscuits".* The panel noted you highlight that this account was not yours and this was confirmed in Witness 1's oral evidence that it was written and signed by her. The panel also had sight of the Supporting Service Users with Diabetes Policy, issued in July 2018 and reviewed in July 2021.

The panel heard oral evidence from Witness 1, where she confirms that you had told her you did not encourage Resident C to complete their breakfast/carbohydrates. The panel noted the concerns raised regarding the accuracy of Witness 1's recollection due to the gap between 2019 and 2022. However, it considered that Witness 1's oral evidence was consistent with her statement and taken under oath. The panel noted there was no information or documentary evidence before it to undermine the reliability of Witness 1.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charge 4a and 4b, and therefore, there is a case to answer.

Charge 4c (i)

The panel had regard to Witness 1's oral evidence and her witness statement which stated that *"in the morning, the Registrant checked Resident C's blood glucose levels, which were recorded as 4.9 mmol/L"* and that after Resident C refused breakfast, *"the Registrant came back to Resident C to check his blood sugar levels"*. The panel had no

information or evidence to the contrary that would suggest that you did not check Resident C's blood glucose levels after he suffered from low blood sugar/a hypoglycaemic attack.

Further, the panel noted that the date was not particularised, in so far as it alleges that between 1 June 2019 to 31 July 2019/on or around 6 June 2019. It noted that there was uncertainty surrounding the date of this incident as Witness 1 stated that she *"[does] not recall the exact date"*.

The panel determined that there was insufficient evidence so that it would find the facts of charge 4c(i) proved and therefore, there is no case to answer.

Charges 4c (ii), 4c (iii) and 4d

Charges 4c (ii), 4c (iii) and 4d were admitted by you at the outset of this hearing.

Charge 5

The panel noted that it lacked information on this charge, such as the name for the patient in question or a MAR chart showing that you had not documented giving PRN medication to the patient, when you should have.

The panel also had sight of the supervision record between you and Witness 1 on 23 December 2019. It noted that a PRN protocol was raised in this supervision record and this was signed by you. The panel considered that the supervision record simply stated a target that documenting the PRN medication had to be done, not that you did not do it. Further, in her oral evidence, Witness 1 confirmed that she did not see that you were not documenting PRN medication but was made aware of this by Witness 4.

However, the panel also had regard to the oral evidence and the witness statement of Witness 1, which stated in relation to this allegation on 23 September 2019:

“At this supervision, I discussed with the Registrant two incidents, which were raised in a recent visit by our Quality Improvement Lead, [Witness 4]. The first one regarding the audit medication. I had found that the Registrant had not documented a PRN medication, which is medication that is taken as needed, on the MAR chart for a patient. I do not recall the name of the patient. I explained the process to the Registrant, which involved documenting the medication given and how much was given on the reverse of the MAR chart.”

The panel heard oral evidence from Witness 1, which was consistent with the supervision record. Witness 1 also explained to the panel, that supervision records were often utilised as a method of communicating in writing what actions are to be taken by and/or are required of each nurse.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charge 5, and therefore, there is a case to answer.

Charge 6

The panel had regard to the oral evidence and the witness statement of Witness 1, which set out:

“We also discussed another incident where a carer had left the Home whilst on duty, and the Registrant had not informed me of the event. I told the Registrant that, if working short staffed, she should inform me. I was on call that weekend, so would have been able to support in the event of an absence leaving the nurses short-staffed.”

The panel heard oral evidence, which was consistent with this supervision record, and noted that the supervision record held between you and Witness 1 was signed, and therefore, it could be inferred this was acknowledged by you at the time.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charge 6, and therefore, there is a case to answer.

Charge 7a (i) and 7a (ii)

The panel considered this charge and each sub charge separately.

The panel had regard to the oral evidence and witness statement of Witness 1, which set out:

> *"55. I described the other areas that [Colleague B] and I had concerns about. Specifically, I told the Registrant that her care plans and progress notes were not detailed enough and missed vital information, and that she was not looking forward to see what medication and stock needed to be ordered to prevent shortages. I provided the Registrant with my own book on care plans to assist the Registrant with writing them. I know that [Colleague B] and [Witness 4] also sat down with her, and [Witness 2], the Clinical Lead, provided support. This assistance was given throughout the Registrant's entire employment at the Home."*

The panel also had regard to the supplementary statement provided by Witness 1, which stated in relation to charge 7a (i):

> *"At paragraph 55 of my first statement I referenced that I had concerns about the Registrant's care plans and progress notes. That they were not detailed enough and missed vital information…I know the Registrant missed vital point when I checked her care plan for a resident who had returned from hospital and his care plans needed updating. The Registrant missed that the resident was only able to use his left hand for feeding himself and required his food to be prepared so that it*

was easy for him to maintain his independence, she did not mention that he required a spoon or plate guard to assist him."

In respect of charge 7a(ii), the panel noted that Witness 1's supplementary statement continued on to expand that:

"She frequently left out of care plans about asking for consent before undertaking tasks on residents, or maintaining privacy and dignity"

The panel also had sight of the supervision record dated 14 January 2020, which supported Witness 1's evidence.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 7a(i) and 7a(ii), and therefore, there is a case to answer.

Charges 7b and 7c

The panel considered this charge and each sub charge separately.

The panel had regard to the oral evidence and witness statement of Witness 1, which set out:

"I asked the Registrant a few questions about percutaneous endoscopic gastrostomy (PEG) feeds…Although the Registrant knew they were kept in the pharmacy, she did not know where to order the feed from and did not ask her colleagues about the origin of the feed."

The panel noted it heard seemingly contradictory evidence from Witness 2's oral evidence, that information about *'the origin of PEG feeds would be written on the care plans anyway'*, so in the event that you did not initially know, by referencing the care plan

you would know, as it would be included in the care plans. Witness 2 also maintained in oral evidence that you appeared to *'know you would get PEG feeds from the pharmacy but would not know before pharmacy'*.

However, the panel had sight of the supervision record dated 14 January 2020, and noted that this did not mention any concerns about not knowing where to order PEG feeds nor a suggested action to be taken in moving forward to ask colleagues about its origins. The panel had no documentary evidence before it to support that PEG feeds were a genuine concern.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 7b and 7c, and therefore, there is a case to answer.

Charge 8a and 8b

The panel considered this charge and each sub charge separately.

The panel had regard to Witness 1's oral evidence and witness statement, which stated that:

> *"The Registrant had missed from Resident H care plan that he only used one hand to feed himself… The Registrant should have made a note of this increase in weight, as Resident H was overweight and therefore had an increased risk of choking. I asked that the Registrant rewrite Resident H care plan, however this was not done".*

The panel had sight of the supervision record dated 14 January 2020, which stated under actions to be taken:

"Explain to [Witness 1] to ensure vital information is also added in to care plans such as Resident H limitations on how to feed himself and the concern regarding his weight."

The panel noted there were no care plans before it in relation to Resident H.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 8a and 8b, and therefore, there is a case to answer.

Charge 9 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to Witness 1's oral evidence and witness statement, which set out:

"The care plan for another resident, who I do not recall the name of, did not contain any explanation regarding their extremely low BMI of 13. The Registrant, to my knowledge, did not alert anyone to this fact, even though they were underweight and at high risk. There was no indication in the care plan about their low BMI or that they were under the care of a dietician [sic], or how to promote healthy weight gain."

The panel had sight of the supervision record dated 14 January 2020, which stated under actions to be taken:

"Explained that evaluation does not explain no weight gain as BMI 13."

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 9a, 9b and 9c, and therefore, there is a case to answer.

Charge 10 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to Witness 1's oral evidence and witness statement, which set out:

> *"A third resident, whose name I do not recall, had a care plan for their personal care. All the Registrant had written however was that the person preferred a shower rather than a bath. There was nothing about oral care, the resident's other preferences, how the resident's privacy and dignity was to be upheld, and the patient's consent, which should have been included in the care plan."*

The panel noted that there were no care plans before it or notes on the supervision record specifically referring to this concern nor can Witness 1 be certain that she hadn't heard this evidence from another colleague. However, it also noted that the record stated that you and Witness 1 *"discussed care plans that [you] had written"*.

The panel had sight of the Home's Care Plan Policy, which *"aims to ensure that individualised care is assessed, planned, implemented, evaluated and recorded in the resident's confidential Care File".*

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 10a, 10b, 10c and 10d, and therefore, there is a case to answer.

Charge 11 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to Witness 1's oral evidence and witness statement, which set out:

"The Registrant's evaluation of care plans would also be very basic when it came to residents whose care had not changed, simply containing the phrase no change. I would expect these care plans to still contain the requisite detail, such as describing if there had been any choking incidents, any weight gain or loss by the resident, if the resident is managing to independently feed themselves, and to note any adaptations. All basic information must be updated in the care plan. Otherwise, they are updated yearly."

The panel had sight of the Home's Care Plan Policy, which provided guidance on care plans. The panel heard consistent oral evidence from Witness 1 and other witnesses of what standard/detail is expected in care plans for residents in general.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 11a, 11b and 11c, and therefore, there is a case to answer.

Charge 12 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to Witness 1's oral evidence and witness statement, which stated that:

"We also discussed the Registrant's reasoning for not catheterising one of the residents, Resident G. The Registrant stated that she had had a bad experience previously when re-catheterising. I replied that she needed to ask for help rather than ignore the problem. The Registrant explained there were no catheters to re-catheterise Resident G, and also confirmed that she had not ordered more catheters when she found out that there were none. It was the previous nurse who catheterised Resident G using the last catheter who should have ordered them.

However, the Registrant failed to order more stock when she discovered there was none left. It is the responsibility of the nurses to order stock when it needs to be ordered. This led to a delay in Resident G having his catheter changed."

The panel had sight of the supervision record dated 14 January 2020, which stated under actions to be taken:

"To stock of catheters in building for Resident G to be catheterised, need to ensure when last catheter is used to order straight away. [Witness 1] wasn't the only person involve other staff will have supervisions with this matter".

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 12a and 12b, and therefore, there is a case to answer.

Charge 13a

The panel had regard to Witness 1's oral evidence and witness statement, which stated that:

"I did not think the Registrant had passed any of her competencies. I believe I reviewed the Registrant's care plans, PEG competency, medication administration, and her wound assessment. The Registrant did not know how to order feeds for residents, care plans for residents were not altered when resident began or changed supplements, and her wound assessment was not completed with new wounds."

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charge 13a, and therefore, there is a case to answer.

Charge 13b

Charge 13b was admitted by you at the outset of this hearing.

Charge 14a(i)

Charge 14a(i) was admitted by you at the outset of this hearing.

Charge 14a(ii) and 14a(iii)

The panel had regard to the oral and written evidence of Witness 1 and Witness 2, which set out that Resident D's notes should have recorded observations including temperature, blood pressure and pulse rate following a positive UTI test. The panel had sight of Resident D's patient notes, which show a record of a positive UTI test result but no record of temperature, blood pressure or pulse rate or observation that these have been checked.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 14a(ii) and 14a(iii), and therefore, there is a case to answer.

Charge 14b

The panel had regard to the oral evidence and witness statements of Witness 1 and Witness 2. It noted that their statements did not specifically refer to pain experienced by Resident D. The panel had regard to Resident D's patient notes and could not find any record of pain. The panel had no evidence or information before it that Resident D was in pain. It, therefore, concluded that you would not have had to ask whether Resident D was in pain if there was no indication of this.

The panel heard oral evidence in support of this charge but considered it was tenuous and limited.

The panel determined that there was insufficient evidence so that it would find the facts of charge 14b proved and therefore, there is no case to answer.

Charges 14c and 14d

The panel considered this charge and each sub charge separately.

The panel had regard to all of the evidence before it. It considered that the witness statement of Witness 1 and Resident D's patient notes refer to a different date from 8 February 2020. The panel concluded that the evidence before it was tenuous, inconsistent and vague. It also noted that the NMC seemingly conceded that the incident described in the witness evidence appeared not relate to the same incident as in the patient notes.

The panel considered whether to suggest an application to amend the charge in relation to the dates, but even then, the evidence before it was of such insufficient probative value that it would be unfair to you.

The panel determined that there was insufficient evidence so that it would find the facts of charge 14c and 14d proved and therefore, there is no case to answer.

Charges 15a, 15b and 15c

The panel noted that charges 15a, 15b and 15c were admitted by you at the outset of this hearing.

Charge 15d

The panel noted that the NMC accepted that there was no admissible evidence before the panel to support this charge and accordingly, there is no case to answer.

Charge 16

The panel noted that the NMC concede that notwithstanding that they are entitled to rely upon hearsay evidence, such evidence as there is of such a tenuous nature that the fact could not properly be found proved. Accordingly, the panel determined that there was insufficient evidence so that it would find the facts of charge 16 proved and therefore, there is no case to answer.

Charge 17 (in its entirety)

The panel considered this charge and each sub charge separately.

The panel had regard to the oral and written evidence of Witness 1, Witness 2, Witness 3 and Witness 4. Witness 4 specifically noted that the care plans were of *"poor quality, not being person-centred and lacking detail"*, they were *"vague and did not explain how to care for the resident".* Witness 2 noted that the care plans *"lacked compassion and empathy towards the resident".*

Witness 4, in her oral evidence, she stated that the care plans produced by you lacked detail that was required for example failed to record on the care plan the resident use of incontinence pads.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 17a, 17b and 17c, and therefore, there is a case to answer.

Charge 18a-18f

The panel noted that charges 18a, 18b, 18c, 18d, 18e and 18f were admitted by you at the outset of this hearing.

Charge 18g

This charge relates to an incident where Resident B kicked out during personal care and her leg made contact with a member of staff's teeth, causing a minor laceration (skin tear) on the resident's leg. You are alleged to have failed to escalate this and failed to complete an incident form or a wound chart, which you have admitted.

The panel heard evidence from Witness 1 that *"the Registrant failed to document the injury and failed to report the incident to home management, as required by the Home's policies".*

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 18g, and therefore, there is a case to answer.

Charges 19a – 19e

The panel considered this charge and each sub charge separately.

The panel had regard to the oral and written evidence of Witness 1.

In respect of charges 19a, 19b and 19c, Witness 1 stated that following the incident concerning Resident A you failed to complete the necessary paperwork, which she defined as a Risk Assessment, an Incident Form and a Care Plan. In Witness 1's Management Report into the incident involving Resident A she stated that you "*did not act on the phone call from Witness 5, she did not check that the agency nurse…… had completed incident forms or completed risk assessment".*

In respect of charge 19d, Witness 1 stated in her witness statement that *"the Registrant also failed to document in the progress notes that she reviewed Resident A's mood"*. She also recorded in her witness statement with respect to the handover notes completed by

you on 5 March 2020 that she would have expected more detail following a suspected self-harm and comments about Resident A's mood and behaviour.

With respect to charge 19e, Witness 1 stated in her witness statement that *"it is also not documented in the progress notes that the Registrant instigated 15 minute checks although this is what she reported doing"*.

The panel had regard to the oral evidence and documentary evidence before it. It determined that sufficient evidence had been presented to find the facts proved in charges 19a, 19b, 19c, 19d and 19e, and therefore, there is a case to answer.

Charge 19f

With respect to charge 19f the only evidence provided in support of this charge is from Colleague B which the panel have decided is inadmissible. Consequently, the panel determined that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 19f proved.

Charges 20 (in its entirety)

The panel noted that charges 20a, 20b and 20c were admitted by you at the outset of this hearing.

Lack of competence

The panel determined that the charges you have admitted and those yet to be determined if proved provide a fair sample of your work and potentially raised concerns as to your competence.

The panel divided the allegations of lack of competence into the following areas: medicine administration, escalation/safeguarding and record keeping.

The panel determined that charges 1, 2, 3 and 5 relate to medicine administration, charges 4, 6, 12, 14, 15, 17, 18 and 19 relate to escalation/safeguarding and charges 7, 8, 9, 10, 11, 13, 14, 15, 17, 18 and 19 relate to record keeping/documentation. The panel noted that in some of the charges the areas in respect of lack of competence overlapped.

In respect of the medication administration errors, the panel noted there were six errors over three days and noted that you had made some admissions to charges relating to the MAR chart. The panel determined there was sufficient evidence before it to support a finding that your medication administration competency could have fallen short of the standard expected of you as a registered nurse.

With regards to escalation and safeguarding of patients, the panel noted that these allegations are not isolated incidents and that you are an experienced nurse with many years of service. The panel also considered the witness evidence on your PIP engagement, it considered there was some evidence that you received support, the panel bore in mind that whether this was enough would be determined at a later stage, but concluded that, at this stage, there was sufficient evidence to support a finding of lack of competence in relation to escalation and safeguarding.

In respect of record keeping, the panel had regard to the patient notes before it. The panel was not presented with any audit of your care plans despite the fact that a number of charges relate to record keeping. Nevertheless, the panel determined there was sufficient evidence from three witnesses that your record keeping was not up to the standard expected of you as a nurse, and therefore there was sufficient evidence before it to support a finding of impairment by reason of lack of competence.

The panel determined there is a case to answer in respect of the charges relating to lack of competence as there is sufficient evidence that could support such a finding, and it therefore follows that there may be a basis for a finding of impairment.

Misconduct

The panel noted that you made admissions to charges 20a, 20b and 20c. The panel considered that your conduct by approaching Colleague B whilst being under investigation, could be deemed as improper and unprofessional, and therefore could support a finding of misconduct.

In respect of these admitted charges, the panel determined that there was sufficient evidence to support a finding of impairment by reason of misconduct.

Decision and reasons on interim order

This case is adjourning until 14 March 2024. In these circumstances, the panel considered whether or not to impose an interim order. The NMC made no representations in this regard. Ms Michaels reminded the panel of the submissions she made when the case was adjourned on the last occasion, namely that an order was not necessary to protect the public, nor would one be in the public interest. There is no suggestion that an order would be in your interest.

The panel heard and accepted the advice of the legal assessor and determined that the situation had barely changed since the last decision it made when dealing whether an interim order was neither necessary nor required on public protection and public interest grounds respectively. Accordingly, it determined not to make an interim order.

Background

You were referred to the NMC on 15 June 2020 by Witness 6, a Home Manager at Priory Group Limited. The charges arose whilst you were employed as a Registered Nurse at the Beeches Nursing Home (the Home).

The majority of the residents at the Home were described as *'nursing patients'*. With a total of 45 beds spread across two floors, each floor was staffed with one nurse during both day and night shifts.

The allegations gave rise to concerns about your practice, particularly in relation to medication errors, failure to adequately respond to medical emergencies, poor documentation, and issues with communication and professionalism with other staff. Around September 2019, you were placed on a Performance Improvement Plan (PIP), which consisted of ongoing and regular competency assessments. Your PIP was intended to conclude on 24 February 2020. However, Witness 1 and 7 were not satisfied that you met its objectives nor demonstrated an overall improvement in your clinical practice.

Some key points about the alleged incidents include:

- Administering the incorrect medication dosage to a resident due to not reading their Medication Administration Record (MAR) chart.
- Failing to properly manage a resident's hypoglycaemic shock episode and not knowing how to use necessary medical equipment, namely, a glucagon syringe. Also, you allegedly told Witness 1 that you left biscuits for the resident after their refusal to have breakfast and did not check the resident’s blood sugar levels after.
- Inadequate response to a potential urinary tract infection in a resident and alleged failure to properly document any necessary observations/checks in relation to this.
- Lack of proper documentation regarding care plans, incidents, and resident assessments. In February 2020, Witness 4 audited care plans at the Home, finding yours lacking in quality, person-centeredness, and detail.
- Allegations of negligence in handling resident safety, including an instance of self-harm attempt and a skin tear around March 2020.
- Inadequate communication and professionalism, including failure to address concerns raised during supervision.

A disciplinary process in relation to your alleged conduct at the Home and the grievances you raised began around May 2020. A disciplinary hearing took place on 21 May 2020. The allegations culminated in your dismissal from the Home on 4 June 2020. You later found employment at another care centre. However, additional allegations of unprofessional conduct post-employment were raised as, on 24 December 2021, you allegedly contacted your former manager on social media and sent them accusatory/inappropriate messages.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Michaels, who informed the panel on your behalf that you made admissions to charges 2a-c, 4c(ii), 4c(iii), 4d, 13b, 14a(i), 15a, 15b, 15c, 18a-18f and 20a-20c. The panel therefore finds these charges proved in their entirety, by way of your admissions.

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 Paterson and Ms Michaels.

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: At the time, was a Deputy Manager at The Beeches (the Home);
- Witness 2: At the time, was a Clinical Lead at the Home;

- Witness 3: At the time, was a Healthcare Assistant at the Home;

- Witness 4: At the time, was the Quality Improvement Lead for The Priory Group;

- Witness 5: At the time, was a Healthcare Support Worker visiting Resident A.

- Witness 6: At the time, was a Home Manager at the Priory Group and made the initial referral to the NMC.

The panel also heard evidence from you under oath.

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

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

At the outset of the panel's determination on facts, it addressed the matter of records signed by you. The panel had regard to your oral evidence that despite having signed the supervisory meeting notes, you said you had done so without reading them properly because of your frame of mind at the time. It also noted that you felt you were being treated unfairly at work, did not have the best working relationship with your manager and did not want to be confrontational. Nevertheless, the panel considered that you are an experienced nurse, and would have known the importance of reading documents such as

a supervision record and a letter of serious concern before signing them. Consequently, the panel was satisfied that where you had signed documents, that you had read them.

Charges 1a, 1b and 1c

> *"1) On one or more of the following dates incorrectly administered one furosemide tablet to Resident I, instead of 2 tablets as prescribed:*
>
> *a) 29 June 2019*
> *b) 30 June 2019*
> *c) 4 July 2019"*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the oral and written evidence of Witness 1, the supervision meeting notes, your handwritten statement and the letter of serious concern on 15 July 2019, the Home's medication policy and your oral evidence.

The panel was satisfied that Witness 1's oral evidence was consistent with her witness statement. It noted that Witness 1 stated a different medication on her initial statement, however, this was later corrected. The panel considered that the contemporaneous documentary evidence on 15 July 2019 largely supports Witness 1's evidence. It noted that the supervision meeting notes were signed by you and the Home Manager.

Further, the panel had regard to your handwritten statement, where you appeared to admit that in relation to Resident I:

> *"I wasn't concentrating on the mar chart and administered the medication without reading the instructions…I then gave the wrong dose. I didn't realise this until the Deputy Manager pointed it out to me. I was devastated at the time and couldn't believe that I had made this error."*

The panel determined that it was more likely than not that you had incorrectly administered one furosemide tablet to Resident I, instead of two tablets as prescribed. Witness 1 outlined that this took place on 29 and 30 June 2019 and 4 July 2019. The panel noted that there were no patient records, e.g. a MAR chart for Resident I, before it to confirm the medication prescribed to the resident. However, it was satisfied that Witness 1's oral evidence was reliable.

The panel noted the submissions by Ms Michaels regarding the credibility of Witness 1, who was subject to her own Fitness to Practice (FtP) hearing. However, the panel could not be satisfied that this amounted to her providing unreliable evidence as it determined that Witness 1 could still provide a credible account at this hearing notwithstanding the findings in other FtP proceedings or that Witness 1 was regarded by you and others as a *'harsh'* manager.

The panel accepted the evidence of Witness 1 because it is largely corroborated by the documentary evidence in support of this charge. It also noted your admissions to charge 2 in relation to another medication error concerning Resident I on the same dates in question. The panel determined that, on the balance of probabilities, it was more likely than not that you had incorrectly administered one furosemide tablet to Resident I, instead of two tablets as prescribed on 29 and 30 June 2019 and 4 July 2019.

Accordingly, the panel finds charges 1a, 1b and 1c proved.

Charges 3a, 3b and 3c

> *"3) On one or more of the following dates while administering medication to Resident I did not review the relevant MAR Chart/Medication box:*
>
> *a) 29 June 2019*
> *b) 30 June 2019*

c) 4 July 2019"

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the same evidence it considered in charge 1. The panel accepted the evidence of Witness 1 as it is largely corroborated by the documentary evidence in support of this charge. It also had particular regard to your handwritten statement, where you appeared to admit that in relation to Resident I:

> *"I wasn't concentrating on the mar chart and administered the medication without reading the instructions on the mar chart. I don't know why I didn't read the instructions but I then gave the wrong dose."*

The panel was satisfied that, on the balance of probabilities, it was more likely than not that, while administering medication to Resident I on 29 and 30 June 2019 and 4 July 2019, you did not review the relevant MAR Chart/Medication box.

Accordingly, the panel finds charges 3a, 3b and 3c proved.

Charges 4a and 4b

"4) Between 1 June 2019 to 31 July 2019/On or around 6 June 2019:

a) Did not encourage Resident C to eat/complete their breakfast/carbohydrates.

b) Did not check on Resident C after they had failed to eat their breakfast."

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence, the 'Management of the Diabetic Protocol' and Resident C's patient records.

The panel had regard to Witness 1's statement that:

> *"…The Registrant told me that she had left biscuits for Resident C after he refused to eat his breakfast and explained what had happened before I arrived.*
>
> *[The Home Manager] and I asked why the Registrant did not use either orange juice or jelly babies, as per protocol, or something with carbohydrates, for the treatment if a hypoglycaemic attack.*
> *…*
> *The Registrant said she did not check on Resident C after breakfast and when I asked her why not, she said that she felt she did not need to…under the policy, the Registrant should have checked on Resident C, as he had not eaten his breakfast, which would have affected his blood sugar levels. The Registrant did not do so"*

The panel was satisfied that Witness 1's oral evidence was consistent with her statement.

The panel also had regard to your oral evidence. It noted that when asked about the allegation that you did not encourage Resident C to have breakfast, you stated that it is *"not for a staff nurse to assist the residents with their meals"* and that on this occasion, you asked the carers to let you know if Resident C had his breakfast or not, but that they did not come back to you so you *"assumed there wasn't a problem"*, which you admitted was *"wrong and should have asked them"*.

The panel noted that you returned to the patient when informed by the carer that Resident C was unwell but at that point, the patient had already entered a hypoglycaemic state and was 'fitting'. The panel considered that charge 4b specifically pertains to monitoring Resident C's well-being due to his refusal of breakfast, which could impact his blood sugar

levels. It noted that you were unaware of whether Resident C had consumed his breakfast, indicating a failure to assess his condition prior to the onset of the seizure.

The panel was satisfied that, on the balance of probabilities, it was more likely than not that you did not encourage Resident C to eat/complete their breakfast/carbohydrates as you stated in oral evidence that this was not your task because you were busy with the medication round and you had asked the carers to let you know if he had not eaten his breakfast.

The panel was also satisfied that, on the balance of probabilities, you did not check on Resident C after they had failed to eat their breakfast as you had *'assumed'* that there was no problem and admitted that you did not check when you say you should have.

Accordingly, the panel finds charges 4a and 4b proved.

Preamble for the following charges

In respect of the following charges, from charge 5 onwards, the panel was satisfied that there was evidence to support that you were subject to a Performance Improvement Plan, which was instigated in early September 2019.

Charge 5

> *"5) On or before 23 September 2019 did not document that you had administered a PRN medication."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1 and 4, your evidence and the supervision record dated 23 December 2019.

The panel noted that it was Witness 1's evidence that Witness 4 had raised this concern following her visit and audits of the Home. The panel had regard to the evidence of Witness 4, but found a lack of corroborating evidence as Witness 4 stated that:

> *"I am aware that the Registrant may have committed a medication error at the Home at some point. I do not know when this was or the details of any error. I was not involved in the incident in any way."*

The panel noted that while a conversation was purportedly held between you and Witness 1, but there are no documented records of it and therefore Witness 1's evidence is uncorroborated hearsay.

Additionally, the panel reviewed the supervision record referred to by Witness 1 dated 23 December 2019. It found Witness 1's statement and the supervision record to be ambiguous, lacking specifics or details regarding the alleged documentation error. Moreover, the patient in question remained unidentified, and the panel was not provided with patient records or a MAR chart to substantiate the medication error claim.

The panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel finds charge 5 not proved.

Charge 6

> *"6) On or before 23 September 2019 did not inform Colleague A that an unknown carer had left the home whilst on duty."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence and the supervision record dated 23 December 2019.

The panel had regard to the evidence of Witness 1, which stated that:

> *"We also discussed another incident where a carer had left the Home whilst on duty, and the Registrant had not informed me of the event."*

The panel also had regard to your oral evidence that you did not know about the incident this allegation refers to, and you denied that Witness 1 or The Home Manager spoke to you about you failing to tell them about an unknown carer leaving the home whilst on duty.

The panel determined that you could only inform Witness 1 of a carer leaving whilst on duty if you knew about it. The signed supervision record given as evidence in support of this charge on 23 September 2019 does not mention a carer leaving the Home or any failure by you reporting the carer leaving the Home. The panel was not satisfied that you knew of this incident. It also noted that the carer was unknown nor was there a date of the incident in either Witness 1's statement or the supervision records.

The panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel finds charge 6 not proved.

Preamble for the following charges

The panel considered that charges 7a, 8, 9, 10, 11, 13a and 17 all relate to the quality of your care plans. It noted that no care plans had been submitted as evidence.

The panel then considered each of these charges separately and made the following findings:

Charges 7a(i) and 7a(ii)

> *"7) On or before 18 December 2019 you:*

a) *On one or more occasion omitted detailed/vital information from care plans in that you:*

i. *Failed to record that an unknown resident required a spoon/plate guard for assistance.*

ii. *Failed to record consent from residents before undertaking personal care/tasks."*

This charge is found NOT proved in its entirety.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence and the supervision record dated 18 December 2019.

The panel noted that there were no care plans before it to demonstrate that you omitted detailed/vital information. It determined that the sole evidence in support of this charge was that of Witness 1 and her review of your performance.

As a result, the panel concluded that it could not find this charge proved on the balance of probability without further supporting evidence, such as a care plan or more detailed information to specify the resident or clarify the alleged incident.

Due to the lack of corroborating evidence, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel finds charges 7a(i) and 7a(ii) not proved.

Charges 7b and 7c

"7) On or before 18 December 2019 you:

b) *Did not know where to order PEG feed from;*

c) Did not ask your colleagues about the origin of the PEG feed."

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence and the supervision record dated 18 December 2019.

The panel had regard to the evidence of Witness 1, which stated that:

> *"I asked the Registrant a few questions about percutaneous endoscopic gastronomy (PEG) feeds…One of the assessments was whether she knew where the feed ultimately came from. Although the Registrant knew they were kept in the pharmacy, she did not know where to order the feed from and did not ask colleagues about the origin of the feed."*

The panel accepted your oral evidence and noted that you said that you told Witness 1 that you did know where to order the PEG feeds from, but you did not know the origin of the PEG feeds. You explained to the panel that you did not understand what Witness 1 meant by her question, and the panel agreed that the question is vague and ambiguous. You said that you found out by asking colleagues that the source of the PEG feeds was from Abbott Nutrition.

You also stated that you would not typically ask colleagues if you could find out answers yourself but would not hesitate to ask another colleague for information or support. The panel could find no direct corroborating evidence in any of the documentary evidence in the supervision records for these charges and found that the explanation given by you was plausible and credible.

Taking all the evidence into account, the panel was not satisfied that the NMC had discharged the burden of proof.

Accordingly, the panel finds charges 7b and 7c not proved.

Charges 8a and 8b

> *"8) On or before 14 January 2020 failed to record In Resident H's care plan that:*
>
> *a) They could only use one hand to feed themselves;*
>
> *b) Their weight had increased."*

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence, the supervision record dated 14 January 2020 and the Home's Care Plan Policy.

The panel had regard to the evidence of Witness 1, which stated:

> *"…the care plan for one resident, Resident H, stated he was on an adapted diet due to swallowing difficulties and had limitations with the use of one of his hands. Due to a brain injury, Resident H could only hold a fork or spoon with his left hand. The Registrant had missed from Resident H care plan that he only used one hand to feed himself."*

The panel noted that there were no care plans for Resident H before it. However, it had sight of the supervision record on 14 January 2020, which was signed by you and stated under actions to be taken:

> *"Explain to June to ensure vital information is also added in to care plans such as Resident H limitation on how to feed himself and the concern regarding his weight."*

The panel was satisfied that the oral evidence of Witness 1 was consistent with her witness statement. It considered that there was contemporaneous documentary evidence which supported that this concern was raised with you in supervision meetings. The panel determined that, on the balance of probabilities, it was more likely than not that you failed to record in Resident H's care plan that they could only use one hand to feed themselves and that their weight had increased on or before 14 January 2020.

Accordingly, the panel finds charges 8a and 8b proved.

Charge 9a

> *"9) On or before 14 January 2020 failed to record within an unknown patient care plan that they;*
>
> *a) Had a BMI of 13;"*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence, the supervision record dated 14 January 2020 and the Home's Care Plan Policy.

The panel had regard to the evidence of Witness 1, which stated:

> *"The care plan for another resident, who I do not recall the name of, did not contain any explanation regarding their extremely low BMI of 13. The Registrant, to my knowledge, did not alert anyone to this fact, even though they were underweight and at high risk."*

The panel noted that there were no care plans before it. However, it had sight of the supervision record on 14 January 2020, which was signed by you and stated under actions to be taken:

"Explained that [PRIVATE] evaluation does not explain no weight gain as BMI 13."

The panel was satisfied that the oral evidence of Witness 1 was consistent with her witness statement, and there was contemporaneous documentary evidence which supported that it was more likely than not that this concern was raised with you in your supervision meeting on 14 January 2020. The panel determined that, on the balance of probabilities, it was more likely than not that you failed to record within an unknown patient care plan that they had a BMI of 13.

Accordingly, the panel finds charge 9a proved.

Charges 9b and 9c

"9) On or before 14 January 2020 failed to record within an unknown patient care plan that they;

a) …
b) Were under the care of a dietician;
c) How to promote a healthy weight gain."

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 1's evidence. However, it noted that it was the sole evidence in support of this charge and there is no clear reference to the allegations in charges 9b and 9c in the supervision record. Further, it noted that this charge relates to an unknown patient and there were no patient records before it to substantiate the allegations.

Due to the lack of corroborating evidence, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel finds charges 9b and 9c not proved.

Charge 10a, 10b, 10c and 10d

> *"10) On or before 14 January 2020 did not record within an unknown patient care plan:*
>
> *a) Details about oral care;*
> *b) Other preferences of the unknown patient;*
> *c) How their privacy and dignity was to be upheld;*
> *d) Patients consent."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, your evidence and the Home's Care Plan Policy.

The panel found that Witness 1's evidence was the sole evidence in support of these charges as there was no reference to the allegations in charge 10 with any of the supervision records or exhibits, only in Witness 1's statement.

Particularly in respect of charge 10b, the panel noted that there was an indication within Witness 1's evidence that you did record some preferences. Witness 1 stated that: *"All the Registrant had written however was that the person preferred shower rather than a bath"*.

Additionally, the panel was mindful that this pertained to an unidentified patient, with no accompanying patient records to support the alleged concerns.

Given the absence of corroborative evidence and some evidence to the contrary, the panel determined that the NMC had not discharged the burden of proof. Accordingly, the panel finds charges 10a, 10b, 10c and 10d not proved.

Charge 11a

> *"11) On or before 14 January 2020 did not provide the required detail within care plans as you:*
>
> *a) Did not describe if there had been choking incidents;"*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and your evidence.

The panel had regard to the evidence of Witness 1, which stated that:

> *"The Registrant's evaluation of care plans would also be very basic when it came to residents whose care had not changed, simply containing the phrase no change. I would expect these care plans to still contain the requisite detail, such as describing if there had been any choking incidents, any weight gain or loss by the resident, if the resident is managing to independently feed themselves, and to note any adaptations."*

The panel found that the oral evidence of Witness 1 was consistent with her witness statement. It also considered that in your oral evidence, you accept that there was a choking incident which you did not record. Therefore, it was satisfied that, on the balance of probabilities, it was likely that you did not describe a choking incident within the care plans.

Accordingly, the panel finds charge 11a proved.

Charges 11b and 11c

"11) On or before 14 January 2020 did not provide the required detail within care plans as you:

a) …
b) Did not provide detail of any weight gain and / or weight loss;
c) Did not record if an unknown resident was able to independently feed themselves."

These charges are found NOT proved.

In reaching this decision, the panel took into account the same evidence it considered at charge 11a.

The panel recognised that these charges pertained to an unidentified patient, with no accompanying patient records to support the alleged concerns. Given the absence of corroborative evidence and noting that you dispute these charges, the panel was not satisfied that the NMC had discharged the burden of proof.

Accordingly, the panel finds charges 11b and 11c not proved.

Charge 12a

"12) On or before 14 January 2020 you:

a) did not re-catheterise Resident G;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, supervision record of 14 January 2020 and your oral evidence.

The panel found Witness 1's oral evidence to be consistent with her statement that they had discussed your reasoning for not catheterising Resident G.

The panel noted that this supervision record was signed by you. It also noted that you dispute this allegation and that your evidence was that you did catheterise Resident G, albeit later that same day. It also heard evidence from Witness 1 who accepted that you could have done it later in the day following your meeting with her where you were instructed to do so. However, there was no documentary evidence before the panel that you did this.

The panel also heard from Witness 1 that you told her that you previously had a *'traumatic'* experience with catheterisation and that is why you were reluctant to do so.

The panel preferred the evidence of Witness 1 as there is contemporaneous documentary evidence before it which supports the evidence of Witness 1 as this matter was raised with you in a supervision meeting on 14 January 2020. The panel was therefore satisfied that, on the balance of probabilities, it was more likely than not that you did not re-catheterise Resident G.

Accordingly, the panel finds charge 12a proved.

Charge 12b

"12) On or before 14 January 2020 you:

b) did not order more catheters."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the signed supervision record of 14 January 2020 and your oral evidence.

The evidence of Witness 1 stated:

> *"…the Registrant failed to order more stock when she discovered there was none left."*

The panel heard oral evidence from you stating that you did not order more catheters and explained why you did not do so.

Notwithstanding that the evidence would suggest that the responsibility to order more catheters did not just lie with you, nevertheless on the strict wording of the charge, you did not order more catheters.

Accordingly, the panel finds charge 12b proved.

Charge 13a

> *"13) On or before 14 January 2020 you did not:*
>
> *a) alter care plans when residents began and / or changed supplements;"*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and your evidence.

The panel noted that Witness 1's statement was the sole direct evidence in support of this charge.

Additionally, the panel noted that the residents referred to in this charge were not particularised. It also did not have documentary evidence before it, such as the care plans mentioned by Witness 1.

Due to the lack of corroborating evidence for this charge, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel finds charge 13a not proved.

Charge 14a (ii) and 14a (iii)

"14) On 8 February 2020 when caring for Resident D:

a) did not check and / or record:
i. …
ii. blood pressure;
iii. pulse rate."

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, 2 and your evidence, as well as Resident D's patient notes.

The panel had regard to the evidence of Witness 2, which stated:

"I came into work on a Monday and I saw that the Registrant had documented in the notes of Resident D , that she had conducted a urinalysis which had showed signs of a possible infection on the previous Saturday, two days earlier.

I could not see any observations recorded in notes, which I would have expected following a test that showed possible symptoms of an infection…

…

If I had tested a resident's urine and found signs of a possible infection, I would have done a set of clinical observations, including temperature, blood pressure and pulse rate, on the resident to establish how serious the infection was."

The panel found that the oral evidence of Witness 2 was consistent with her statement and expanded on the observations she would have expected from you after finding out that Resident D had a possible infection following a urinalysis.

The panel heard oral evidence from you, in which you stated that you did check Resident D's blood pressure and pulse rate but failed to properly record it. Whilst there was no evidence to suggest that you had not checked Resident D's blood pressure and pulse rate, there was clear evidence that you did not record them. The panel therefore determined that the NMC had proved charges 14a(ii) and 14a(iii) on the balance of probabilities.

Accordingly, the panel finds charges 14a(ii) and 14a(iii) proved.

Charges 17a and 17b

"17) On or before 17 February 2020, within one or more care plans, they:

a) Were not person centred;
b) Did not include detailed documentation and / or information"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 2 and 4, your evidence and the Quality Site Visit notes on 14-17 February 2020 and 2 March 2020.

The panel had regard to the evidence of Witness 2, which stated that:

> *"The Registrant's care plans, on review, were not very professional, by this I mean that they lacked detail in how to care for the resident...*
>
> *…There were multiple care plans that I read, completed by the Registrant, that were very basic…*
>
> *They lacked detail and were drafted in bullet-point fashion, which does not form an individualised care plan. For example, for a sleep care plan, you would need to write if they have drink before bed, like the light on and whether they want the curtains closed. The care plans needed to be details* [sic]*, which writing in bullet points does not allow.*
>
> *They lacked compassion and empathy towards the resident, and failed to specify the care that that individual resident wanted to receive. I believe that the lack of detail came from the lack of knowledge the Registrant had for the residents, meaning that the care plans did not contain information relating to the resident's specific needs, therefore, lacking compassion and empathy."*

The panel found that Witness 2's oral evidence was consistent with her statement and credible. It also considered that the evidence of Witness 4 corroborated this, as it was Witness 4's evidence that:

> *"The audit of the care plans revealed that those care plans that had been completed by the Registrant were of poor quality. I identified them as not being person-centred and lacking details."*

Although the panel noted that it did not have sight of your care plans, nor the audits completed by Witness 2, it determined that there was sufficient corroborative evidence

from Witnesses 1, 2 and 4 to support charges 17a and 17b. It particularly considered that it was Witness 2's duty to review care plans. It also noted that Witness 2 and Witness 4 independently reviewed your care plans.

The panel was satisfied that, on the balance of probabilities, it was more likely than not that one or more care plans completed by you were not person centred and did not include detailed documentation and / or information.

Accordingly, the panel finds charges 17a and 17b proved.

Charge 17c

"17) On or before 17 February 2020, within one or more care plans, they:

c) Were not accurate"

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms Paterson's submission in which she invited the panel to consider that charge 17c might be a repetition of charge 17b and therefore may amount to *'double charging'*. On the basis that the lack of detailed documentation and/or information (charge 17b) was the same as 'not accurate' (charge 17c). The panel agreed with this analysis.

In the circumstances, the panel finds charge 17c not proved.

Charge 18g

"18) On or before 6 March 2020, after assessing Resident B skin tear :

…

g) *Did not notify management that the injury occurred during moving and handling of Resident B."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 6 and your evidence.

The panel had regard to the evidence of Witness 6, which outlined the incident during moving and handling of Resident B, and that you had failed to escalate and complete an incident form or a wound chart. Witness 6 stated that this was particularly important because the wound caused by a human mouth, which has a higher chance of causing infection. It found Witness 6's evidence to be consistent in oral evidence.

The panel also had regard to your oral evidence. It noted that you said you *"did not ring them [management] on the day that it occurred"* because you *"did not think they were interested in what [you] had to say"*. However, when you returned to work another day, you told Witness 1 about it and she said they were already informed.

Therefore, the panel was satisfied, on the balance of probabilities, that on 6 March 2020 after assessing Resident B skin tear, you did not notify management that the injury occurred during moving and handling of Resident B.

Accordingly, the panel finds charge 18g proved.

Charges 19a and 19b

"19) Between 4 - 7 March 2020 after Resident A was found with the call bell around their neck you:

a) *Did not check for/complete a risk assessment;*

b) Did not check for/complete an incident form;

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, 3 and 5, your evidence, Resident A's progress notes, the handover notes, the management report, Witness 5's note following the incident and record of the telephone conversation.

The panel had regard to the evidence of Witness 5, which stated:

> *"I rang The Beeches and spoke to a nurse there. I wrote a record of this phone call…I do not recall the name of the nurse I spoke to, and I later found out that there was no Julie that worked at The Beeches. I first explained who I was, who the call was regarding, and confirmed that I had spoken to my team leader around the incident. I called to advise the staff of the risks of the cord being in room, and that, as the cord should be removed from room, the care staff should check on every 15 to 30 minutes…*
>
> *The nurse who I spoke to seemed quite short with me on the phone. They said that they think the risk assessment and accident and incident form had been completed. I replied that that needed to be checked, and the nurse said they assume they would have been completed. I do not recall if the nurse said that she would check nor if they said the cord from room had been removed as advised. As a result, I did not receive any clarity from the nurse whether they had actually been completed…*
>
> *…I was told that [Witness 1] and the other staff did not have any knowledge of the incident that occurred on 04 March 2020, so the cord was placed back in room. This indicated to me that the staff on 04 March 2020 and the person I spoke to on 05 March 2020 had not included the incident in any handover."*

The panel found the evidence of Witness 5 to be consistent and credible. It had sight of the telephone record dated 5 March 2020, after Resident A was found with the call bell around their neck.

The panel also had regard to the evidence of Witness 1 and 3, which corroborated the evidence of Witness 5. It noted that the name was 'Julie' on the telephone record but noted that Witness 1 confirmed that on 5 March 2020, you were working upstairs as the nurse in charge and received the call. When asked under cross-examination by Ms Paterson if 'Julie' was you, you replied *'yeah'*. On 7 March 2020, Witness 1 states that they went through documentation and did not find any notes or documentation of the previous incident.

Therefore, the panel was satisfied, on the balance of probabilities, that between 4 and 7 March 2020, after Resident A was found with the call bell around their neck, it was more likely than not that you did not check for or complete a risk assessment nor an incident form.

Accordingly, the panel finds charge 19a and 19b proved.

Charge 19c

> *"19) Between 4 - 7 March 2020 after Resident A was found with the call bell around their neck you:*
>
> *c) Did not check for/record the incident within a care plan;"*

This charge is found proved.

In reaching this decision, the panel took into account all the witness and documentary evidence before it. It had particular regard to the evidence of Witness 1:

"I originally checked for any change in the care plan or if a risk assessment had been completed. As nothing was documented..."

The panel also had regard to the evidence of Witness 5:

"The incident should have, furthermore, been clearly documented in Resident A's care notes, even if not handed over."

The panel noted that no care plans for Resident A were placed before it to confirm whether incident was recorded within the care plan.

The panel determined that there was corroborating evidence in support of this charge, the panel was satisfied that, on the balance of probabilities, you did not check or record the incident within the care plan.

Accordingly, the panel finds charge 19c proved.

Charge 19d

"19) Between 4 - 7 March 2020 after Resident A was found with the call bell around their neck you:

d) Did not check for/record accurate details about the suspected self-harm and / or record comments about their mood and / or behaviour;"

This charge is found proved.

In respect of charge 19d, the panel had regard to Resident A's progress notes and the evidence of Witness 1.

Witness 1 stated that:

"I found only one reference to the incident, on the handover notes…I would have expected more detail from both following a suspected self-harm attempt and comments about Resident A's mood and behaviour"

The panel found Witness 1's evidence to be consistent and credible. It was put to you under cross-examination by Ms Paterson that you did not record anything about Resident A's mood and behaviour, and you replied: *"no that's right, I didn't because she seemed okay"*. Furthermore, a review of Resident A's progress notes shows no comment by you about their mood or behaviour.

Therefore, the panel was satisfied, on the balance of probabilities, that between 4 and 7 March 2020, after Resident A was found with the call bell around their neck, it was more likely than not that you did not record comments about Resident A's mood or behaviour.

Accordingly, the panel finds charge 19d proved.

Charge 19e

"19) Between 4 - 7 March 2020 after Resident A was found with the call bell around their neck you:

e) Did not record in their progress notes that you had instigated 15 minute checks and / or carried out 15 minute checks;"

This charge is found proved.

In reaching this decision, the panel had regard to Resident A's progress notes and the evidence of Witness 1 and Witness 5.

The panel had regard to the evidence of Witness 1, which stated in relation to Resident As' incident:

"It is also not documented in the progress notes that the Registrant instigated 15 minute checks, although this is what the Registrant reported doing to me when I spoke to her on 11 March 2020. The Registrant also failed to document in the progress notes that she reviewed Resident A mood, which was particularly shocking…"

The panel found the evidence of Witness 1 to be credible and consistent. The panel also heard oral evidence from you in which you accepted that you did not record that you instigated the 15-minute checks. You explained that this was because they were already in place when you came to work.

The panel was satisfied, on the balance of probabilities, that between 4 and 7 March 2020, after Resident A was found with the call bell around their neck, that you did not record in their progress notes that you had instigated 15-minute checks and / or carried out 15-minute checks.

Accordingly, the panel finds charge 19e 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 (charges 1 to 19) and/or misconduct (charge 20), 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 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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, 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.

Prior to the submissions by the parties on lack of competence, misconduct and impairment, the panel heard further evidence from you.

Submissions on lack of competence and misconduct

In relation to lack of competence, Ms Paterson referred the panel to the relevant NMC guidance (FTP-2B) and stated that this set out that:

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

Ms Paterson submitted that a fair sample of your work has been considered by the panel and the facts found proved demonstrate a lack of competence in relation to several areas of practice, including errors in medication administration, escalation or safeguarding issues, and inadequate record-keeping. She submitted that your actions put patients at risk of harm and fell below acceptable professional standards. She outlined that you were given an opportunity to improve as you were placed on a PIP, and received support, but was never signed off as fully competent.

Ms Paterson also referred to the terms of ‘The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (the Code). She identified the specific, relevant standards where your actions amounted to a lack of competence. Ms Paterson submitted that the facts found proved show that your competence at the time was below the standard expected of a registered nurse.

In relation to misconduct, Ms Paterson submitted that messaging a witness in an unprofessional manner whilst being subject to NMC proceedings was serious as this could be upsetting and intimidating towards the person receiving them. She outlined that the effect that the messages had on your former colleague is unknown because she subsequently stopped engaging, however, the messages risked discouraging her from being a witness in the proceedings. Ms Paterson then identified the specific, relevant standards where your actions were in breach of the Code and amounted to misconduct.

In response, Ms Michaels outlined that the NMC guidance states that when concerns are raised about a nurse’s general competence, the panel should have regard to the nurse’s practising history and consider the context of how these occurred. She submitted that the remaining charges in relation to lack of competence do not amount to a fair sample of your work by which to gauge your competence. She submitted that there was no clear evidence of what support was provided to you, and there was also no evidence of any unwillingness by you to engage with any support. She stated that the panel may also consider that you felt unable to speak to your management team as you felt ignored or treated differently to other members of staff.

In terms of misconduct, Ms Michaels emphasized that this was an isolated incident, and the panel may consider the context in which such circumstances arose. She submitted that you had shown insight into your conduct and made admission at the outset. She submitted that you demonstrated regret and remorse and highlighted that there are no previous nor subsequent incidents.

Submissions on impairment

Ms Paterson 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 Paterson submitted that the areas that the amount to a lack of competence relate to fundamental nursing skills and that you 'sought to minimize' your duties as a registered nurse. While there is some level of insight expressed by you, she submitted that this appears to be limited, especially regarding clinical concerns.

In relation to remediation efforts, she accepted that you had undertaken training courses. However, Ms Paterson suggests that such training may not have been fully effective as although you have positive employment references, these also suggest that there are some ongoing concerns in relation to your lack of confidence in your abilities that made you unable to demonstrate sufficient knowledge in practise.

In terms of the misconduct, Ms Paterson submitted that you expressed insight in how your conduct may have impacted your former colleague and you accepted that what you did was wrong. However, she submitted that this related to an attitudinal/behavioural concern which are often more difficult to address as opposed to clinical concerns.

Due to concerns about both lack of competence and misconduct, and the perceived lack of developed insight and remediation, Ms Paterson contends that there is a risk of repetition, posing a threat to patient safety and public confidence in the profession, and therefore, your practice can be found to be currently impaired.

Ms Michaels submitted that there was no risk of repetition as any lack of competence that may be identified by the panel is capable of being addressed and you have already taken steps to strengthen your practice, such as evidence of additional training and positive testimonials attesting to your good work.

Ms Michaels also informed the panel that you have been working unrestricted since the incident for nearly four years and no further concerns have been raised in relation to your practise. She submitted that you accept you had lost your confidence following your experiences at the Beeches, however, you are working on this and are receiving the right support from your current employer.

Ms Michaels submitted that your current practice and extensive training demonstrate that you are fit to practice and impairment should not be found based on lack of competence.

Regarding the misconduct charge, Ms Michaels informed the panel that you had admitted to the charge at an early stage and had shown significant remorse. It was an isolated incident, there has been no repetition of any similar occurrences and that you were undergoing considerable distress at the time of the incident. Ms Michaels said that this was a 'moment of madness on Christmas Eve'. She went on to say that this action was completely out of character and that not one of the witnesses has described you as confrontational. Consequently, Ms Michaels stated that the risk of repetition is extremely low and that you are not currently impaired by way of this misconduct.

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, *Grant, Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin)*, Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Holton v GMC* [2006] EWHC 2960 (Admin).

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

*'**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

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work cooperatively

To achieve this, you must:

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:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all 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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

22 Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

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."

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

In considering the matter of lack of competence, the panel considered each of the charges found proved individually first, and then collectively. It determined that its findings could be collectively considered under the following categories of concern: medicines administration, safeguarding/escalation and documentation/record keeping.

<u>Medicines Administration</u>

In respect of charges 1 to 3, the panel identified that these related to medicine administration concerns. It noted that this pertained to two drug errors on three different dates, as opposed to a ‘one-off’ scenario. The panel considered your oral evidence. It noted that you said it was a busy working environment and that on reflection you understand the gravity of making a medication error. You also said you can now confidently administer medication, even in an emergency situation.

The panel acknowledged that no actual harm was caused to Resident I, however, it was of the view that a member of the public would be concerned if a nurse were to administer medication without reviewing the resident’s MAR chart. It also noted that you were attending to particularly vulnerable elderly residents and therefore should have taken ‘extra care’ in reviewing and understanding their medical needs.

The panel determined that reviewing a resident’s MAR chart prior to administering medication forms part of fundamental nursing skills. In failing to do so, and such actions resulting in medication errors, on multiple occasions, was below the standard that one would expect of a registered nurse acting in your role, and therefore, amounted to a lack of competence.

Furthermore, it noted, in respect of charge 4d, that knowing how to use the relevant/essential equipment was also a fundamental nursing skill. Having received training on this, your admission that you were unable to demonstrate knowledge of how to use a glucagon syringe also amounted to a lack of competence in this area.

Safeguarding/Escalation

In respect of charge 4, the panel had regard to your evidence. It noted that you said you did not think it was your role to encourage Resident C to eat and that you told carers to let you know if he did not have his breakfast. The panel was of the view that although it may be common practice to entrust tasks to carers, it was not acceptable in this instance as

you were responsible for Resident C's care, and it was not sufficient to 'assume' that there were no problems instead of checking on the resident or asking the carers for an update. It noted that Resident C, in particular, was known to be a 'picky eater' and the consequences of administering insulin to a patient, who then does not eat, should have been known to you. Consequently, there was a greater necessity on you to check on him and whether he had eaten his breakfast.

The panel considered that Resident C suffered a hypoglycaemic attack following this and therefore, actual harm was caused to a resident. It concluded that your actions were below the standard that one would expect of a registered nurse acting in your role, and therefore, these amounted to a lack of competence.

However, in respect of charge 4c(ii) and 4c(iii), the panel determined that your omission to provide/offer orange juice, Lucozade, glucose tablets and/or jelly babies to Resident C did not amount to a lack of competence. It accepted your evidence that you did not provide these as you considered it would not have been significantly beneficial and presented a choking risk as Resident C was already experiencing a seizure.

The panel noted that charge 5 onwards was in the context of you being placed on a PIP as a result of the previous errors you made.

In respect of charges 12a-b, the panel determined that your actions did not amount to a lack of competence. It accepted your evidence that you raised your concerns with Witness 1 about your hesitation in undertaking catheterisation due to a past trauma and the panel considered that it would not expect any nurse to carry out a procedure they do not feel confident in completing. It also accepted your evidence that you did not order more catheters because there were some in the wardrobe, and there was some information to indicate that this may also have been the responsibility of another nurse, and therefore, the panel did not consider that this amounted to a lack of competence.

In respect of charges 13b and 14a(i)-(iii), although the panel noted these were about documentation/record keeping, it considered that the charges also related to safeguarding as these concerned how you managed unwell residents. The panel determined that ensuring that you properly check/monitor vulnerable residents is a basic nursing skill, and your practice was below the standard that one would expect of a registered nurse in your role. Therefore, this amounted to a lack of competence.

In relation to charges 15a-c, the panel considered your evidence that following Resident E having a coughing incident you administered the thickener on the basis that Resident E had previously been given thickened fluids. The panel decided that you should have sought advice from a general practitioner before administering the thickener and that you should have provided clinical justification for your actions within the records. The panel therefore decided that this amounted to a lack of competence.

In respect of 18g, the panel noted that this charge concerned safeguarding and escalation. The panel determined that informing management was fundamental in order to prevent, address or improve training for similar future issues in moving and handling residents and so it was important that you notify them. It concluded that your practice was below the standard that one would expect of a nurse, and therefore, amounted to a lack of competence.

Documentation/Record Keeping

In respect of charges 8a-b, 9a, 11a, 15b, 17a-b, 18a-f and 19a-e, the panel determined that ensuring the proper completion of the residents' records, incident reports, risk assessments is fundamental to their care, and the importance of maintaining documentation to the required standard is essential in demonstrating good nursing practice. Therefore, having found that these were not completed to a satisfactory standard, the panel determined that this amounted to a lack of competence.

The panel determined that charge 18e did not amount to a lack of competence if a camera was not available to photograph the wound.

The panel concluded that you breached the aforementioned sections of the Code, and whilst this does not automatically lead to a finding of lack of competence, the concerns regarding your practice related to basic and fundamental nursing skills. It noted you did not meet all of the competencies to the required standard, despite receiving support from your employer. The panel acknowledged that this support and the working environment at the Beeches was not all that it could have been. However, the panel decided that you were under a professional obligation to take steps to strengthen your practice. The panel considered that the significant concerns relating to your poor practice may have led to the harm of Resident I and could have put other residents at risk of harm.

The panel concluded that your actions, both individually and collectively, formed a pattern of failures over a significant period. The panel determined that your practice fell far below the standard expected of a registered nurse of your experience in your role. In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

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 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. Specifically:

> *'**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*

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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 your actions were serious. Although it did not consider these to be a form of 'threatening', making accusatory comments to a witness via social media whilst NMC proceedings were on-going was unprofessional and a serious departure from the standards expected of a nurse. Notwithstanding your explanation that you sent these messages whilst upset and having been drinking, such behaviour directed at a colleague who was a witness in these proceedings is inexcusable and unacceptable.

In respect of charge 20, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment in relation to lack of competence

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

The panel considered the factors set out in the case of *Cohen* and determined that your failings in respect of your lack of competence can be addressed. The panel had regard to Ms Michaels submissions, the bundle of documents supplied by you and your evidence given at this stage in determining whether you had in fact addressed your lack of competence.

The panel noted that you were extremely remorseful for your actions. The panel also considered the testimonials and training certificates you provided. It was satisfied that you

had taken the necessary steps to strengthen your practise since the incidents and the risk of repetition in this case is now considered to be minimal.

The panel had regard to your answers about how you would handle the situation differently in the future and the fact that you have been consistently practising without any restrictions as a staff nurse for four years, the last two years of which were within two separate nursing homes. The panel noted that some of your employment references comment that you are yet to develop your confidence further to improve your practise. The panel received, earlier in the proceedings in September 2023, a reference from your current employer. The reference letter, dated 6 September 2023, stated the following:

> *"June does lack some confidence however, but this is improving with time although this is understandable under the current circumstances. She is neither arrogant nor complacent regarding her knowledge or skills. She has worked extremely hard to prove herself as a competent practitioner and June has become a very valuable member of the team at Oakwood."*

However, the panel did not find that this apparent lack of confidence meant that you could not practise safely. Your work experience over the past four years without further incident along with your references, testimonials and your evidence led the panel to conclude that you can practise kindly, safely and professionally.

The panel finds that, although your fitness to practise may have been impaired at the time of the incidents, given all of the above, your fitness to practise is not currently impaired by reason of lack of competence.

The panel has carefully considered the public interest in respect of the lack of competence charges found proved. It concluded that that it would not be appropriate in this case to find impairment solely on a public interest basis and that public confidence in the profession will not be undermined by a finding of no impairment given the specific circumstances of this case and the lack of any subsequent fitness to practise issues.

Having regard to all of the above, the panel was satisfied that your fitness to practise is not currently impaired by reason of a lack of competence.

Decision and reasons on impairment in relation to misconduct

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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.'*

The panel determined that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that you showed sufficient insight into your actions. It recognised that you made admissions at the outset of the hearing and demonstrated an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession during your oral evidence. It recognised that you were

acting out of character and extremely remorseful and that you stated, if your former colleague was present, you would apologise to her for your actions in the past.

The panel was satisfied that the misconduct in this case is capable of being addressed and you have taken steps to address it. It noted that this was a single isolated incident. The panel considered that there was not a risk of repetition. The panel could find no evidence that could support a finding of impairment 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.

The panel determined that it was necessary to mark the seriousness of your misconduct as this was unprofessional and unacceptable, particularly, in the context that you were involved in on-going regulatory proceedings in which the Home Manager was a witness. Directing such comments to a witness in proceedings can only be regarded as serious. The panel therefore determined that a finding of impairment was required on public interest grounds in order to uphold proper professional standards and maintain public confidence in the profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired solely on the public interest.

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of two years. The effect of this order is that your name on the NMC register will show that you are subject to a caution 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 Paterson referred to the relevant guidance and identified aggravating factors which may assist the panel in reaching its decision, such as that the conduct occurred during an ongoing investigation and unprofessional messages were sent to a witness of those proceedings. She also identified mitigating factors, which include that the incident was isolated, admissions were made by you at the outset, and you have expressed remorse.

Ms Paterson submitted that starting with the least restrictive option, taking no action would not be appropriate given the breach of fundamental tenets of the nursing profession. A caution order is submitted to be insufficient due to the seriousness of the misconduct and its impact on patient safety and professional standards. Further, she submitted that a conditions of practice order is considered unworkable as the misconduct does not relate to a specific area of clinical practice in need of retraining.

Ms Paterson therefore invited the panel to consider a short suspension. She cited factors that align with cases where suspension may be appropriate which were also present in this case, such as it being a single instance of misconduct without evidence of deep-seated attitudinal problems or repetition. She said that her actions discourages a ‘speaking up culture’ and could potentially have put patients at risk of harm. She submitted that a suspension of three to four months was potentially appropriate to address and serve the public interest in this matter.

The panel also bore in mind Ms Michaels submissions that while the panel has independent judgment in determining the sanction, this should not be punitive but should satisfy the public interest while minimizing interference with the nurse's ability to practice.

Ms Michaels highlighted the importance of proportionality and balancing your interests with the public interest.

Ms Michaels accepted that the panel has found impairment necessary in the public interest due to misconduct. She submitted that the panel must start with the least serious sanction and move on if necessary. In response to the NMC bid of suspension, she submitted that this was not appropriate, and it would be disproportionate. She submitted that this was a case of a single isolated incident, there is lack of risk of repetition, and steps were taken by you to address the misconduct as you immediately attempted to erase the messages.

Ms Michaels invited the panel to consider a caution order as a more appropriate sanction. She outlined some mitigating factors, such as early admission, genuine remorse, and steps taken to prevent future recurrence. She submitted that a caution order would mark the behaviour as unacceptable while allowing you to continue practicing as you have done without issues for the past four years. However, she submitted that if the panel deems a caution order unsuitable, she invited the panel to consider conditions of practice or a short suspension.

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:

- The words used, which gave rise to the misconduct, were said to a witness in these ongoing proceedings.

The panel also took into account the following mitigating features:

- Admissions at the outset of the hearing
- A single isolated incident
- No repetition of such conduct
- You have shown considerable remorse
- [PRIVATE]
- Stressful work environment leading up to dismissal

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct as you had breached fundamental tenets, and the public confidence would be undermined. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 was of the view that you have shown full insight into your conduct. It considered that you made admissions to this at the outset, and, in your oral evidence, you apologised to this panel for your misconduct and showed evidence of genuine remorse. It also noted that you said you took immediate steps to eradicate the message/person from social media and expressed regret for your actions. The panel also noted that you have engaged with the NMC since the referral.

The panel has been told that there have been no concerns of a similar nature raised either before or since this incident. It determined that the risk of repetition was significantly low.

The panel was of the view that the case was at the lower end of the spectrum of impairment. The panel had no evidence to suggest a discouragement of ‘speaking up’. Nevertheless, the panel wished to mark that the behaviour was unacceptable and must not happen again.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel concluded that no useful purpose would be served by a conditions of practice order as it was not necessary to protect the public and these would not be workable. It noted that there is no identifiable area of retraining as this was not a clinical concern.

In making this decision, the panel carefully considered the submissions of Ms Paterson in relation to the sanction that the NMC was seeking in this case. However, the panel considered that it would be unfair and counterproductive to implement a suspension order. The panel considered that a suspension order would be wholly disproportionate. It noted that this was a single isolated incident, which took place over a few minutes almost four years ago. The panel found no evidence of deep-seated attitudinal issues. It noted that the conduct occurred during a period of stress and was not an accurate depiction of your character. No allegations have been made that you were confrontational, and you explained how you would normally avoid confrontation. The panel found you to be an honest witness and noted that you have reflected on this matter since and are deeply remorseful of your actions.

The panel has decided that a caution order would adequately address the public interest. For the next two years, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of 24 months would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but

also send the public and the profession a clear message about the standards required of a registered nurse. It noted that the length of this caution was sufficient to address the seriousness of this case and recognises the effect of these proceedings on you over the past four years.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel's finding, and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.