

NURSING &
MIDWIFERY
COUNCIL

Fitness to practise annual report 2004–2005

Protecting the public through professional standards

NURSING &
MIDWIFERY
COUNCIL

Fitness to practise annual report 2004–2005

Protecting the public through professional standards

Contents

Foreword	3
Trends and issues	4
Case studies	12
Focus on abuse of the elderly	18
Further information	20

Foreword



Jonathan Asbridge

This is the third Nursing and Midwifery Council (NMC) *Fitness to practise annual report*. It provides information about how we deal with complaints about fitness to practise. Our remit is to protect the public, and the work of the NMC panels and committees in considering complaints ensures that the public is protected from those registrants who may be unsafe.

The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 were introduced on 1 August 2004. In the report cases have been dealt with under one of the two sets of legislation.

All those cases reported before 1 August 2004 have been considered under the 1993 Professional Conduct Rules, and all complaints received on or after 1 August 2004 have been considered according to the new rules.



Professor Mary Hanratty

This report provides information about the NMC's work in considering both allegations of misconduct and unfitness to practise due to ill health under the 1993 rules, and allegations that fitness to practise is impaired by reason of misconduct, lack of competence, a conviction or caution, physical or mental ill health, or a determination by another regulatory body in the UK that their fitness to practise is impaired, under the new rules.

Under the old rules, cases are considered by the Preliminary Proceedings Committee (PPC), Professional Conduct Committee (PCC) and Health Committee (HC). Under the new rules, cases are considered by panels of the Investigating Committee (IC), Conduct and Competence Committee (CCC) and Health Committee (HC). Panels and committees are made up of members of the NMC, registrants and lay panellists.



Professor Alan Ferguson

The fitness to practise directorate, members of Council and panellists have worked extremely hard to ensure that both systems run side by side effectively. A programme of training has been implemented during the year under report for all members, panellists, staff and legal assessors.

There have been a number of summits with key stakeholders throughout the UK to consider the new legislation and to ensure that the new powers and procedures are understood. The powers to deal with lack of competence were discussed in some detail.

The new legislation has given the NMC a greater range of powers in order to protect the public. In addition to the power to remove a registrant from the register by the making of a 'striking off order', the NMC now has the power to impose a 'suspension order', a 'conditions of practice' order, or a 'caution' order of one to five years.

The NMC's remit is to protect the public. It is vital that the work of fitness to practise is carried out efficiently, and that the processes are fair and transparent.

Jonathan Asbridge
NMC President
Chair of the Professional
Conduct Committee

Professor Mary Hanratty
NMC Vice President
Chair of the Preliminary
Proceedings Committee

Professor Alan Ferguson
NMC Council Member
Chair of the Health Committee

November 2005

Trends and issues

New allegations of misconduct

The number of allegations of misconduct against registered nurses, midwives and specialist community public health nurses fell slightly this year. In 2003-2004, the NMC received a record 1,460 complaints. This year, we received 1,389.

UKCC 2000-2001	UKCC 2001-2002	NMC 2002-2003	NMC 2003-2004	NMC 2004-2005
1,240	1,304	1,301	1,460	1,389

Who makes the complaints?

Anyone can make a complaint, but in practice the largest number (60%) come from employers, usually in association with disciplinary proceedings at the workplace.

The NMC receives complaints from the police (14%), who are obliged to inform the regulatory body of any criminal conviction received by a practitioner on the NMC register. Last year the NMC was notified of 276 convictions, many of which were minor matters unlikely to lead to any further action, however, some involved serious convictions for rape, other violent crimes, downloading pornography, and dishonesty.

Complaints are also received directly from the public (17%), colleagues, Supervisors of Midwives, the National Care Standards Commission and others.

Where do the complaints come from?

While complaints are received from all four countries of the UK the majority are from England. The percentage of practitioners resident in each country during the year is also shown.

Country	Number of complaints	% of practitioners resident in each country	% of complaints in each country
England	1,151	77.36%	82.88%
Wales	60	4.77%	4.32%
Scotland	136	9.65%	9.76%
Northern Ireland	29	3.24%	2.08%
Outside the UK	13	4.65%	0.96%
Total	1,389		

Cases under the Professional Conduct Rules 1993 (old rules)

What happens to those complaints dealt with under the 1993 rules?

When a complaint is received a panel of the PPC considers it. The panel decides whether there is a case to answer and whether there is enough evidence to support the complaint. It has to consider whether an allegation is likely to lead to removal from the register.

Many complaints are closed at an early stage because they may be trivial, not supported by evidence or concern matters that would not call into question the registrant's fitness to practise. Many convictions may fall into this category, for example, minor motoring offences.

Where the allegations are serious and the PPC believes they could lead to removal from the register, solicitors will investigate and report on the strength of the evidence supporting the charges, which must meet the criminal standard of proof.

During 2004-2005, the PPC considered 1,403 cases and made the following decisions as shown in the table below. Figures for 2003-2004 are also given for comparison.

Judgement	NMC 2003-2004	NMC 2004-2005
Case closed	875	615
Further investigation required	393	514
Referred to professional screeners (for consideration of health cases)	53	43
Cautioned	30	41
Referred to the PCC	160	190
Total	1,511	1,403

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

Cautions issued under the 1993 Professional Conduct rules

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

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

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

Recording action taken

Records of cautions are retained for five years. Anyone checking the practitioner's registration with the confirmation service during that period is informed of the caution. If the practitioner is referred again to the PPC or the PCC during that five-year period, the committee will be informed of the caution.

Professional Conduct Committee

The Council is committed to transparency and accountability in its fitness to practise work, and Professional Conduct Committee (PCC) hearings are held in public. The press is usually present as well as any observers. Respondents or their employers sometimes ask for proceedings to be held in private. The PCC may agree to this if it is to protect the identity of a victim of the alleged offences in particularly sensitive circumstances, such as child abuse cases. However, the potential embarrassment of the respondent, or the business reputation of the respondent's employer, would not be accepted as reasons for holding the hearing in private.

Location of PCC cases 2004 – 2005

The PCC usually sits in the country in which the case originated. In England, 90 cases were heard at the NMC's offices as well as at other locations in the capital.

In 2004-2005, cases were also heard in Belfast, Blackpool, Bournemouth, Cardiff, Cheltenham, Chester, Chesterfield, Edinburgh, Exeter, Liverpool, Penrith, Plymouth, Leeds, Manchester, Newquay, Sheffield, Wakefield and Wetherby.

During the year, the PCC sat on 354 days, and considered 235 cases of alleged misconduct and 7 applications for restoration to the register.

Professional Conduct Committee decisions

Judgement	NMC 2003-2004	NMC 2004-2005
Removed from the register	127	106
Cautioned	45	35
Misconduct proven but no further action	2	3
Facts or misconduct not proven	13	6
Cases adjourned	74	63

Categories of misconduct

The majority of cases heard by the PCC concern practice-related matters (96.6%). The remaining 3.4% were not related to practice. These are usually matters reported to the NMC following a conviction in the criminal courts. A registrant can be called to account for behaviour not related to practice if it is considered that public trust and confidence in the professions might be undermined, or if such behaviour constitutes a risk to the public. Most non-practice-related matters concern dishonesty, violent crime, and sexual offences (including downloading pornography).

Of the practice-related charges, 12% related to the maladministration of drugs, 17% to the neglect of basic care and unsafe clinical practice, and 6% concerned poor record keeping. A further 4% concerned failing to report incidents and failing to take appropriate action in an emergency. A total of 39% of the charges concerned poor practice, and this represents a slight increase on the figures for 2003-2004.

Sexual, physical and verbal abuse of patients or clients accounted for 13% of charges. Dishonesty, such as theft from patients or employers or claiming falsely to have qualifications, accounted for 10% of the charges. Poor management practices and bullying made up 4.6%, and failing to collaborate with colleagues accounted for a further 4%. The remaining 26% of charges covered miscellaneous matters including breach of confidentiality, failure to obtain consent, sleeping on duty or being unfit for duty through the use of alcohol or drugs.

Cases under the NMC Fitness to Practise Rules 2004 (This section discusses cases received after 1 August 2004)

Investigating committee (IC)

Once an allegation of unfitness to practise is received at the NMC, it is referred to a panel of the IC. The registrant, who has been reported, is sent a copy of the allegations and supporting information, and is invited to submit a written response that is put before the panel.

The panel may ask for more information. For example, it can ask solicitors to carry out further investigations, or ask the registrant to undergo a practice or medical assessment. The complainant may also be invited to respond to any particular points the registrant raises in their written response.

Case to answer

The panel of the IC must decide whether there is a 'case to answer'. This means that the panel must be reasonably satisfied that the facts of an allegation are capable of proof, and that if proven, those facts could lead to a finding that the registrant's fitness to practise is impaired. Fitness to practise has been defined as 'a registrant's suitability to be on the register without restriction'.

If the panel finds there is no case to answer it will close the case. If it finds there is a case to answer it will refer the case either to the CCC or to the HC.

Investigating Committee decisions 2004 – 2005

Outcome of cases considered	Number
Further investigation	216
Adjourn	28
Refer to CCC (Conduct/Caution/Conviction)	5
Refer to CCC (Lack of Competence)	2
Refer to HC	1
Consideration of fraudulent or incorrect entry in the register	1

There were no hearings of the Conduct and Competence Committee, conducted under the new rules, to consider allegations of unfitness to practise.

Applications for restoration to the register

The Professional Conduct Rules 1993 allowed for an application for restoration to be made at any time after removal. However, the NMC (Fitness to Practise) Rules 2004 require that an application for restoration shall not be made before a period of five years has elapsed from the date of removal from the register.

There are transitional provisions in place governing those applications for restoration which were made after the 1 August 2004, where the person had been removed under the old rules. These allow for a person to make a first application for restoration before a five-year period has elapsed.

The committee hearing the application can attach a conditions of practice order to any successful application for restoration.

During 2004-2005 the committee considered 7 applications for restoration to the register and accepted 4 of these. This compares with 2 successful applications from a total of 18 the previous year.

The CCC considers all applications for restoration. The applicant must attend to be questioned by the committee. Restoration cases are heard on a designated day and the President always chairs the Committee. Two references must be supplied, one of which must be from a current employer who is fully aware of the circumstances surrounding the removal from the register.

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

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

The committee must also consider whether public confidence in the professions is likely to be maintained if that practitioner were to be restored to the register.

When a practitioner has been restored to the register, the previous removal will be disclosed to those confirming the practitioner's registered status for a period of five years from the date of the restoration.

Unfitness to practise due to ill health

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

A person may be referred to the HC in one of two ways. This may be a direct referral, for example, by an employer. There were 73 direct referrals during the year. Alternatively, during the course of considering a professional conduct case, a referral may be made from either the PPC or the PCC if it appears that the practitioner is unwell. The PPC made 53 referrals this year and there was 1 referral from the PCC.

If the screeners for the HC feel there may be a current health problem, then the practitioner is invited for examination by two medical examiners. The medical evidence enables the screeners to decide whether to refer a practitioner to the HC. During the year, the screeners met on 36 occasions and considered 352 cases. 29 cases were closed and 151 were referred to the HC. The remaining cases are still in progress.

Health Committee

The HC meets in private because of the confidential nature of the medical evidence involved. During 2004-2005, there were 42 HC meetings, at which 193 cases were considered. The cases considered by the HC concern sensitive issues of the respondent's medical history such as mental health matters or experiences such as child sexual abuse.

Under the Professional Conduct Rules 1993 the HC had the power to postpone judgement in a

case. This power was used in circumstances where the committee wanted to review the case at the end of a period of supported practice to see if an individual was now able to practise safely. In 2004-2005, 13 cases resulted in postponed judgement.

However, after the 1 August 2004, as part of the transitional provisions of the legislation, it is no longer possible to postpone judgement. In 'old rules' cases, where postponed judgement might previously have been considered, the HC can now consider applying any of the full range of new sanctions under the NMC (Fitness to Practise) Rules 2004. One of these would be the imposition of a 'conditions of practice order'. During 2004-2005, 3 conditions of practice orders were applied.

Allegations relating to unfitness to practise considered by the HC were as follows:

Allegations	Percentage
Alcohol abuse	39.06%
Drug abuse	20.31%
Depressive illness	21.35%
Other mental illness	18.23%
Physical illness	1.04%

Health Committee decisions

Decision	NMC 2003-2004	NMC 2004-2005
Fitness not impaired – case closed	63	62
Fitness impaired – suspended	46	42
Fitness impaired – removed	13	2
Judgement postponed	41	13
Adjourned	54	36
Applications to terminate suspension	14	13
Conditions of practice order		3
Interim suspension orders		3
Total	217	174

Of the remaining 19 cases, 1 was referred back to the PPC, 1 was not restored, 9 were not heard, and a further 7 were withdrawn.

Interim suspension

Under the Professional Conduct Rules 1993

The NMC has the power to order the suspension of registration while an investigation is under way. The committee uses this power if it appears that there is a serious risk to the public in allowing an individual to practise pending the outcome of an investigation.

A practitioner under police investigation for a serious criminal offence against patients would almost certainly be subject to interim suspension. An interim suspension may also be imposed if it is considered to be in the practitioner's own interest. This includes situations, for example, where practitioners are accused of stealing and self-administering drugs.

The practitioner who is being considered for interim suspension has the right to be present at the hearing and to be represented.

Under the NMC Fitness to Practise Rules 2004

There are two types of interim order under the new rules:

- ▶ an 'interim suspension order'
- ▶ an 'interim conditions of practice order'.

Both orders can be imposed by a panel for a period of up to 18 months. A panel will consider imposing such an order if the case before it is of a very serious nature and requires immediate public protection. Such a case may involve crimes of violence against patients, such as rape or assault. Another example may concern the personal use by the registrant of controlled drugs intended for a patient, which could result in the patient being deprived of pain relief.

During the reporting year, there were 20 interim suspension orders, and 7 conditions of practice orders.

Appeals and judicial reviews 2004-2005

There were 3 appeals during the reporting year.

One appeal was on the grounds that the nurse's representative had been incompetent and that the proceedings had therefore been unfair. The appeal was dismissed on the basis that the legal advisor to the Conduct Committee had acted to mitigate the effects of the incompetence, and that the respondent had had a full opportunity to put his case on credibility but had been disbelieved.

In another case it was decided that where an appeal had been made outside the time limit specified in the Nurses, Midwives and Health Visitors Act 1997, the High Court had no powers to extend it.

Another appeal was dismissed on the basis that there was no duty on the NMC to give reasons for its decisions on matters of fact, particularly in relation to the credibility of witnesses.

Council for Healthcare Regulatory Excellence (CHRE)

Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002, the CRHE has the power to appeal against a decision of the NMC (or the decision of other regulatory bodies) on the grounds that it is unduly lenient.

All decisions of fitness to practise panels are referred automatically by the NMC to the CRHE for consideration.

Case studies

This year, 39% of the charges considered by the Professional Conduct Committee concerned poor practice, and three case summaries have been chosen to reflect this.

The first case concerns a nurse in an Accident and Emergency Department who was involved in a system of triage. Poor record keeping was a feature in this case, including the falsification of records.

In the other two cases, poor record keeping also features, in conjunction with failures in drug administration. The NMC's *Guidelines for records and record keeping* state that the quality of record keeping is a reflection of wider standards of professional practice. Careless and incomplete record keeping often highlights wider problems with an individual's practice. Last year 6% of the charges concerned record keeping, with a further 12% accounted for by poor drug administration.

We have included an additional section which focuses on abuse of the elderly, with a case study to illustrate this issue.

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

Case 1

An adult nurse (RN1), who was working as an emergency nurse practitioner based in a hospital, faced allegations relating to the system of assessing patients which is known as triage.

It was alleged that she:

- ▶ failed to triage patients properly
- ▶ failed to complete triage documentation
- ▶ falsely represented that she had completed the triage documentation
- ▶ failed to deal properly with a complaint relating to the treatment of a patient in the triage process.

The nurse did not attend the hearing and wasn't represented in her absence but she had written to admit all the charges.

The incidents occurred within six months of the nurse taking up her post. During the course of the hearing, the committee heard evidence from her line manager that, during her induction, the nurse had learnt about the triage system and that the protocol for conducting triage was clearly displayed in the Accident and Emergency Department.

Details of the incidents

Whilst the nurse was on duty a three year old child was brought to the hospital by her family. She had been injured when falling down steps. The receptionist booked them in and they waited. An ambulance man informed the family that it was likely that they would be sent to another hospital if a fracture was diagnosed. So, after waiting for about 40 minutes, the family decided to go to the

other hospital. The parents complained that no triage assessment had been carried out before they left. The nurse's manager told the committee that the notes, however, had been filled out as if the patient had been triaged.

Another charge concerned the nurse carrying out triage in a public area. A patient had fractured her elbow after collapsing in the street. After the receptionist had booked her in, the nurse spoke to her in the waiting room and documented this as the triage session. The witness stated that others had also been triaged in a public area. The patient's friend, who had accompanied her, advised the patient to inform the nurse that she was going to make a complaint. The nurse's line manager said she had not been informed about this complaint and no record had been made. Furthermore, the discharge notes had not been completed properly.

The third set of circumstances concerned a patient who had come to the hospital with a chemical substance in his eye that was very painful. At 11:30am the nurse carried out triage and assessed him as a low priority. He remained in significant pain and discomfort and, at 1.05pm, the nurse's line manager reassessed him as urgent, obtained details of the chemical and irrigated his eye with normal saline. When questioned, the nurse stated that, on examination, she believed it was just dust in his eye. However when the nurse's line manager had seen him, he was wearing an intact patch and bandages which had been put on at work before he was taken to the hospital. The line manager said that, in her opinion, the initial triage was poorly carried out.

Decision on misconduct

The nurse had written to admit the facts of the charges and the committee decided that the charges amounted to misconduct.

The chairman said that by claiming to have triaged a child when she had not done so, appropriate treatment was delayed with potentially serious consequences. She had compounded this by creating a false record.

The chairman went on to say that triaging a patient in a public area compromised the privacy, dignity and confidentiality of the patient and also failed to show respect for the patient.

Failure to complete discharge notes could have had serious consequences.

The nurse had failed to meet her obligations under *The NMC code of professional conduct: standards for conduct, performance and ethics*.

Previous history

The nurse's line manager said that similar issues had been raised in the past concerning the quality of the nurse's triage and record keeping. She had failed to take recordings of the temperature of a child who had presented as being generally unwell with pyrexia. The nurse had been counselled following this incident. The nurse did not put forward any mitigation.

Judgement

The committee decided to remove the nurse's name from the register. The chairman stated that her actions had not been in isolation, had been repeated several times and clearly demonstrated unsafe practice.

The committee had no mitigation to take into account, such as information as to further training, testimonials or references. It had nothing to show that the nurse had any insight into what she had done wrong, nor had she made any expression of regret.

Case 2

An adult nurse (RN1 and 2) was employed as a staff nurse at a nursing home and faced charges relating to record keeping and the administration of medicines. She also faced a charge concerning the poor quality of a hand-over.

The nurse was present and represented by UNISON. She admitted the facts of all the charges.

Details of the incidents

The nurse had been working at the nursing home for just over five years and the incidents in the charges spanned a six-month period.

One of the incidents concerned an insulin-dependent diabetic patient whose blood glucose levels had remained high despite being on insulin. The nurse looking after him on the early shift had been sufficiently worried about him to contact the doctor. She had been monitoring him closely and gave a full hand-over to the respondent nurse.

When the respondent nurse handed over to the night shift she mentioned that the patient needed his BM test to be done at midnight and that he was being checked more often than usual. However, she did not give any information about the concerns over his condition, which had been expressed and acted upon by the nurse on the early shift.

When the night nurse went to check the patient at midnight she found him with rapid and shallow breathing and was unable to get a reading for his BM test. She called an ambulance and on his arrival at hospital the patient was found to be in a diabetic coma and suffering from pneumonia. The respondent nurse had made no entries in the patient's notes during her shift, but had subsequently written in the notes.

Other incidents concerned the administration of medicines. A care assistant gave evidence that the nurse often failed to give drugs at the time prescribed and he stated that he felt she was 'rather haphazard' in her approach. On one occasion, for example, she had signed for a medication which she did not know for certain had been given.

Similarly, on the same shift, the nurse signed that a nebuliser had been administered to a patient. The practice was for the new nebuliser to be washed after the first dose of the day had been administered and left out unpackaged to be used next time. However, when the next dose came to be given, the nebuliser was still in its packaging and, therefore, it was clear that the first dose had not been given.

There were 14 incidents concerning the nurse's failure to record the pulse of patients on Digoxin. At the disciplinary hearing, the nurse explained that she knew the importance of taking the pulse but she did not always remember to do this.

Decision on misconduct

The nurse admitted all the facts of the charges, which were found to be proven by the committee, and she admitted that the facts amounted to misconduct. The committee found her guilty of misconduct.

The chairman said that she had failed to comply with her obligations as a registered nurse to keep proper and accurate records. She had also failed to communicate effectively within the nursing team, and had therefore not ensured that her patients received safe and competent care.

The committee heard from the nurse's manager who said that the nurse had undergone an induction programme, which included record keeping and diabetic care.

Mitigation was put forward by the nurse and her representative. She had suffered ill health and family bereavements. Her working environment was stressful and the nurse had been working long hours and split shifts. The nurse was remorseful, and accepted that the care she had provided had been poor. She was now in employment and had references from her employer who knew about the proceedings taking place before the NMC.

Previous history

Disciplinary action had previously been taken against the nurse concerning poor recording of drug administration, and failing to examine a patient when a carer had reported that the patient was in pain. She had been given a final written warning and had undertaken further training in the administration of medicines but had declined further training in the care of the diabetic patient.

Judgement

The committee decided to remove the nurse's name from the register with immediate effect. The chairman said that the committee had considered the mitigation before them, the fact that she had admitted misconduct in relation to eight charges, her expressions of remorse in relation to that conduct and the explanation she provided with the references she had submitted. The chairman expressed sympathy for the crises she was facing during that period but considered that her actions demonstrated a lack of understanding concerning the administration of medication and the essential requirement of good record keeping.

She said the committee was influenced by the repetitive nature of her conduct, the fundamental mistakes that were made and ultimately her failure to take personal responsibility for those errors. The chairman stressed that each registered nurse is accountable for her own practice. The chairman said that it could not be satisfied that she could deliver safe and competent care as a registered general nurse.

Case 3

An adult nurse (RN1) had been working on night duty in a nursing home for over three years. She faced 12 charges of failing to record properly the administration of medication, making retrospective entries in the records, and failing to ensure that medication was actually taken by a resident. The charges spanned a period of a month. She admitted facts and misconduct in relation to all the charges and was present at the hearing but not represented.

Details of the incidents

The nursing home was part of a group of homes in the area, and had 70 beds. The head of operations for the nursing home group had noticed that controlled drug entries had not been counter-signed. This was discussed with the respondent and no disciplinary action was taken.

One month later, the nurse manager at the nursing home discovered that no entries had been made for two residents on three separate dates in the drug administration record. The next nurse on duty was unable, therefore, to see whether the drugs had been omitted, given or refused by the resident. A disciplinary meeting was set up to deal with this.

A further charge concerned a nurse working on the morning shift who had received a hand-over from the respondent nurse after night duty. When she went to administer the morning medication, she saw that none of the drugs at 10pm had been signed for in the medication administration record. She then discovered that the respondent was still in the nursing home and at 10.30am was signing for the previous night's drug administration.

During the hearing the committee heard from the home manager that the respondent had been supervised and monitored following an incident where entries in the controlled drug book had not been counter-signed. The committee heard that the nurse had been given a final written warning in relation to the entries in the controlled drugs register.

Decision on misconduct

The committee considered that the nurse was guilty of misconduct in respect of the charges she faced.

The head of operations for the nursing home group gave evidence that she had become involved when concerns were raised by the nurse manager. Together they had explored whether the respondent needed further guidance or training but the nurse herself said that she did not need further training, and she undertook to make accurate records in future.

Following the disciplinary hearing she had been given a final written warning and her performance was monitored.

The head of operations said she was generally a good and caring nurse and she couldn't understand why the nurse couldn't make proper records of drug administration.

The respondent appeared in person. She admitted facts and misconduct in relation to all the charges and gave evidence in mitigation. During 2003 she hadn't been coping very well but hadn't realised it at the time. She said there had been bullying at the workplace and she was on medication for anxiety and depression for which she had a long history. At the time of the incident her medication had been increased. She had been very tired and her mother had been ill following a stroke. She had also had severe financial problems, which led to her house being repossessed. In answer to questions from the committee the nurse said she hadn't informed her manager of her difficulties.

Previous history

There had been similar issues with the nurse's drug administration during her previous employment in a local NHS trust. The Divisional General Manager gave evidence that she had been dismissed from the trust for theft or attempted theft, failure to comply with legal requirements concerning drug administration, taking medication for her personal use, and increasing the dose of a patient's night sedation without a prescription.

He gave evidence that he had not been approached personally to give a reference for the nurse, but that a ward sister who had given her a reference referred to the fact that she had been dismissed following a disciplinary matter.

The home manager was recalled to give evidence and she said that she had followed up the references because of her concern about the disciplinary action, but that she had not been given the full facts about the nurse's dismissal.

Judgement

The committee decided to remove the nurse's name from the register with immediate effect. The chairman said that the committee had recognised her openness in admitting facts and misconduct, recognised that she was portrayed as a caring nurse and noted the difficulties in her personal life. However the committee felt that the misconduct was of a serious nature, involving vulnerable patients, and that her practice was fundamentally incompatible with continuing as a registered nurse.

Her acts and omissions showed reckless and repeated departures from the relevant standards set out in *The NMC code of professional conduct: standards for conduct, performance and ethics*. The patients were put at risk by her failure to record accurately the administration of medication. Therefore for the protection of the public and to uphold the good standing of the profession, the nurse's name should be removed from the register with immediate effect.

Abuse of the elderly

Elder abuse is one of the most serious social problems facing the UK today and yet one of the least acknowledged. There has been little recent research conducted around it and there is very little public awareness of how widespread it is.

The recent drama, *Dad*, which was shown on the BBC in February 2005 was developed with advice from some of the major charities that work with older people throughout the UK. Recent television programmes such as 'Panorama' and 'Dispatches' have also highlighted instances of poor care or abuse occurring in hospitals.

Abuse can occur anywhere, from the home to the care setting. The fitness to practise committees deal with allegations of elder abuse, which occur mainly in the nursing and residential home environment where the most vulnerable are nursed. This does not necessarily mean that more abuse occurs in these places. It may just be that monitoring and inspection, together with the small number of staff employed, means that abuse is more likely to come to light and be reported to the NMC.

We have been reviewing the way in which we collect essential statistics about abuse of the elderly within the UK. We've introduced new measures for the forthcoming year to monitor cases of abuse in detail. Statistics about the prevalence and geographical location of abuse across the UK will be recorded from all completed conduct hearings.

We will continue to work with other regulators, health providers and employers to establish an exchange of information that can help to protect patients. We are also keen to highlight the issue of elder abuse as part of nurse training, focusing particularly on the competencies of care and compassion. This will include how to recognise, report and prevent such abuse.

The NMC code of professional conduct: standards for conduct, performance and ethics (the Code) states that each registered nurse, midwife and specialist community public health nurse must act to identify and minimise the risk to patients and clients. They must act quickly if they have good reason to believe that they or a colleague, from whatever profession, may not be fit to practise for reasons of conduct, health or competence. The Code also states that they should be aware of the legislation, which protects those who raise concerns about health and safety issues.

Elderly people deserve high quality care and to be treated with dignity and respect. We hope that reassuring people about how to report these incidents will lead to a reduction in abuse cases.

Case study

The Professional Conduct Committee considered the case of a registered mental health nurse, working in the nursing unit of a dual registered home. The registrant faced seven charges, was present at the hearing and represented by a barrister. Five charges were denied. The two admitted charges involved removing a patient's brace, which contradicted her care plan, and a failure to complete a duty round.

Details of incidents

One charge concerned restraining a patient by standing on his foot. The patient was in his eighties and suffered from dementia. After the patient had become upset and agitated the respondent slid

his foot down the patient's shin to rest on his foot to restrain him. The respondent was interrupted by a care assistant who pushed him away upon seeing the incident.

The second charge involved the inappropriate restraining of another patient, who was in his sixties and also suffering from dementia. After a fight between two residents the respondent pinned one patient to the ground by sitting on top of him after he had fallen. As he got off, the patient swung out at him and he put his foot on the patient's chest to hold him down.

It was alleged that the registrant wrote up and administered a prescription drug that had been discontinued for an elderly patient, and that he administered a larger dose than specified on the prescription of another. The matron described how drugs had been discontinued or changed, and that the respondent had failed to note these alterations.

The respondent was also charged with responding to a care assistant's request for a patient's bandages to be changed, with words similar to, 'He can bleed. I'm fed up of changing them'. The patient concerned suffered from a skin condition that meant her bandages often needed changing. The respondent had changed the bandages earlier that day but refused to do so when the care assistant requested his help.

The admitted charges concerned removing a patient's brace contrary to her care plan, but at the request of the patient. The respondent felt that his actions were made in response to a patient in pain who held the right to refuse treatment. Another admitted charge detailed the respondent's failure to complete patients MAR charts properly on a duty round.

Committee decisions

After hearing evidence from five witnesses and from the respondent, all seven charges were found proved by the Committee. The charge concerning the removal of the patient's brace was found not to amount to misconduct.

The committee stated that it believed the Council's witness were truthful in their accounts of the incidents. In finding misconduct proved they said that the respondent had failed to act in a manner so as to promote and safeguard the interests and well being of patients and clients. They also considered that he acted in a manner that was detrimental to the interests, condition and safety of the patients in his care.

Previous history

The respondent failed to provide any references from his current employers, although he submitted a list of in-house service training he had completed. Evidence was heard that, at a previous place of employment, the registrant was suspended pending a disciplinary hearing and he had handed in his resignation. A character witness who had worked with the respondent at that home gave evidence that he was a punctual and reliable nurse. The respondent reported that at the time of the incidents he was feeling under stress.

Judgement

The committee decided to remove the nurse's name from the register with immediate effect and said that the removal should not be for a specified period of time. The respondent had been found guilty of six charges of misconduct involving actual or potential harm to vulnerable patients over a period of seven months. The committee also said that his behaviour had fallen well below the standards expected of a registered nurse and that their decision was made in order to protect the public.

Further information

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

Published by the Nursing and Midwifery Council in November 2005.

Information 11.05

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org

Protecting the public through professional standards