Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 16 August – Wednesday 24 August 2022

Virtual Hearing

Name of registrant:	Rebecca Jane Maher
NMC PIN:	91C1384E
Part(s) of the register:	Registered Nurse – Adult Nursing (March 1994) Registered Midwife (September 2000)
Relevant Location:	Windsor and Maidenhead
Type of case:	Misconduct
Panel members:	Darren Shenton (Chair, Lay member) Margaret Marshall (Registrant member) Seamus Magee (Lay member)
Legal Assessor:	Jayne Salt
Hearings Coordinator:	Jasmin Sandhu
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Miss Maher:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 2, 3, 4a, 4b, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 8c, 9, 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13ai, 13aii, 13b, 13c, 14, 15a, 15b, 15c, 15d, 15e,16a, 16b, 17a, 17b, 19, and 20
Facts not proved:	Charges 10c, 18a and 18b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you, a registered nurse:

1. Whilst being supervised on 19 July 2019:

(a) Incorrectly recorded the amount of microlax enema that had been received. **[PROVED]**

(b) Did not check the number of enemas received against the number recorded on the box. **[PROVED]**

(c) Did not have the prescription for microlax enema checked and countersigned by another RGN. **[PROVED]**

(d) Signed a MAR sheet to confirm that paracetamol had been given to [Resident A] prior to administering it. **[PROVED]**

(e) Did not sign MAR charts confirming that medication had been administered to residents. **[PROVED]**

2. On 17 August 2019, when administering oxycodone to [Resident B], did not have the entry checked and /or signed by a second checker. **[PROVED]**

3. On 29 August 2019, when administering oxycodone to [Resident B], did not have the entry checked and/or signed by a second checker. **[PROVED]**

4. On 15 November 2019. in relation to [Resident C]:

(a) Did not administer a Fencino patch, which was due. **[PROVED]**

(b) Did not sign the MAR chart to confirm that you had administered Calfovit to the resident. **[PROVED]**

5. On 18 November 2019 and/or 20 November 2019, did not complete the stock balance after you had administered medication. **[PROVED]**

6. On one or more of the following occasions administered an incorrect dose of memantine to [Resident D]:

(a) 30 October 2019. **[PROVED]**

(b) 13 November 2019. **[PROVED]**

(c) 14 November 2019. **[PROVED]**

7. On 28 December 2019:

(a) Did not record and/or administer [Resident C]'s Fencino patch, which was due. **[PROVED]**

(b) Did not record and/or administer [Resident C]'s Calfovit, which was due. **[PROVED]**

8. On 6 January 2020, did not follow colleague 1's instructions to carry out the following checks on [Resident E]:

(a) Repeat urine analysis and/or record any results. **[PROVED]**

(b) Take physiological measurements and /or record them. **[PROVED]**

(c) Carry out an oral assessment and/or record them. **[PROVED]**

9. Did not update colleague 1 and /or colleague 2 in relation to [Resident E]'s condition. **[PROVED]**

10. On 11 January 2020, in relation to [Resident A]:

(a) Incorrectly completed the accident report form. **[PROVED]**

(b) Did not review the resident's BMI score. **[PROVED]**

(c) Recorded an incorrect BMI score. **[NOT PROVED]**

11. On 3 January 2020 did not adequately complete the following documents in relation to [Resident F]:

(a) Power of attorney assessment. **[PROVED]**

(b) AMT. **[PROVED]**

12. On 20 January 2020, when reviewing the care plan for [Resident G] did not on one or more of the following occasions identify that the wrong name was on the care plan

(a) 3 December 2019. **[PROVED]**

(b) 2 January 2020. **[PROVED]**

(c) 20 January 2020. **[PROVED]**

13. On an unknown date prior to 26 February 2020, in relation to [Resident H]

(a) Left the following medication in an unlocked drawer:

i. Memantine. **[PROVED]**

ii. Sertaline. **[PROVED]**

(b) Did not administer medication which was found in the unlocked drawer to the resident namely Memantine and Sertaline. **[PROVED]**

(c) Signed the MAR chart to indicate that you had administered Memantine and Sertaline to the resident when you knew you had not. **[PROVED]**

14. Your actions at charge 13 c were dishonest in that you sought to create the impression that you had administered the medication to the resident when you knew you had not. **[PROVED]**

15. On 29 February 2020, when reviewing the PRN protocols for one or more of the following residents:

(a) In relation to [Resident I], incorrectly recorded the frequency of dose for cocodamol. **[PROVED]**

(b) In relation to [Resident J], incorrectly recorded the frequency of dose for ibuprofen gel as 48 hourly. **[PROVED]**

(c) In relation to [Resident K], incorrectly recorded the dosage for paracetamol. **[PROVED]**

(d) In relation to [Resident L], recorded that codydramol was administered to alleviate symptoms of loose stool which is incorrect. **[PROVED]**

(e) In relation to [Resident M], recorded that a salbutamol nebuliser was prescribed to alleviate pain which was incorrect. **[PROVED]**

16. In relation to [Resident N], did not record/ and or administer one or more of the following medications on one or more of the following dates:

(a) Respiridone on 28 February 2020. **[PROVED]**

(b) Lactulose on 3 March 2020. **[PROVED]**

17. In relation to [Resident G], did not adequately record and/or administer ketoprofen gel on one or more of the following occasions:

(a) 28 February 2020. **[PROVED]**

(b) 3 March 2020. **[PROVED]**

18. On 3 March 2020, in relation to [Resident A]:

(a) Did not record and/or administer paracetamol which was due at 12.00hrs. **[NOT PROVED]**

(b) Did not follow correct procedure in recording your error of recording that paracetamol had been administered at 17.00hrs when it had not. **[NOT PROVED]**

19. On 3 March 2020, in relation to [Resident O] did not record and/or administer Lansoprazole which was due at 07.00 hrs. **[PROVED]**

20. On an unknown date prior to 15 April 2020 made a comment about a resident being malodourous which was unprofessional. **[PROVED]**

AND, in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Maher was not in attendance, nor was she represented, and that the Notice of Hearing letter had been sent to her registered email address by secure encrypted email on 14 July 2022. Miss Maher was sent a further email on 9 August 2022 with the revised hearing dates of Tuesday 16 August 2022 – Wednesday 24 August 2022.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and, amongst other things, information about Miss Maher's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. It noted that Miss Maher was sent the revised hearing dates on 9 August 2022 by email. The panel also noted that the hearing link contained in the Notice was not being used for this virtual hearing due to technical issues and that Miss Maher was sent a copy of the new link by the Hearings Coordinator by email on 16 August 2022.

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

Decision and reasons on proceeding in the absence of Miss Maher

The panel next considered whether it should proceed in the absence of Mrs Maher. It had regard to Rule 21 and heard the submissions of Mr Kennedy who referred it to the cases

of *R v Jones (Anthony William) (No.2)* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

Mr Kennedy submitted that there had been no engagement by Miss Maher with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Mr Kennedy invited the panel to proceed in the absence of Miss Maher.

The panel accepted the advice of the legal assessor who reminded it that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones.*

The panel decided to proceed in the absence of Miss Maher. In reaching this decision, the panel considered the submissions of Mr Kennedy, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* and to the overall interests of justice and fairness to all parties. The panel noted that:

- No application for an adjournment has been made by Miss Maher;
- Miss Maher has not engaged with the NMC and has not responded to any of the correspondence sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses are scheduled to attend this virtual hearing to give oral evidence and not proceeding may inconvenience those witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019-2020 and a further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

The panel bore in mind that the Notice of Hearing sent to Miss Maher on 14 July 2022 indicated that the hearing would be starting on 15 August 2022 (yesterday) and contained a different hearing link. It was aware that Miss Maher had been sent the revised hearing dates as well as a copy of the new hearing link in advance of this hearing. There has been no response from her.

The panel noted that there is some disadvantage to Miss Maher in proceeding in her absence. She will not be able to challenge the evidence relied upon by the NMC at this virtual hearing and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Maher's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided to proceed in the absence of Miss Maher. The panel will draw no adverse inference from Miss Maher's absence in its findings of fact.

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

Mr Kennedy made an application to hear parts of this hearing in private on the basis that there will be some reference to [PRIVATE]. The application was made pursuant to Rule 19.

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

Having heard that there will be some reference to [PRIVATE], the panel determined to hold this hearing partly in private to maintain her privacy and confidentiality. As such, the panel will go into private session as and when matters relating to [PRIVATE] are raised.

Background

Miss Maher was referred to the NMC on 16 April 2020, at which time she was employed as a registered nurse at The Manor Care Home (the Home). The referral raises concerns in relation to Miss Maher's:

- Record-keeping;
- Medication administration;
- Monitoring and escalation of the deterioration of patients; and
- Attitude towards patients.

Miss Maher started working at the Home on 7 August 2018. Her employer was aware that Miss Maher was subject to a condition of practice order imposed by the NMC from an unconnected fitness to practise hearing. As a re-introduction to the workplace, Miss Maher was allocated to the smaller Christopher Unit, which accommodated a maximum of 14 residents with a variety of presentations. This was also to assist Miss Maher transitioning from an acute Trust to a Home healthcare setting.

[PRIVATE]

In July 2019, a routine audit took place at the Home. It is alleged that on 19 July 2019, whilst being supervised, Miss Maher made a number of medication errors, namely: failing to follow the correct procedure when receiving and booking in medication; failing to follow the correct procedure when administering medication; and failing to sign for medication following its administration. These errors were discussed with Miss Maher at an investigatory meeting on 31 July 2019.

A further audit was carried out and it was revealed that Miss Maher had allegedly signed for the administration of Oxycodone on 17 August 2019 and 29 August 2019 but failed to have this checked and countersigned by another nurse, as required.

On 11 September 2019, a further investigatory meeting was held with Miss Maher, following which the concerns about her medication management were escalated for a disciplinary hearing. The disciplinary hearing took place on 13 September 2019 and Miss Maher was issued with a final written warning.

In November and December 2019, a number of further alleged medication errors were identified and discussed with Miss Maher. These included that she:

- Failed to administer a Fentanyl patch to a resident on 15 November 2019 but had signed to say that she had.
- Recorded incorrect stock balances.
- Administered an incorrect dose of Memantine on three occasions.
- Failed to administer a Fentanyl patch or Calfovit medication to a resident.

It is also alleged that on 6 January 2020, Miss Maher failed to record the observations of a deteriorating resident and did not report this back to the Clinical Care Manager (Colleague 1), as she had been instructed to do so. This led to a further disciplinary investigation.

Later in January 2020, a number of further record-keeping errors were identified. These included that Miss Maher allegedly completed an accident and incident report form inaccurately, completed Power of Attorney documentation incorrectly, and made errors in a care plan for a resident.

On 26 February 2020, it is said that Colleague 3 found a plastic medication pot in an unlocked drawer in the nursing station on Christopher Unit. This contained two tablets which were identified as Memantine and Setraline. Further, Mrs Maher allegedly indicated on the relevant resident's MAR chart that this medication had been administered when it had not been. It is alleged that Miss Maher's conduct in this regard was dishonest.

On 29 February 2020, Miss Maher was asked to complete the PRN protocol sheets for the residents in all three units of the Home. These were subsequently discovered to contain many errors.

It is also alleged that Miss Maher failed to record and/or administer medication to two residents on 28 February 2020 and 3 March 2020.

An investigatory meeting was held on 3 March 2020 and Miss Maher was removed from her role of registered nurse and assumed the role of senior carer. She was prevented from carrying out medication rounds until a disciplinary hearing could take place.

It is also said that in the light of the ongoing concerns about Miss Maher's practice, there were sufficient grounds to proceed to a disciplinary meeting. This took place on 8 April 2020, at which she was dismissed with notice.

On 15 April 2020, whilst in her notice period, a report was made by a carer that Miss Maher allegedly refused to provide personal care to a resident and had made comments about the resident or their room being '*malodourous*'.

Witness evidence

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

- Colleague 1: Clinical Care Manager at the Home
- Colleague 2: Manager at the Home
- Colleague 3: Registered Nurse at the Home (at the time of events)

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kennedy to amend the stem of charge 11. [PRIVATE]. Mr Kennedy submitted that this amendment would provide clarity and more accurately reflect the evidence.

Original charge:

11 On 3 January 2020 did not adequately complete the following documents in relation to Resident P:

…

Proposed amendment:

11 On 3 January 2020 did not adequately complete the following documents in relation to [Resident F]:

…

The panel accepted the advice of the legal assessor who referred it to Rule 28 as follows:

'28.(1) At any stage before making its findings of fact, in accordance with [rule 24(5) or (11)], the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) [or the Fitness to Practise] Committee, may amend –

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'

The panel considered that such an amendment, as applied for, was for the purposes of clarity and accuracy. It was satisfied that there would be no prejudice to Miss Maher and no injustice would be caused to either party by the proposed amendment being allowed. The panel therefore decided to allow the application.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy and the advice of the legal assessor.

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 made the following findings:

Charges 1a, 1b, and 1c

1. Whilst being supervised on 19 July 2019:

(a) Incorrectly recorded the amount of microlax enema that had been received.

(b) Did not check the number of enemas received against the number recorded on the box.

(c) Did not have the prescription for microlax enema checked and countersigned by another RGN.

These charges are found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1, including her oral evidence, witness statement and accompanying exhibits. The panel considered Colleague 1's evidence (as a whole) to be clear and comprehensive, with helpful cross-references to her exhibits.

In Colleague 1's witness statement, she detailed that during her medication audit on 19 July 2019, it was found that Miss Maher incorrectly recorded the amount of microlax enema that had been received, did not check the number of enemas received against the number recorded on the box, and did not have the prescription checked and countersigned by another registered general nurse (RGN). Furthermore, in her oral evidence Colleague 1 set out the normal procedures for medicines being received from the Boots pharmacy, the usual medicines provider for the Home, along with the procedure for emergency prescriptions. Colleague 1 stated that there was a discrepancy with the amount of enema received and that the Home's medication policy was not followed.

The panel also had regard to the one-to-one supervision record dated 22 July 2019 (three days after the event), in which it was outlined that there was an incorrect amount of stock supplied (quantity of stock recorded as five when there was at least eight received) and that the prescriptions were not countersigned by another RGN.

Furthermore, this record also sets out Miss Maher's response to events '*During the discussion and feedback [Miss Maher] came across as being on the defensive at times, referring that 'that's night staff' responsibility to record stock balance— 'I was not one* [sic] *shift'… [Miss Maher] explained that it had been a stressful day when booking in [Resident E's] prescription, she had been asked to help a colleague with booking in a resident medication on another unit and she had been asked to carry out a medication round for another unit*.'

The panel determined that on the basis of the above, there was sufficient evidence to find this charge proved.

Charge 1d

1. Whilst being supervised on 19 July 2019:

(d) Signed a MAR sheet to confirm that paracetamol had been given to [Resident A] prior to administering it.

This charge is found proved.

The panel had regard to the witness statement from Colleague 1 in which she sets out that Miss Maher had signed a medication administration record (MAR) sheet to confirm that paracetamol had been administered to [Resident A], even though the chart indicated that the resident had refused their medication (having being coded as '*E*'). This was also confirmed in the one-to-one supervision record dated 22 July 2019 '[Resident A] *Paracetamol prescription had been signed, signature then crossed out and then coded 'E'*.

Colleague 1 provided clear evidence to the panel, supported by documentary policy that the procedure for administering any drug to a patient was to administer the drug first and then endorse the MAR chart to this effect. This is a fundamental nursing practice that ensured the safe administration of drugs to patients.

Whilst the panel did not have sight of this MAR chart, it did take into account Miss Maher's own admission as recorded during the one-to-one supervision. Miss Maher accepted that she did not follow the correct procedure as she was '*stressed out'*, having been called to help out with a medication round on another unit.

The panel was of the view that although it did not have sight of the relevant MAR chart for [Resident A], Miss Maher's own admission, together with the evidence from Colleague 1, whose evidence it considered compelling, was sufficient to find this charge proved.

Charge 1e

1. Whilst being supervised on 19 July 2019:

(e) Did not sign MAR charts confirming that medication had been administered to residents.

This charge is found proved.

The panel noted that in both her witness statement and oral evidence, Colleague 1 set out that Miss Maher did not sign for medication once it had been administered to the residents. This was also consistent with the supervisory record of 22 July 2019 in which it detailed that once a resident takes their prescribed medication, their MAR chart must be signed '*at the point of care'*, which it was not.

The panel concluded that whilst there is no MAR chart before it, the clear evidence of Colleague 1 suggesting that the charts had not been signed, is sufficient to find this charge proved.

Charges 2 and 3

2. On 17 August 2019, when administering oxycodone to [Resident B], did not have the entry checked and /or signed by a second checker.
3. On 29 August 2019, when administering oxycodone to [Resident B], did not have the entry checked and/or signed by a second checker.

These charges are found proved.

The panel concluded that these charges are proved to the extent that the oxycodone entry was not signed by a second checker.

In reaching this decision, the panel had regard to the evidence from Colleague 1. In her witness statement, Colleague 1 states that Miss Maher signed to confirm administration of Oxycodone for the resident as the first nurse but failed to have the entry checked and counter signed. Colleague 1 provided a copy of the entries from the controlled drug books

for the relevant dates, in which the panel noted that the relevant MAR chart had only been signed on one occasion, by Miss Maher. There were no signatures from a '*second checker*'.

For charge 2, the panel determined that the entry was written by Miss Maher and the gap for the '*given/disposed by'* space had not been completed. For charge 2, the gap was the other way round and the space for '*witnessed by'* had not been completed. This entry too appeared to have been written out by Miss Maher. Colleague 1 provided evidence that Miss Maher was the RGN with responsibility for drugs administration on this date. She further clarified that the responsibility carried by the '*second checker'* carries equal responsibility for the administration of drugs safely to patients and that both roles are indistinct in the '*administering*' of the actual drugs.

Having identified gaps in the relevant records, the panel determined that there was sufficient evidence to find these facts proved.

Charge 4a

4. On 15 November 2019 in relation to [Resident C]:

(a) Did not administer a Fencino patch, which was due.

This charge is found proved.

The panel took into account the witness statement from Colleague 1, in which she sets out that one of the other RGNs during a later review of the patient's MAR chart had noticed that [Resident C] did not have a Fencino (Fentanyl) patch administered the day before on 15 November 2019 when it had been prescribed. Miss Maher was the RGN with responsibility for this patient's medication on this date.

The panel noted that this was discussed during the one-to-one supervision record dated 19 November 2019, in which Colleague 1 stated that the resident's Fencino patch had been omitted on 15 November 2019 and that there was no reason for this omission.

On the basis of the above and in the absence of any contradictory evidence, the panel was satisfied that there was sufficient evidence to find this charge proved.

Charge 4b

4. On 15 November 2019 in relation to [Resident C]:
(b) Did not sign the MAR chart to confirm that you had administered Calfovit to the resident.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's witness statement in which it is detailed that Miss Maher '*appeared*' to have administered the Calfovit but then failed to sign for the administration. This was indicated by a '*dot*' on the MAR chart next to Calfovit on 15 November 2020. Additionally, a reduction in the stock balance was consistent with the drug having been administered.

During the record of the one-to-one supervision meeting held between Miss Maher and Colleague 1 on 19 November 2019, it was acknowledged that the Calfovit was administered but had not been signed for.

On the basis of the above, the panel was satisfied that there was sufficient evidence to find this charge proved.

Charge 5

5. On 18 November 2019 and/or 20 November 2019, did not complete the stock balance after you had administered medication.

This charge is found proved.

In reaching this decision, the panel had regard to the witness statement from Colleague 1 in which it is stated that her audit identified that Miss Maher failed to record stock balances of medications during the medication rounds on 18 November and 20 November 2019. This is reiterated in the supervision record dated 20 November 2019 in which a concern identified was that Miss Maher had not completed stock balances after her administration on 18 and 20 November 2019. Miss Maher did not provide an explanation for this during the supervisory one-to-one meeting.

The panel also bore in mind that during her oral evidence Colleague 1 explained that although there was a collective responsibility of RGNs to ensure that balance stocks were maintained, this omission was an individual omission from Miss Maher.

Based on all the evidence before it, the panel concluded that this charge is found proved.

Charges 6a, 6b and 6c

6. On one or more of the following occasions administered an incorrect dose of memantine to [Resident D]:
   (a) 30 October 2019.
   (b) 13 November 2019.
   (c) 14 November 2019.

These charges are found proved.

The panel had regard to the witness statement from Colleague 1, in which she stated that [Resident D] was prescribed two tablets of memantine (an anti-psychotic medication) however, on 30 October 2019, 13 November 2019 and 14 November 2019, Miss Maher

only administered one. Further, Colleague 1 exhibits the MAR sheet for [Resident D] dated 28 October 2019 to 24 November 2019 which confirms this.

The panel was of the view that, Colleague 1's evidence was sufficient to find these charges proved.

Charge 7a and 7b

7. On 28 December 2019:
(a) Did not record and/or administer [Resident C]'s Fencino patch, which was due.
(b) Did not record and/or administer [Resident C]'s Calfovit, which was due.

These charges are found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1. In her witness statement, Colleague 1 stated that she received a report from Colleague 4 (the Unit Manager on Heather Unit) that [Resident C] had not received their Fencino (Fentanyl) patch or Calfovit at 17:00 on 28 December 2019. Colleague 1 exhibited the relevant MAR sheet for [Resident C], which indicates that they were not given their Fencino patch or Calfovit.

The panel also had regard to the one-to-one supervision record dated 30 December 2019, in which it is outlined that Miss Maher was aware of Windsor Care LTD medication policy and guidelines set down by the NMC, and that she had been asked to administer medication on Heather Unit.

The panel received evidence that during the one-to-one supervision meeting with Colleague 1, when challenged, Miss Maher stated that she had been asked to administer medication on another Unit as [that] nurse had gone off duty sick. Miss Maher said she was concerned at the time as she had already administered the medication on Christopher unit.

Taking into account the evidence from Colleague 1, together with Miss Maher's admission and explanation as to why she omitted to administer [Resident C]'s Fencino patch and Calfovit, the panel concluded that these charges are proved.

Charges 8a and 8b

8. On 6 January 2020, did not follow colleague 1's instructions to carry out the following checks on [Resident E]:

(a) Repeat urine analysis and/or record any results.

(b) Take physiological measurements and /or record them.

These charges are found proved.

The panel noted that during her oral evidence, Colleague 1 detailed that she instructed Miss Maher to repeat a urine analysis and take physiological measurement checks, then to update her or Colleague 2 in relation to the resident's condition. Colleague 1 explained that as neither her nor Colleague 2 had received an update, she checked the patient's record herself and found that no record of any assessment had been made. The panel had regard to [Resident E]'s diary entries and record of care plan which indicate that a repeat urine analysis was not carried out and physiological measurements were not taken.

The panel also considered the minutes of the supervisory meeting dated 20 January 2020, during which Miss Maher accepted that she did not take a repeat urine analysis or physiological measurements for [Resident E] and stated '*day before busy, that's my only excuse*'.

On the basis of the direct evidence from Colleague 1, together with Miss Maher's own acceptance of her omissions, the panel finds these charges proved.

Charge 8c

8 On 6 January 2020, did not follow colleague 1's instructions to carry out the following checks on [Resident E]:

(c) Carry out an oral assessment and/or record them.

This charge is found proved (on the basis of not recording the assessment).

The panel took into account evidence from Colleague 1 who provided screenshots of text messages between her and Miss Maher. The panel considered that these messages indicate that Miss Maher did complete an oral assessment of the resident, given her level of detail outlined '*Her oral assessment was a score of two, she has plaque on her teeth. she has no obvious dental pain, she has at least one broken tooth front bottom right which doesn't seem to cause any pain or discomfort, she eats and drinks well…*'. The panel also noted that Colleague 1 stated that Miss Maher carried out an oral assessment, but that there was no documentation completed in respect of this assessment.

On the basis of the above, the panel concluded that this charge is found proved to the extent that whilst Miss Maher did carry out an oral assessment for [Resident E], she did not record this assessment. In reaching this decision, the panel took a '*common sense'* approach to the wording of the charge, in the context of the instructions given by Colleague 1 to Miss Maher to undertake a number of checks for this resident. The panel was satisfied that Miss Maher most likely did carry out an oral assessment of the resident, but she did not record this, and it was not until Colleague 1 followed up with her later that day in a text message that she provided this detail. The panel therefore found this charge proved.

Charge 9

9. Did not update colleague 1 and /or colleague 2 in relation to DP's condition.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence from Colleague 1, in which she stated that Miss Maher did not update her or Colleague 2 about [Resident E]'s condition, which then triggered a disciplinary investigation. The panel had regard to this investigation report which confirms that Miss Maher did not provide an update in relation to [Resident E]'s condition, and that Colleague 1 had to reach out to Miss Maher by text message to follow up on this.

On the basis of the above, and in the absence of any contradictory evidence, the panel concluded that this charge is proved.

Charge 10a

10. On 11 January 2020, in relation to [Resident A]:
(a) Incorrectly completed the accident report form.

This charge is found proved.

The panel had sight of the accident report forms dated 11 January 2020 which indicated that it was not completed in full and that there were inaccuracies. This is also confirmed by Colleague 1 in both her witness statement and oral evidence.

The panel also had regard to the minutes of the supervision meeting dated 20 January 2020 during which Miss Maher accepted that she did not complete the form in accordance with the requirements. However, the panel concluded that completing the form was relatively straight forward and was a routine activity at the Home, and that the actions to be taken in the event of the accident were fundamental nursing practice.

On the basis of all the evidence before it, the panel was satisfied that there is sufficient evidence to find this charge proved.

Charge 10b

10 On 11 January 2020, in relation to [Resident A]:

(b) Did not review the resident's BMI score.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1 who confirmed in her oral evidence that a body mass index (BMI) review was required as part of the '*waterlow assessment'*, an assessment to determine the condition of a person's skin. The panel had regard to the accident report forms dated 11 January 2020 which indicates that [Resident A]'s most recent BMI review (at the time) was 4 January 2020.

In the absence of any documentary evidence to suggest that Miss Maher reviewed [Resident A]'s BMI, the panel concluded that this charge is proved.

Charge 10c

10 On 11 January 2020, in relation to [Resident A]:

(c) Recorded an incorrect BMI score.

This charge is found NOT proved.

Having found that Miss Maher did not review [Resident A]'s BMI score, the panel determined that this charge is not proved. It could not find that Miss Maher recorded an incorrect BMI score for [Resident A].

Charges 11a and 11b

11. On 3 January 2020 did not adequately complete the following documents in relation to [Resident F]:

(a) Power of attorney assessment.

(b) AMT.

These charges are found proved.

In reaching this decision, the panel had regard to Colleague 1's witness statement, in which she set out that [Resident F] had a lasting power of attorney for finance. However, the box for finance wasn't ticked. Further, the resident's daughter was the nominated attorney, but that no contact details for her were documented.

The panel had sight of the Power of Attorney Assessment form for [Resident F] dated 3 January 2020 and noted that it had been sparsely completed by Miss Maher. Further, the panel had regard to the abbreviated mental test (AMT) for [Resident F] dated 3 January 2020 which also had not been completed.

In addition, the panel also took into account the minutes of the supervisory meeting dated 20 January 2020, in which Miss Maher accepted that she was responsible for completing the documentation and could not provide an explanation for not doing so *'I have no idea why not completed'*.

However, the panel concluded that the content of the requirements of the form were basic and the completion of which was a fundamental nursing requirement for a registered nurse within a care home setting.

On the basis of all of the above, the panel determined that Miss Maher did not adequately complete [Resident F]'s power of attorney assessment or their AMT. This charge is therefore found proved.

Charge 12a, 12b and 12c

12. On 20 January 2020, when reviewing the care plan for [Resident G] did not on one or more of the following occasions identify that the wrong name was on the care plan

(a) 3 December 2019.
(b) 2 January 2020.
(c) 20 January 2020.

These charges are found proved

The panel noted that the NMC accepts that the initial errors in [Resident G]'s care plan for the above dates could not be attributed to Miss Maher. This was also confirmed by Colleague 1, who, in her witness statement stated: '*cannot say for certain that Bex wrote the paragraph where* [Resident G] *is referred to as "*[Resident G]*" so I cannot attribute that error to Bex.'*

The panel was of the view that although there is no evidence to suggest that these initial errors were made by Miss Maher, she had an ongoing responsibility, as the RGN reviewing the care plans, to identify any errors and ensure the accuracy of these records. The panel had sight of [Resident G]'s care plan which shows that the wrong resident's name was used. It took into account the evidence from Colleague 1 who stated that Miss Maher failed to identify not only this incorrect name, but the gender of the patient as well.

On the basis of all of the above, the panel was satisfied that there was sufficient evidence to find these charges proved.

Charge 13a(i) and 13a(ii)

13. On an unknown date prior to 26 February 2020, in relation to [Resident H]
(a) Left the following medication in an unlocked drawer:
    i. Memantine.
    ii Sertaline.

These charges are found proved.

In reaching this decision, the panel took into account the evidence from both Colleague 1 and Colleague 3.

In Colleague 3's local statement dated 26 February 2020, she set out that she found two tablets in a medicines pot in the top drawer at the nurses station and reported this to Colleague 1.

In Colleague 1's witness statement, she confirms the account of Colleague 3 and exhibited photographs of the medication found. Colleague 1 further detailed that she was able to identify what the tablets were (Memantine and Sertaline) and who they were prescribed for [Resident C] by using patient records. The panel had regard to [Resident H]'s MAR chart which shows that they were prescribed Memantine and Sertaline at the relevant time.

Colleague 1 also stated that when questioned about these two tablets found, Miss Maher admitted to it straight away and explained that she put the medication into the drawer as she was called to assist with a GP round.

On the basis of all the evidence before it, the panel determined that there was sufficient evidence to find this charge proved.

Charge 13b

13 On an unknown date prior to 26 February 2020, in relation to [Resident H]
(a) Did not administer medication which was found in the unlocked drawer to the resident namely Memantine and Sertaline.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague 1, in which she stated that although [Resident H]'s MAR sheet had been completed,

indicating that the drugs had been administered, it is likely that they hadn't received their medication given the two tablets that were found in the medication pot.

The panel also bore in mind its previous finding that Miss Maher left a tablet of Memantine and a tablet of Sertaline in an unlocked drawer. In this regard, whilst the panel noted that the MAR chart had been signed for, it was not satisfied that Miss Maher administered this medication to the resident, given that they were found in the medication pot at the nursing station on that day.

This charge is therefore found proved.

Charge 13c

13 On an unknown date prior to 26 February 2020, in relation to [Resident H]
(b) Signed the MAR chart to indicate that you had administered Memantine and Sertaline to the resident when you knew you had not.

This charge is found proved.

The panel had sight of [Resident G]'s MAR chart for 26 February 2020 which showed that the two separate entries for Memantine and Sertaline had been signed for at the relevant time the drugs should have been administered. The panel heard clear evidence from Colleague 1, that to any other medical professional, a signed MAR chart would indicate to them that the drugs had actually been administered correctly.

The panel also had regard to Colleague 1's witness statement, in which it is stated that during a telephone call, Miss Maher admitted that she had left the medication in the unlocked drawer and that she did not administer them to [Resident H].

The panel determined that, on the balance of probabilities, Miss Maher did sign the MAR chart to indicate that she had administered [Resident H]'s medication when she knew she had not. This charge is therefore found proved.

Charge 14

14. Your actions at charge 13 c were dishonest in that you sought to create the impression that you had administered the medication to the resident when you knew you had not.

This charge is found proved.

In considering whether Miss Maher's actions were dishonest, the panel had regard to the the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was his conduct dishonest by the standards of ordinary decent people?

As per its findings in charge 13c, the panel determined that Miss Maher signed the MAR chart to show that she had administered [Resident H]'s medication when she knew she had not.

In considering whether Miss Maher's conduct would be regarded as dishonest by the standards of '*ordinary decent people'*, the panel bore in mind her state of mind at the time of this incident. At the investigatory meeting on 3 March 2020 and the follow-up meeting on 11 March 2020, Miss Maher accepted that she was responsible for placing the medication in the drawer and signing the MAR chart and knew she shouldn't have done this. [PRIVATE]

Whilst the panel took this into consideration, it was of the view that signing for medication which she knew she had not administered was a deliberate act and would be regarded as dishonest by the standards of ordinary decent people. The panel therefore found Miss Maher's actions at charge 13c to be dishonest. This charge is therefore found proved.

Charge 15a

15. On 29 February 2020, when reviewing the PRN protocols for one or more of the following residents:
    (a) In relation to [Resident I], incorrectly recorded the frequency of dose for cocodamol.
    (b) In relation to [Resident J], incorrectly recorded the frequency of dose for ibuprofen gel as 48 hourly.
    (c) In relation to [Resident K], incorrectly recorded the dosage for paracetamol.
    (d) In relation to [Resident L], recorded that codydramol was administered to alleviate symptoms of loose stool which is incorrect.
    (e) In relation to [Resident M], recorded that a salbutamol nebuliser was prescribed to alleviate pain which was incorrect.

This charge is found proved.

The panel received direct evidence from Colleague 1 who stated that Miss Maher was asked to complete and subsequently review the PRN protocol documentation for residents within the Home. It also had sight of the PRN protocols for Residents [I], [J], [K], [L], and [M] for 19 February 2020. The following errors were identified by Colleague 1, whose evidence was relied on by the panel:

- With regard to [Resident I], Miss Maher has recorded the frequency of dose for Cocodamol incorrectly as well as the minimum time interval.
- With regard [Resident J], Ibuprofen gel was prescribed for up to three administrations in 24 hours, but Miss Maher had recorded the frequency of dose as 48-hourly.
- In relation to [Resident K], the paracetamol dosage was incorrect, as was the maximum dose in 24 hours.
- In regard to [Resident L], Codydramol was recorded as administered to alleviate symptoms of loose stool, which was inaccurate.

- In relation to [Resident M], Miss Maher had a Salbutamol Nebuliser prescribed to alleviate pain. This was incorrect as the medication was a broncodilator which could be used when [Resident M] showed signs of breathlessness.

The panel also had regard to Miss Maher's admissions during the investigatory interview dated 3 March 2020 and the investigatory meeting on 11 March 2020, during which she accepted that she incorrectly completed the documentation but could provide no rationale for her deficiency. When a number of the errors were pointed out to her, Miss Maher accepted that '*that's terrible it was cut and pasted'*, and further explained '*I was stressed I was rushing…'*.

On the basis of all of the above, the panel determined that this charge is found proved.

Charge 16a

16. In relation to [Resident N], did not record/ and or administer one or more of the following medications on one or more of the following dates:

(a) Respiridone on 28 February 2020.

This charge is found proved.

The panel was provided with the MAR chart for [Resident N] which shows that there were signatures missing for the relevant entries on 28 February 2020. It also noted that the stock balances for Respiridone indicated that it was not administered on this day.

This is supported by the Colleague 1's evidence, who, in her witness statement, set out: *'I noticed a signature missing for* [Resident N]*'s Risperidone at 17:00 hrs dose on 28 February 2020 and noticed that no stock balance was recorded*.'

On the basis of the above, the panel was satisfied that this charge is proved.

Charge 16b

16 In relation to resident CM, did not record/ and or administer one or more of the following medications on one or more of the following dates:
(b) Lactulose on 3 March 2020.

This charge is found proved.

In reaching this decision, the panel took into account the MAR chart for [Resident N] which shows that there were signatures missing for Lactulose on 28 February 2020. It also had regard to the witness statement of Colleague 1 who stated, *'I also noticed a missing signature for a dose of Lactulose at 08:00 hrs on 3 March 2020*.'

Whilst it did could not determine any evidence from the stock balances on the MAR chart, the panel decided that there was sufficient evidence to find this charge proved.

Charges 17a and 17b

17 In relation to [Resident G], did not adequately record and/or administer ketoprofen gel on one or more of the following occasions:
(a) 28 February 2020.
(b) 3 March 2020.

These charges are found proved.

The panel took into account the evidence from Colleague 1 and the MAR chart entries for the dates where Miss Maher was responsible for medication. It noted that there was a dot recorded on [Resident G]'s MAR chart for the relevant time and entry and considered that this was not an adequate record to indicate that ketoprofen gel was administered to the resident on 28 February 2020 and 3 March 2020.

On the basis of the above, the panel concluded that it was more likely than not that Miss Maher had not administered and/or recorded the ketoprofen gel on these two dates. These charges are therefore found proved.

Charge 18a

18 On 3 March 2020, in relation to [Resident A]:
(a) Did not record and/or administer paracetamol which was due at 12.00hrs.

This charge is found NOT proved.

Whilst the panel heard evidence from Colleague 1 and had sight of [Resident A]'s MAR chart, in light of the illegibility of the record, which contained several markings and '*crossing outs'*, the panel considered that it was unclear who was responsible for the resident on that day to a sufficient standard. On this basis, it determined that this charge is not found proved.

Charge 18b

18 On 3 March 2020, in relation to [Resident A]:
(b) Did not follow correct procedure in recording your error of recording that paracetamol had been administered at 17.00hrs when it had not.

This charge is found NOT proved.

On the basis of all the evidence before it, which included the fact that during the disciplinary meeting held with Miss Maher during the afternoon of 3 March 2020, she had been removed from her responsibilities as a RGN, which included responsibility for medication administration. The panel determined that Miss Maher was not responsible for the recording of paracetamol which was administered to [Resident A] at 17:00. Therefore, this charge is not found proved.

Charge 19

19. On 3 March 2020, in relation to [Resident O] did not record and/or administer Lansoprazole which was due at 07.00 hrs.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1, who, in her witness statement and oral evidence, set out that Miss Maher, as part of the day team, was responsible for the administration of Lansopraole at 07:00. The panel had regard to [Resident O]'s MAR chart for the relevant date which shows that no entry was made for Lansorapole at the relevant time. The Home policy was, if a patient was sleeping at 07:00, the medication was to be administered by the day staff on their morning medicine administration round at 08:00. This was the responsibility of Miss Maher. This medication was only to be administered during the morning. Further, the panel noted that there was no reduction in the stock balance for Lansorapole that day, suggesting that this had not been administered.

On the basis of all of the above and in the absence of any contradictory evidence, the panel concluded that this charge is proved.

Charge 20

20. On an unknown date prior to 15 April 2020 made a comment about a resident being malodourous which was unprofessional.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence from both Colleague 1 and Colleague 2 who detail that Miss Maher refused to

assist with the personal care for the resident and said that either the resident or their room was '*malodourous*'.

The panel also had regard to the minutes of the disciplinary meeting dated 15 April 2020, during which Miss Maher admitted to making a comment in respect of the resident/the resident's room being malodourous, claiming that it was made in '*jest*'. The panel considered that a comment about a resident's malodour in this context was unprofessional and could not be regarded as simply a '*jest'.*

On the basis of all the above, the panel was satisfied that there was sufficient evidence to find this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel was provided with an impairment bundle by Mr Kennedy. The bundle consisted of a previous fitness to practise determination from 27 June 2018 relating to Miss Maher and the performance of her duties as a registered midwife. The outcome of which was the imposition of a conditions of practice order for a period of 18 months. Mr Kennedy informed the panel that an order from the previous fitness to practise proceedings was still in place. The panel was not provided with any further information in respect of Miss Maher's compliance with this conditions of practice order and considered only the context of the determination.

The panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Maher's fitness to practise is currently impaired. The panel was aware that whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct and impairment

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

Mr Kennedy also referred the panel to 'The NMC code of professional conduct: standards for conduct, performance and ethics (2015)' (the Code). He identified the paragraphs of the Code which the NMC submit have been breached in this case.

Mr Kennedy acknowledged that whilst each individual allegation relating to poor clinical practice may not of itself constitute misconduct. However, taken together, the clinical care provided by Miss Maher fell far below the standards of care expected of a registered nurse and therefore collectively amounted to misconduct.

Mr Kennedy submitted that the failings of Miss Maher were wide-ranging and occurred over a nine-month period and exposed residents in the care home to a real risk of harm. He identified that the areas of concern in Miss Maher's clinical practice related to the following broad areas:

- Record-keeping
- Medication administration

- Failure to follow instructions
- Failure to communicate effectively with colleagues
- Poor medication knowledge
- Dishonesty in the workplace setting

Mr Kennedy submitted that Miss Maher's conduct fell far below the standards expected of a registered nurse and does amount to misconduct.

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kennedy stated that as the failings in this case are clinical failings, remediation is possible. However, he submitted that Miss Maher has not remedied the deficiencies in her practice and therefore there remains a risk of repetition. Mr Kennedy submitted that Miss Maher did not admit to any of the allegations, albeit the burden is on the NMC to bring its case. Mr Kennedy informed the panel that Miss Maher has not engaged in these proceedings at any stage. Therefore, there has been no evidence of reflection to demonstrate that she is aware of the impact of her conduct on patients, colleagues, and the wider nursing profession. Mr Kennedy further submitted that Miss Maher has not provided evidence of any training or good practice since these events. In addition, he reminded the panel that Miss Maher made several errors, despite being subject to a conditions of practice order (as was imposed in 2018). Mr Kennedy submitted that in the absence of remediation, a finding of current impairment is necessary to protect the public.

Mr Kennedy further submitted that there is a public interest in having safe nurses to treat and care for patients and as such, a finding of current impairment is also required on public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments, including: *Roylance v General Medical Council, Cheatle v General Medical Council [2009] EWHC 645 (Admin), R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin), Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant, Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. It found that Miss Maher's conduct was in breach of the following sections of the Code:

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this you must:

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

10.2 identify any risks or problems that have arisen and the

steps taken to deal with them, so that colleagues who use the records have all the information they need

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must, as appropriate:

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, as appropriate:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel considered that breaches of the Code do not automatically result in a finding of misconduct. However, it found that Miss Maher had made numerous and repeated errors impacting the safe delivery of care to a number of residents, which when taken collectively, are serious.

The panel considered that Miss Maher's clinical care had fallen well below the standards expected of a registered nurse in the following areas:

- Record-keeping
- Medication administration
- Failure to follow instructions
- Failure to communicate effectively with colleagues
- Poor medication knowledge

In addition, having already determined that a false and misleading entry in the medical records of a patient was in itself a dishonest act and it had the potential to place the patient at an unwarranted risk of harm. This constitutes misconduct in its own right.

The panel determined that Miss Maher's conduct constituted a serious departure of the conduct and standards expected of a nurse and does amount to serious professional misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of her misconduct, Miss Maher's fitness to practise is currently impaired.

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

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

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

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

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

The panel determined that limbs a – d are engaged in this case. It considered that patients were put at a risk of harm as a result of Miss Maher's clinical failings; Residents were not given their medication at the correct times, medical records and documentation were not completed, patient assessments were not carried out, and Miss Maher did not follow basic instructions, nor communicate effectively with colleagues. The panel was of the view that by putting patients at a risk of harm, Miss Maher has breached fundamental tenets of the nursing profession. It further found that given Miss Maher's lack of integrity and honesty, she has brought the nursing profession into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty serious.

The panel bore in mind the case of *Cohen v General Medical Council,* in which the court set out three factors which it described as being '*highly relevant'* to the determination of the question of current impairment:

(a) Whether the conduct that led to the charge(s) is easily remediable?
(b) Whether it has been remedied?
(c) Whether it is highly unlikely to be repeated?

The panel considered that the clinical failings in this case are capable of remediation. It was of the view that the dishonesty allegation would be more difficult, but not impossible to remediate.

The panel considered whether Miss Maher has taken steps to address the failings in her practice. Miss Maher has not provided any evidence to this panel to demonstrate any insight or understanding of the impact of her actions on either patient safety, public confidence in the profession, or colleagues in the workplace. She has failed to engage in any of these fitness to practise proceedings, despite nurses having a duty to engage with their regulator. The panel was therefore unable to determine whether Miss Maher had taken any steps to remediate any of her failings or strengthen her practice.

In addition, Miss Maher has not provided evidence of any further training undertaken reflection, or remediation. In this regard, the panel determined that Miss Maher has not demonstrated a development of any insight. The panel also bore in mind that Miss Maher continued to make numerous and repeated errors, despite being subject to an existing conditions of practice order since June 2018, which covered similarly broad areas of clinical practice. Given this finding, the panel could not be satisfied that these errors would not be repeated.

In the absence of any remediation or insight, the panel determined that there is a risk of repetition should Miss Maher practise unrestricted. As such, it concluded that a finding of impairment is necessary on the grounds of public protection.

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

In this regard, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that an informed member of the public, aware of the misconduct in this case, would be concerned if a finding of current impairment were not made. The panel therefore also finds Miss Maher's fitness to practise impaired on public interest grounds.

Sanction

The panel decided to make a striking-off order. The effect of this order is that the NMC register will show that Miss Maher has been struck-off the register.

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.

Submissions on sanction

Mr Kennedy informed the panel that the conditions of practice order, relating to the unconnected case, imposed in June 2018 was replaced with a suspension order, following a review in June 2020. That suspension order remains in place and is scheduled to be further reviewed on 8 September 2022. Mr Kennedy also told the panel that there has

been some engagement from Miss Maher in relation to that case in that she has complied [PRIVATE]. Furthermore, at a review on 22 January 2022, information was received from a [PRIVATE] that Miss Maher had been working as a healthcare assistant (HCA).

Mr Kennedy stated that the NMC's sanction bid is that of a striking-off order. He submitted that the concerns in this case raised fundamental concerns surrounding Miss Maher's professionalism and that public confidence would not be maintained if she were not removed from the register. Mr Kennedy submitted that a striking-off order in this case is the only sanction to protect patients, members of the public, and maintain professional standards.

[PRIVATE]

The panel accepted the advice of the legal assessor who referred it to Article 29 of the Nursing and Midwifery Order (2001) (the Order) and to the cases of *Raschid and Fatnani v GMC* (2007) 1WLR 1460, *Watters v NMC* (2017) EWHC (Admin), and *Parkinson v NMC* (2010 EWHC (Admin).

Decision and reasons on sanction

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

The panel considered the following to be aggravating features in this case:

- Previous regulatory findings against Miss Maher for broadly similar concerns
- Lack of insight and remorse
- A pattern of misconduct over a period of time

- Conduct which put patients at risk of harm
- Dishonesty in a workplace setting which is directly linked to patient care.

[PRIVATE] The panel identified no other mitigating features in this case.

The panel had regard to the NMC guidance on '*Considering sanctions for serious cases'* (SAN-2) and considered that Miss Maher's dishonesty was at the lower end of the spectrum. In reaching this decision, the panel considered that Miss Maher's dishonesty was confined to a single incident and was not premeditated. Additionally, when confronted about her actions, Miss Maher immediately admitted that she had placed the drugs in a drawer next to the resident's bed.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the ongoing public protection issues identified.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the concerns and the ongoing public protection issues identified, an order that does not restrict Miss Maher's practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Maher's registration would be a sufficient and appropriate response. Given Miss Maher's lack of engagement, remediation and insight, the panel was not satisfied that if it was to impose any conditions, that Miss Maher would comply with them. The panel also noted that the previously imposed conditions of practice order from the unrelated Fitness to Practise case had not been effective in remedying the previous concern. Furthermore, the panel concluded that the placing of conditions on Miss Maher's registration would not adequately address the seriousness of this case and would not uphold the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. Whilst there has been no evidence of harmful deep-seated or attitudinal concerns, the panel noted that Miss Maher had not engaged with these proceedings. This case concerns a pattern of misconduct which is wide-ranging and occurred over a period of time. Miss Maher has not demonstrated any insight, remorse, or remediation regarding her failings. The panel also noted there was a repetition of broadly similar concerns that had been dealt with in the unconnected Fitness to Practise case and that the sanction imposed in that case was still in effect when the issues in this case occurred.

The panel was of the view that Miss Maher's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Maher's actions is fundamentally incompatible with her remaining on the register and as such, determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in that it would not protect patients or maintain confidence in the nursing profession.

Finally, in considering a striking-off order, the panel took note of the following paragraphs of the SG:

- *'Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

The panel was of the view that these concerns do raise fundamental questions about Miss Maher's professionalism and that public confidence in the profession would not be

maintained should she remain on the NMC register. The panel considered that the findings in this case demonstrate that Miss Maher's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Therefore, the panel determined that a striking-off order in this case was the only sanction that would sufficiently protect patients, the public, and maintain professional standards.

The panel considered that this order was necessary to protect the public and maintain public confidence in the profession.

This will be confirmed to Miss Maher in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Maher's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy, who submitted that an interim order is necessary to protect the public and is otherwise in the public interest. Mr Kennedy submitted that an interim suspension order for a period of 18 months is necessary to cover any possible appeal period. He submitted that an interim suspension order would be appropriate as it would be consistent with the panel's decision to impose the substantive striking-off order.

The panel heard and accepted the advice of the legal assessor who referred it to Article 31 of the Order.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate, due to the reasons already identified in its decision for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow sufficient time for an appeal to be made by Miss Maher, should she wish to do so.

If no appeal is made, then the interim suspension order will be replaced by the substantive striking-off order 28 days after Miss Maher is sent the decision of this hearing in writing.

That concludes this determination.