Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 27 February 2023 to Friday 3 March 2023 and
Monday 6 March 2023 to Thursday 9 March 2023

Virtual Hearing

Name of Registrant:	Annita Mace
NMC PIN	01I5919E
Part(s) of the register:	Registered Adult nurse, level 1 (21 September 2004)
Relevant Location:	Rotherham
Type of case:	Misconduct
Panel members:	Pamela Johal (Chair, Lay member) Sharon Peat (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Robin Leach
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Mr Samuel March, Case Presenter
Mrs Mace:	Present and represented by Ms Neair Maqboul, 7 Harrington St Chambers (7HS), instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a, 1b, 1c, 1d 2a, 2b, 3, 4, 5a, 5b, 5c, 7, 8a, 8b, 8c, 8d, 9, 10, 11, 12, 13
Facts not proved:	Charge 6
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (9 months)
Interim order:	Interim conditions of practice order (18 months)

Details of the charges (as read)

That you, a registered nurse:

1) On 9 March 2018;

    a. Incorrectly recorded on Resident 1's daily notes that you had administered a dose of 5mg of Midazolam to Resident 1, when you had administered a dose of 2.5mg.

    b. Recorded in Resident 1's medication administration record ("MAR") that you had administered 0.5ml of Midazolam when you should has recorded the entry as 2.5mg.

    c. Failed to record in the controlled drugs book the amount of Midazolam discarded following the administration of Midazolam to Resident 1.

    d. Failed to record the time and/or date and/or a signature for the administration of the Diamorphine to Resident 1 on Resident 1's MAR chart.

2) On 20 June 2018 on three occasions;

    a. Incorrectly recorded in the controlled drugs book that you had administered 2.5ml instead of 2.5mg of Midazolam to Resident 2.

    b. Failed to record the amount of drug discarded in the controlled drug book following the administration of Midazolam to Resident 2.

3) On or around the 25 June 2018, incorrectly recorded in Resident 3's notes that the Home had received a box of Furosemide for Resident 3 when they had not.

4) On 25 June 2018 failed to call the pharmacy upon discovering a box of Simavastin labelled as Furosemide for Resident 3 and/or when Resident 3's Furosemide was not delivered.

5) Between 3 July 2018 and 23 August 2018 told Colleague A and/or Colleague B;

    a. That you had carried forward a box of furosemide from a previous cycle to administer to Resident 3, or words to that effect

    b. That you had carried forward a strip of furosemide from a previous cycle to administer to Resident 3, or words to that effect.

    c. That you had told another nurse to look in the returns for a box of the medication to administer to Resident 3, or words to that effect

6) Your actions at charge 5a) and/or 5b) and/or 5c) were dishonest in that you were attempting to create a misleading account about whether or how Furosemide was available to be administered to Resident 3.

7) On 1 July 2018 failed to obtain a second signature when booking in Resident 4's medication on the MAR.

8) In relation to the administration of Diamorphine and/or Midazolam to Resident 4 on 1 July 2018 and/or the 2 July 2018, failed to;

    a. Start a care plan.
    b. Record where the needle was inserted.
    c. Record the date and/or time of when the needle was inserted.
    d. Record when the needle was due to be taken out.

9) Failed to record a start date on Resident 4's MAR.

10) Recorded for the administration of Midazolam and/or Diamorphine to Resident 4 in their June MAR or pre-recorded the administration of Paracetamol to Resident 4 in their July MAR.

11) On 2 July 2018, failed to record on Resident 4's MAR that you had administered a dose of Midazolam and/or Diamorphine at 7.40pm.

12) Between June 2016 and 23 August 2018, failed to carry out the medication count on a daily basis.

13) On 21st May 2019 failed to sign one or more residents' MARs after completing one or more mediation rounds.

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

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

At the outset of the hearing, Mr March made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to your [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Maqboul on your behalf indicated that she supported the application to the extent that any reference to [PRIVATE] should be heard in private.

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

The panel determined to rule on whether or not to go into private session. It decided to go into private session in connection with [PRIVATE], as and when such issues are raised in order to preserve your right to privacy.

Admissions

A case management form ("CMF"), signed by you and dated 28 September 2022 contained admissions to the following charges:

That you a registered nurse,

1) *On 9 March 2018;*

    a. *Incorrectly recorded on Resident 1's daily notes that you had administered a dose of 5mg of Midazolam to Resident 1, when you had administered a dose of 2.5mg.* ***(Admitted)***

    b. *Recorded in Resident 1's medication administration record ("MAR") that you had administered 0.5ml of Midazolam when you should has recorded the entry as 2.5mg.* ***(Admitted)***

    c. *Failed to record in the controlled drugs book the amount of Midazolam discarded following the administration of Midazolam to Resident 1.* ***(Admitted)***

    d. *Failed to record the time and/or date and/or a signature for the administration of the Diamorphine to Resident 1 on Resident 1's MAR chart.* ***(Admitted)***

2) *On 20 June 2018 on three occasions;*

    a. *Incorrectly recorded in the controlled drugs book that you had administered 2.5ml instead of 2.5mg of Midazolam to Resident 2.* ***(Admitted)***

    b. *Failed to record the amount of drug discarded in the controlled drug book following the administration of Midazolam to Resident 2.* ***(Admitted)***

3) *On or around the 25 June 2018, incorrectly recorded in Resident 3's notes that the Home had received a box of Furosemide for Resident 3 when they had not.* ***(Admitted)***

4) *On 25 June 2018 failed to call the pharmacy upon discovering a box of Simavastin labelled as Furosemide for Resident 3 and/or when Resident 3's Furosemide was not delivered.* ***(Admitted)***

5) *Between 3 July 2018 and 23 August 2018 told Colleague A and/or Colleague B;*

    a. *That you had carried forward a box of furosemide from a previous cycle to administer to Resident 3, or words to that effect.* ***(Admitted)***

    b. *That you had carried forward a strip of furosemide from a previous cycle to administer to Resident 3, or words to that effect.* ***(Admitted)***

    c. *That you had told another nurse to look in the returns for a box of the medication to administer to Resident 3, or words to that effect.* ***(Admitted)***

7) *On 1 July 2018 failed to obtain a second signature when booking in Resident 4's medication on the MAR.* ***(Admitted)***

8) *In relation to the administration of Diamorphine and/or Midazolam to Resident 4 on 1 July 2018 and/or the 2 July 2018, failed to;*

    a. *Start a care plan.* ***(Admitted)***
    b. *Record where the needle was inserted.* ***(Admitted)***
    c. *Record the date and/or time of when the needle was inserted.* ***(Admitted)***
    d. *Record when the needle was due to be taken out.* ***(Admitted)***

9) *Failed to record a start date on Resident 4's MAR.* ***(Admitted)***

10) Recorded for the administration of Midazolam and/or Diamorphine to Resident 4 in their June MAR or pre-recorded the administration of Paracetamol to Resident 4 in their July MAR. ***(Admitted)***

11) On 2 July 2018, failed to record on Resident 4's MAR that you had administered a dose of Midazolam and/or Diamorphine at 7.40pm ***(Admitted)***

12) Between June 2016 and 23 August 2018, failed to carry out the medication count on a daily basis. ***(Admitted)***

13) On 21st May 2019 failed to sign one or more residents' MARs after completing one or more mediation rounds. ***(Admitted)***

Decision and reasons on facts

The panel heard from Ms Maqboul on your behalf, who confirmed to the panel that you made full admissions to charges 1a, 1b, 1c, 1d, 2a, 2b, 3, 4, 5a, 5b, 5c, 7, 8a, 8b, 8c, 8d, 9, 10, 11, 12, 13**.**

The panel found at this stage in the proceedings all charges admitted proved in their entirety.

Chronology of events

June 2016	You began employment at Moorgate Lodge Nursing Home.
March - July 2018	Concerns raised about your practice at Moorgate Lodge Nursing Home.
September 2018	You were dismissed from Moorgate Lodge Nursing Home.
September 2018	Current NMC referral received.
October 2018	You commenced employment with Crown Care at Clarence House.
July 2019	You were dismissed by Crown Care at Clarence House and new concerns raised with the NMC.

In reaching its decisions on the facts in particular Charge 6, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr March on behalf of the NMC and by Ms Maqboul your representative.

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

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

- Witness 1: (under oath) — Assistant Manager, Clarence House Care Home
- Witness 2: (under affirmation) — Park Lane Healthcare Limited Operations Director
- Witness 3: (under affirmation) — Deputy Manager, Moorgate Lodge Nursing Home at the time of the allegations

The panel also heard evidence from you under oath.

Witness 1's evidence (Day 1)

Witness 1 told the panel that she is currently the interim deputy manager at Clarence House Care Home (the Home). She said she acted in the manager's role for a period of time. She gave the panel a description of the layout of Home, that there was approximately 20 - 25 beds on each floor. She said that residents who required medications were given them at different times of the day according to their needs.

Witness 1 said that she worked closely with you and up until the Medication Administration Record (MAR) chart incident had no concerns in relation to your ability.

In relation to the unsigned MAR chart Witness 1 told the panel you accepted that you had not signed and you did not seek to challenge this or blame anyone else (Charge 13).

Ms Maqboul suggested to Witness 1 that she had stated that you could sign the charts when you were next at work, suggesting she did not consider it to be so serious that it needed to be rectified immediately. Witness 1 responded that she had checked the stock of medications remaining and knew that all medication had been given but you had not signed the MAR charts.

Witness 1 was referred to her statement in which she stated: *'We had a full and frank conversation. I told her this was not acceptable and if repeated, then it would be a formal matter dealt with by the care home...'*, and told the panel you were apologetic about the error and described some of the pressures you were facing at the time.

Witness 1 was asked by the panel what her understanding was in relation to your NMC referral. She said she was aware of the NMC investigation as you had explained the errors you have made and your [PRIVATE] at that time, [PRIVATE] when the MAR charts were not signed, [PRIVATE] and this appeared to [PRIVATE] which contributed to how you were working. Up until this point Witness 1 was very positive about your professionalism and your working practice.

Witness 2's evidence (day 2)

Witness 2 told the panel that he is currently a director at the Moorgate Lodge Nursing Home and was the chair of your disciplinary meetings on 23 August 2018 and 7 September 2018. He confirmed that he does not have a nursing background or any formal clinical qualifications. He told the panel that he was the only appropriate director available at the time to conduct your disciplinary hearing. He said that he has a legal background and in his role as operations director he oversees human resources.

Witness 2 was asked by the panel who took minutes of the disciplinary meetings to which he said an administrator did, however he could not say if all of what was discussed was included in the minutes. He was asked by the panel whether you had an

opportunity before they were circulated to sign the minutes or raise any questions about their contents and accuracy. He told the panel that he could not recollect due to the time that has elapsed since then but considered this to be standard practice.

Witness 2 was referred to the part in his written statement of 5 June 2019, which states '*Even if it was the fault of another nurse, which we had not established, she had been knowingly administering someone else's returned medication, or there was no furosemide at all and she had been signing to say it had been given when it had not',* he conceded that it was a possibility it could have been the fault of Ms 2.

Witness 2 stated that he believed Ms 2 had been subject to formal action in respect of the Furosemide issue and recalled requesting that both you and Ms 2 were treated equally in terms of the process adopted.

Witness 2 was referred to the part in his written statement, which states that you: *'signed the MAR chart to say she had given the furosemide 5 times (29 June to 3 July 2018) despite there being evidence there was none of that drug in that building...'.* He was asked whether there may have been some Furosemide somewhere else in the Home. He was no longer confident in his assertion.

Witness 2 was asked if he was aware that you had requested time off due to [PRIVATE] and that this request was refused. He stated it was not. He was asked if he was aware of [PRIVATE] that you were experiencing at the time; he said he was aware of some historic issues. He confirmed that your [PRIVATE] were not considered as part of the disciplinary process.

Witness 2 (Day 5)

Witness 2 was recalled to give further evidence on this day.

Ms Maqboul asked him whether he thought the language he used in the disciplinary meetings was strong phraseology and sometimes inappropriate. Phrases such as *'common sense dictates'* and '*tried to shift the blame'* were used in relation to your

responses to his questions and you were criticised for changing your answer in relation to the Furosemide. He said he did not think he used particularly strong or emotive language.

Ms Maqboul put to Witness 2 that in his evidence he said that Ms 2 had been subject to a formal warning from the current manager and he said he had always assumed that to be the case. However, he accepted that with hindsight and based on the evidence before the panel today, he now believes due to the absence of records, this may not have been the case that she was given a formal warning, more likely an informal warning was given. He said that other witnesses would be better placed to provide more insight into what the outcome was. Ms Maqboul asked what steps he took to check if Ms 2 was given a formal warning, he replied that he has over four hundred employees to oversee and did not know details of every disciplinary process in place.

Witness 2 was asked who had interviewed Ms 2 and how long did her interview last to which he replied he had *"no idea"* to both questions. Ms Maqboul suggested that Witness 2 was notified that there were issues with Ms 2 and subsequently had conversations with the manager in this regard. He said that he would not necessarily follow up such matters as Ms 3 was more experienced and best placed to do so.

Witness 2 produced a handwritten statement from Ms 2 made at the time of the incident, which was disclosed for the first time at this hearing at the request of the panel. In that statement Ms 2 said that she definitely gave Resident 3 the correct medication, namely the Furosemide, and that Resident 3 would have highlighted any shortfall as she always counted her medication.

Witness 2 told the panel that the record keeping from the disciplinary meetings was poor due to the length and complexity of the meetings and that it was not proper for him to interfere with the contents of them.

Witness 3's evidence (Day 3)

Witness 3 told the panel that she is no longer at Moorgate Lodge and left in 2019.

In response to Ms Maqboul's questions, Witness 3 confirmed that apart from your investigation, she had undertaken two previous investigations in 2018. She said she had been in the post a few weeks before your investigation commenced. Witness 3 told the panel that she had not worked on shift with you but she would speak to you on each shift and found you to be very welcoming; she said '*I can't fault Annita, to be honest'.* She also said she often sat in handovers in the mornings and that you were invested in ensuring the work was done, that you were caring and knew the residents well which was invaluable.

Witness 3 was referred to the investigatory meeting which she conducted on 31 July 2018. When asked what recruitment took place when you left the Home, she said they employed another nurse to fill your role and took on another registered nurse besides to manage demand.

She said that she was aware that you were experiencing [PRIVATE]. When asked who was responsible for approving leave and providing additional support, Witness 3 stated it would be Ms 3, the Home manager.

Witness 3 was asked by the panel whether it was protocol or policy to put details of wasted discarded controlled drugs in the controlled drugs book, or whether it was just good practice to do so. She said it was the Home's policy to record it in the controlled drugs book. The panel referred Witness 3 to the copy of the controlled drugs book record page in the Exhibits in relation to the Midazolam and the column marked '*Given / Disposed by signature'* which shows that the columns are not used as described by the columns in the particular book.

Witness 3 was referred to the part in her statement which refers to a '*box'* of Simvastatin which was incorrectly labelled by the pharmacy as Furosemide. She was asked by the panel if a '*blister pack'* is the same as a *'dosette box'* and she confirmed that it was. She was asked if it is possible that the prescription was issued from the pharmacy and you had a little stock left. She said Ms 2 said it was not given and was just signed for.

Witness 3 was referred to the part in her statement which related to the prescribed and administered Midazolam and Diamorphine and was asked why they are not on the July drug sheet. Witness 3 claimed that the June MAR chart was used as no other MAR chart was available. The Midazolam appeared to have been added on to June MAR chart but should have been on the July MAR chart. It appears that the June MAR chart was used instead of the July MAR chart in error to document the Midazolam and Diamorphine administration.

Witness 3 confirmed that she conducted a thorough investigation into Ms 2's actions in relation to the Furosemide independently of your investigation and confirmed Ms 2 was investigated first, then your investigation was concluded. Witness 3 told the panel that when she had spoken to Ms 2 as part of her investigation, Ms 2 initially claimed that she had administered the Furosemide, as documented in the endorsed MAR chart, but when presented with Witness 3's findings of her investigation, conceded that she could not have administered it as she was informed that none had been delivered by the pharmacy.

When questioned by the panel, Witness 3 maintained her assessment that there must have been no Furosemide delivered by the pharmacy. Witness 3 was asked whether, as part of her investigation, she had asked the pharmacy to conduct an audit into what Furosemide had been delivered to the Home. Witness 3 claimed she had spoken to the pharmacy but had not asked them to do an audit.

Witness 3 confirmed that her investigation findings did not reveal that you had highlighted, as required, that there had been an error in the delivery of the Furosemide, but she confirmed that she was unaware of your completion of a 24 Hour Report or that that you had placed a note under the managers door notifying her to that effect at the time.

Witness 3 was referred to her statement in which she stated there was no Furosemide recorded in the returns book which also indicated that there was no Furosemide available at the Home. She stated that she was confident that this was the case and maintained her assessment that Resident 3 must have gone 10 days without Furosemide. In support of this, Witness 3 stated in evidence that Resident 3's

Furosemide dose had never been varied by their GP, but when challenged confirmed she had documented this as being the case in her witness statement in January 2018.

Witness 3 was asked if she was aware that you [PRIVATE] and had requested time off from work and it was refused. She said it was not mentioned in their private conversation.

Witness 3 said that there may be other notes and documents in relation to Ms 2's investigation, however as she no longer works at the Home, she did not have access to the notes.

Your evidence (day 4 and 5)

You gave an overview and background to your career. You told the panel that you started your career as a carer for twenty years before qualifying as a registered nurse in 2004. You said that you did not have a good working relationship with Ms 3, the manager at the Home and you felt that she did not like you and there was a personality difference between you. You said you had asked her to keep you updated if you had done anything wrong.

You told the panel that you [PRIVATE]

You told the panel you tried to get help [PRIVATE] and you were too busy supporting them and neglected yourself.

You told the panel that in 2018 [PRIVATE].

You told the panel that you went to see Ms 3 when you got the phone call [PRIVATE] when your shift was finished. You then asked her if you could at least keep your mobile phone with you to keep up to date on what was happening; she agreed and said to keep it on silent. You went to speak to her a little later on to tell her [PRIVATE].

You told the panel in response to the concerns you raised, she walked you to the reception area and said "*when you walk through these doors and come into my Home*

you leave everything else outside and do not bring it into work at the Home". You told her [PRIVATE] and you needed some time off, she said you would not get paid. You told the panel that it was a concern for you if you were not paid as [PRIVATE]. You told the panel that Ms 3 told you that you are in the Royal College of Nursing (RCN) and they have a [PRIVATE] and you should get in touch with them. You told the panel that as one human being to another, you felt humiliated and disgusted. You told the panel that your f[PRIVATE].

In relation to Charge 6 you told the panel that your understanding of the Furosemide issue and how it was stored in relation to Resident 3, is that she had been on Furosemide for some considerable time regarding her heart complaint. Sometimes the dose was varied, withheld, increased or decreased. You said you worked with Ms 2 as much as you did with any other nurse, she was on a different floor.

You told the panel that you made a note to self in relation to the Simvastatin being delivered instead of the Furosemide and put a note under the manager's door about it. You said you spoke to Ms 4 and she told you to speak to Ms 2 which you did. You told the panel that Ms 2 told you to leave the Furosemide and she would deal with it the next day. You said that you thought there was Furosemide in the building because Ms 2 had told you where it was, at the back of the cupboard.

You told the panel in relation to your disciplinary meeting with Witness 2, the manner in which you were dealt with during the meeting made you nervous and you could not remember things. You further told the panel that you did not want to get your colleague Ms 2 into trouble.

You told the panel that in your new job you have the support from your manager, deputy manager and nurses and they are responsive to any concerns you may have. You said you did not have to ask, they put a plan of action in place and arranged for the deputy manager to work alongside you on shift, who checks your MAR charts, controlled drugs book and your hand over documentation. You said it immediately had the effect of reducing your stress which was good.

You told the panel that you cannot envisage doing anything else; nursing is your life. You said that you are now [PRIVATE] and do not think you will be able to start another job. You said nursing is your passion and dedication. You said you love what you do and that you loved the resident care aspect of your job which is what you trained for and worked in for forty years.

Ms Maqboul asked why you felt you needed to protect Ms 2, You said you are just that type of person. You said you already knew you would get into trouble for it and did not see any point in involving anyone else. You said that it would have been difficult to work with Ms 2 in the workplace and you would have to leave as she was a long-standing member of staff and it would be her word against yours and you would have lost.

The panel clarified with you the dates of the previous NMC referral. You said that they were from November 2004 – November 2006 and was dealt with in 2010 when you received a conditions of practice order regarding administration of medications and medications management. You told the panel that the order was revoked in November 2011.

In cross-examination you said it was a very busy home and there was too much work for only two nurses. This problem was raised with management by some nurses. However, you said you were too scared to complain by yourself.

You reiterated the fact that you would never put residents at risk. [PRIVATE] you did not feel that you were putting residents at risk. Although your [PRIVATE] told you to walk out, you said that you could not do that.

In respect of the dishonesty allegation, you said that the wrong medication had been sent by the pharmacy. You informed the manager by putting a note under her door. You also told Ms 2 about the wrong medication being sent and made a record on the 24 hour report sheet.

You said that you did not carry any Furosemide forward. Further, there was no Furosemide in the '*Returns Box'*. You said you would not have been allowed to take it out of the '*Returns Box*', because that would have been considered to be re-prescribing.

On your return to work there were Furosemide tablets in the trolley for Resident 3. You cannot say where the tablets came from.

You accepted that there were three possible scenarios. Firstly, Resident 3 had been deprived of Furosemide for ten days. Secondly, someone else's medication had been given to her. Thirdly, there had been a failure to return the medication to the *'returns box'* at some point in time. You agreed that all three scenarios would amount to serious irregularities.

You agreed that you said the words contained in Charges 5a, 5b and 5c intentionally, knowing they were untrue at the time you said them. You said them in order to protect Ms 2. You said that did not believe, however, that you were being dishonest.

In re-examination you were asked why you felt the need to protect Ms 2. Your answer was *'I am that type of person…I already knew that I would be in trouble……I did not want to involve anyone else……my life would have been difficult in the workplace'*.

Closing Submissions

Mr March submitted that the panel in respect of dishonesty should apply the test as laid out in the case of *Ivey v Genting Casinos*.

He repeated the evidence given by you, namely that you accepted that you knew the statements made by you in Charges 5a, 5b, 5c were untrue, and that you said them intentionally in order to mislead. He submitted that this amounted to the dishonesty alleged in Charge 6.

He further stated that any sympathy the panel might have for you had no bearing on the issue of dishonesty.

In response, Ms Maqboul submitted that the panel must consider things in the round and in context, and thus the culture in the home was relevant.

She reminded the panel that it was for the NMC to prove their case.

She criticised the unsympathetic and unfair manner in which the disciplinary hearings had been conducted, the poor minute taking, and the fact that you had not been offered the opportunity to comment on the minutes arising from the second hearing in September.

She commented also on the fact that Ms 2 had not been called to give evidence, and generally questioned the lack of thoroughness of the investigation.

Decision And Reasons On Facts

The panel heard and accepted the advice of the legal assessor. He directed the panel to the case of *Ivey v Genting Casinos* in relation to dishonesty.

The panel considered the evidence of all the witnesses called, the statement of Ms 1 which was read, as well as all the documentary evidence. In particular the panel assessed the credibility and recollections of the witnesses.

The panel reminded itself that it would decide which facts, if any, had been proved by the NMC.

The panel were aware that all charges, except Charge 6, had been admitted by you at the commencement of the hearing.

Charge 6

The panel found this charge not proved.

‘That you, a registered nurse:

6) *Your actions at charge 5a) and/or 5b) and/or 5c) were dishonest in that you were attempting to create a misleading account about whether or how Furosemide was available to be administered to Resident 3.’*

The panel then considered the wording of Charge 6 where it is alleged that you acted dishonestly in respect of statements made by you to Witnesses 2 and 3. The panel noted that you had admitted making those statements which form the subject matter of Charges 5a, 5b and 5c.

However, the panel found that you did not attempt to create a misleading account about whether, or how, Furosemide was available to be administered to Resident 3, for the following reasons:

Firstly, the MAR chart for Resident 3 does not purport to show that a new supply of Furosemide had been checked in - in other words that is consistent with your account that the pharmacy sent Simavastin, and not Furosemide.

Secondly, the MAR chart records that you and Ms 2 administered Furosemide to Resident 3 over a number days. Ms 2 administered for the first 4 days of that cycle recording the running total daily followed by you. This is confirmed by Ms 2 in her handwritten statement. The panel have no reason to doubt Ms 2’s account, particularly in the absence of the NMC’s failure to call her to explain the position, and concluded that Resident 3 was given Furosemide as prescribed.

Thirdly, the panel concluded that you endeavoured to give an honest account during the Investigation Meeting on 31 July 2018. You made it clear at that meeting that Resident 3 received her medication from spare Furosemide tablets left over from the previous month.

The panel concluded that your misleading statements were made to Witnesses 2 and 3 after being subjected to unnecessarily harsh questioning during the two disciplinary hearings later on in August and September 2018. The panel accepted that you were put

under pressure at those two hearings and you made those statements to protect your work colleague Ms 2. Those statements were not made, however, to create a misleading account about whether, or how, Furosemide was available to be administered.

In coming to this conclusion the panel noted that the minute taking at the two hearings was inadequate. This was confirmed by Witness 2. In respect of the second hearing, you should have been sent the minutes for your consideration and comment. It appears a large part of the second hearing was concerned with the Furosemide issue making it all the more important for you to have sight of the minutes.

Accordingly, the panel found Charge 6 not proved. As stated earlier, the panel found the other charges proved by way of admission.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

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

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

Mr March identified paragraphs 10,10.3; 10.4; 8, 8.2, 8.6 of the Code as the specific, relevant standards where your actions amounted to misconduct.

Mr March submitted there being a large number of charges does not mean that misconduct has been found generally. He submitted that broadly, all of the admitted charges relate to poor record keeping a failure to record details that should have been recorded or were incorrectly recorded. He submitted that if records are not properly made it could make a difference to a colleague coming on a later shift, especially in an emergency, there could be a risk of serious harm to residents if records are not properly kept.

In relation to Charge 5, Mr March submitted that whilst your statements were not dishonest, it is still the case that you have accepted that you knew these statements were not true, and the panel has found you gave false accounts to protect a colleague. Mr March submitted that the panel may wish to consider whether paragraph 8 of the Code could still be engaged, as you knowingly gave an inaccurate account even if the intention behind it was not dishonest, and even if it was to protect another nurse colleague.

Mr March submitted that your actions fall short of the conduct expected of a registered nurse and amount to misconduct.

Mr March 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 cited reference the case of *and Grant* [2011] EWHC 927 (Admin) as applicable case law.

Mr March submitted that your fitness to practise is currently impaired by reason of your failure to accurately record MAR charts and failure to carry out medication counts. He submitted that these failures put residents at risk of harm and are a risk to the public.

Mr March submitted that you had previously been referred to the NMC for similar concerns, and even if some time has elapsed since that referral, you should have been more mindful of the matters in the charges currently being addressed. He submitted that this is likely to be of concern to members of the public were you to return to practise without restriction.

Mr March acknowledged that there were a number of contributory factors which lead up to these events. However, he submitted that record keeping is a fundamental nursing skill and you fell below the standards expected of a registered nurse in this regard. He submitted that the nursing profession and the NMC as its regulator is likely to be undermined if no action is taken. He submitted that these were not isolated incidents and are in the context of you having been referred previously in relation to medication management and communication failures.

Ms Maqboul, at the outset of her submissions, told the panel that you accept that your actions amount to misconduct. She submitted that in spite of the prevailing environment at the Home, you recognise that there is a duty on you to adhere to the Code.

Ms Maqboul submitted, however, that you do not accept that you are currently impaired. She submitted that you have gone to some lengths to ensure that these matters never reoccur and that your practice has since been strengthened. Ms Maqboul submitted that she has no disagreement with the test in *Grant*, however a breach of a standard in the

Code does not automatically mean that a nurse's fitness to practise is impaired. She submitted that the panel is duty bound to consider what has happened since then.

In relation to the previous referral, Ms Maqboul submitted that it be properly disregarded by the panel as that incident happened over seventeen years ago and the most serious of the current matter has fallen by the wayside. She asked the panel to bear in mind that you did your best to give an honest and transparent account of events and you did not shy away from doing so, despite the situation at the time.

Ms Maqboul submitted that the panel should consider the level of remorse you have demonstrated, the level of insight shown and your strengthening of practice undertaken since these allegations. Ms Maqboul told the panel of the uncomfortable atmosphere at the Home speaks for itself. She submitted that deficiencies at the Home as well as the [PRIVATE] affected you at the time. She submitted that in light these matters the panel should consider that they contributed to how you performed your job at the time.

Ms Maqboul referred the panel to your oral evidence you gave when you described yourself as a *'super mum';* you were looking after everyone else however no one was looking after you. She submitted that you have since put plans in place to ensure these events would not happen again. She referred the panel to your reflective statement piece and submitted that six years on, you have reflected significantly and told the panel that you are now properly supported in the workplace.

Ms Maqboul referred the panel to what she described as a crucial piece of evidence that is before the panel, which is information from the Deputy Home Manager at Swallow Wood Care Home where you are currently employed, who have offered you a permanent job once the outcome of these present matters are concluded. She submitted that it goes to demonstrate how you are going forward from these events and that discussions, checks and measures being undertaken ensure this does not occur again.

Ms Maqboul submitted that you recognise that during your time at the Home you *'got yourself in a bit of mess in things'* however she told the panel that you wish to assure and emphasise to the panel that you do learn from your mistakes.

Ms Maqboul submitted that you had little faith in yourself at the time. She submitted that you took a very long time from you being a healthcare assistant before becoming a registered nurse. She submitted that this shows what type of person you are; nursing is your life and you are unsure what you would do without it. Ms Maqboul told the panel that this was a very stressful and isolating period in your career.

Ms Maqboul invited the panel to find that your fitness to practise is not impaired and no restrictions are needed to be put to your practice.

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

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the NMC 2015 Code (the Code).

The panel was of the view that your actions did fall short of the standards expected of a registered nurse, and that your actions amounted to breaches of the NMC 2015 Code. Specifically:

> *'**Introduction to paragraph 6***
> *...You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice...*
>
> ***Work co-operatively***

8.6 share information to identify and reduce risk

Keep clear and accurate records relevant to your practice

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

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

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

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

20.9 maintain the level of health you need to carry out your professional role

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel noted that Charges 1d, 2b, 5, 8, 11 and 13 carried a significant of resident harm occurring, as they could have caused other staff at the Homes to commit further medication errors. The panel further noted that you have admitted misconduct. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Residents 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 residents' and the public's trust and confidence 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 resident or residents at unwarranted risk of harm; and/or*

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

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

d) *...*

The panel determined that limbs a, b and c of the *Grant* test were engaged.

The panel considered that you made admissions and you have demonstrated an understanding of how your actions could put residents at a risk of harm. The panel determined that you have a reasonable level of insight and you have demonstrated an understanding as to why what you did was wrong and how this could impact negatively on the reputation of the nursing profession, and further, you have attempted to reflect on how you would handle such situations differently in the future.

The panel was satisfied that your errors in this instance are capable of being remediated. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that some of the evidence from you in this case has been very encouraging, such as your reflective statements, the supportive references and testimonials from Swallow Wood Care Home and that you have been offered a

permanent position by them. The panel were of the view that it shows that you have put a lot of work and effort into strengthening your practice and that you have reasonable insight into your failings and are also remorseful for your errors.

However, the panel determined that whilst you are developing your clinical practice, there is a risk of repetition. The panel considered that you will need time to develop [PRIVATE] to maintain those professional standards when [PRIVATE] in the event you come under stress in the future. The panel determined that this is remediable however cannot say with certainty that it has been remediated.

The panel determined that it would want to see evidence that the plans and measures that are being put in place have been achieved and continue over a period of time. The panel determined that it does not have sufficient evidence before it of you having performed safely and effectively in relation to medication management and medication administration. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel took note of the fact that there had been a previous findings made against you by the NMC, but gave them limited weight due to the fact that the matters complained of happened seventeen years ago.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment on public interest grounds were not made in this case. The panel determined that a finding of impairment on public interest grounds is also required and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of nine months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr March submitted that the sanction to be determined is entirely a matter for the panel and that each sanction is to be considered in ascending order. He submitted that to do doing nothing or to impose a caution order would not be appropriate given that the charges found carry a significant risk of harm and would plainly be insufficient to provide the level of oversight required to address the concerns identified.

Mr March submitted that a conditions of practice order could be appropriate and if the panel so minded to impose a conditions of practice order, a suggestion would be to include a level of supervision over a significant period of time in relation to medication management. He submitted that this might go some way towards protecting residents and would also give you an opportunity to further strengthen your practice.

Mr March asked the panel to consider very carefully the following aggravating factors in this case:

- A significant number of incidents and charges found proved that amount to

misconduct

- The serious communication failures and multiple failures and irregularities
- The further incident at a second Home and the risk of repetition
- This is not your first referral in relation to medication management which ought to be given some weight

Mr March submitted the striking off sanction bid may be considered no longer appropriate given that the dishonesty charge has been found not proved and has now fallen away.

The panel also took into consideration submissions made by Ms Maqboul on your behalf. Ms Maqboul submitted that any reference made to communication failure at the Home should be disregarded as it relates to the disciplinary process you had and should not be an aggravating factor. She submitted that the sanction bid put forward by the NMC in relation to the dishonesty charge which has fallen away. She submitted that the priority is to ensure that all that the checks and measures and support are able to be evidenced in some way. She told the panel that you accept that no order or caution order would be appropriate.

Ms Maqboul submitted that you have undertaken a significant amount of training and have shown a commitment to your professional development. She referred the panel to the reference from your current employer who speaks in high regard of you.
She submitted that there has been a significant lapse of time since the allegations and you have worked at your current employer in a supportive environment for the last five years without any concern, she further submitted that checks and measures are already in place and have been for the last five years.

Ms Maqboul invited the panel to impose a conditions of practice order for a period of six months and suggested that conditions include fortnightly meetings with your line manager to discuss any areas of concern or any extra measure that may be required to be put in place. She also suggested that you provide a further reflective piece before any review hearing or meeting as there may be further areas you would like to reflect on.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The previous 2006 NMC referral (to a limited extent)
- The further incident at the second Home in May 2019
- The number of failings that lead to misconduct over a period of time

The panel also took into account the following mitigating features:

- [PRIVATE] which coincided with the errors made
- The apparent unsupportive and blame culture at the Home where you worked
- You have shown genuine remorse
- You made admissions at the investigation meeting and gave a true account of the relevant facts at the earliest opportunity
- The numerous testimonials, references and evidence that state that you are an excellent, caring and compassionate nurse and you are held in high regard
- You have actively strengthened your practice, remediation and undertaken training over the last 5 years whilst in the workplace
- You have developed open, honest and supportive working relationships in your current employment at the new Home

The panel also noted that it has been clear to see throughout the hearing the salutary effect this process has had on you. The panel also took into account the NMC Guidance on sanctions.

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 number of allegations. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in all the circumstances.
The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the panel's findings. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate sanction. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case, in relation to the specific elements which related to the concerns of your medications management and administration.

The panel bore in mind that your professional circumstances have now changed and that you are well supported by your colleagues and line manager. It noted the positive testimonials you have received from your colleagues. The panel was of the view that a fully informed member of the public would be reassured if you were to return to nursing practice with appropriate safeguards and supervision.

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

The panel carefully considered the imposition of a suspension order but concluded that it was disproportionate and wholly inappropriate in all the circumstances. It follows the same applies to the imposition of a striking-off order.

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

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

For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must keep the NMC informed about anywhere you are working by:
    a. Telling your case officer within seven days of accepting or leaving any employment.
    b. Giving your case officer your employer’s contact details.

2. You must keep the NMC informed about anywhere you are studying by:

    a. Telling your case officer within seven days of accepting any course of study.

Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a copy of these conditions to:

    a. Any organisation or person you work for.
    b. Any agency you apply to or are registered with for work.
    c. Any employers you apply to for work (at the time of application).

d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

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

6. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from either your line manager or your home manager or deputy manager who must be a registered nurse giving details of your progress.

7. You must ensure that you are directly supervised when administering medicines and performing any medicines management work, and in particular the record keeping and documentation regarding medicines. This supervision to be continued until such a time as the home manager or deputy home manager confirms that supervision is no longer required as they have complete confidence in your ability to perform safe and effective medicine administration and management.

   Following this confirmation routine audit evidence of medicine management and record keeping should be established to provide ongoing evidence of your good practice. At least one week before the next NMC review or meeting a statement from your line manager, home manager or deputy home manager affirming their confidence in your ability to administer and manage medicines and confirming that you have maintained a high standard

8. You must keep a reflective profile in which you record any difficult or disputed events, saying what happened and what you did and then how you could have managed or acted differently to achieve a better outcome. This reflection is a personal document but could be shared if necessary when reviewing your personal development plan (PDP)

9. You must work with your line manager, home manager or deputy home manager who must be a registered nurse to create a PDP which addresses the concerns about:
    1. Medicine administration and management and record keeping.
    2. [PRIVATE]

You must send your case officer your PDP or a section which covers the above concerns within one month of this hearing.

A copy of the PDP with progress towards the aims noted and signed by the supervisor must be sent to the NMC at least one week prior to the next NMC review or meeting

10. You must meet with your line manager, home manager or deputy home manager who must be a registered nurse on a fortnightly basis to discuss your progress towards the aims set out in your PDP.

The period of this order is for nine months. The panel was of the view that an order for this period of time would enable you to demonstrate a sustained period of safe and effective nursing practice. Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

This will be confirmed to you in writing.

Any future panel reviewing this case would be assisted by:

- Your attendance at the next review or meeting

- A further reflective piece demonstrating your learning and development

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr March. He invited the panel to impose an interim conditions of practice order in the same terms of the substantive conditions of practice order made by the panel. He submitted that an interim order was necessary on the grounds of public protection and public interest.

Ms Maqboul made no submissions in respect of the NMC's application for an interim order.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The

conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months due to cover any potential period of appeal.

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

That concludes this determination.