Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 2 October 2023 – Friday, 6 October 2023
Monday, 9 October 2023 – Friday, 13 October 2023
Monday, 16 October 2023 – Friday, 20 October 2023
Monday, 23 October 2023 – Tuesday, 24 October 2023

Virtual Hearing

Name of Registrant:	**Oluwakemi Oyebisi**
NMC PIN	20K0393O
Part(s) of the register:	RN1: Adult nurse, level 1 (12 November 2020)
Relevant Location:	Surrey
Type of case:	Misconduct/Lack of competence
Panel members:	Shaun Donnellan (Chair, lay member) Jonathan Coombes (Registrant member) Lorna Taylor (Registrant member)
Legal Assessor:	Suzanne Palmer
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Katherine Higgs, Case Presenter
Mrs Oyebisi:	Present and not represented
Facts proved:	Charges 1, 2, 3, 4, 5a, 5b, 6, 7, 8, 9, 10, 11, 12a, 13, 14, 15, 17b, 17c, 17d, 18a, 18c, 18ei, 18eii, 18f, 18g, 19, 20, 21a, 21b, 22a, 22b and 24
Facts not proved:	Charges 12b, 16a, 16b, 16c, 16d, 17a, 17e, 18b, 18d and 23
Fitness to practise:	Impaired

Sanction:	Conditions of practice order (2 years)
Interim order:	Interim Conditions of practice order (18 months)

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Higgs, on behalf of the NMC, to amend the wording of charge 2.

The proposed amendment was to change the date of charge 2 from “1 February 2021” to “3 February 2021”. It was submitted by Ms Higgs that the proposed amendment would provide clarity and more accurately reflect the evidence.

Proposed Amendments

That you, between October 2020 and June 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse:

2. On ~~1~~ **3** February 2021, failed the IV medications assessment test.

You did not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, between October 2020 and June 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse:

1. Between October – November 2020, failed 3 drug assessment and/or drug calculation test papers.

2. On 3 February 2021, failed the IV medications assessment test.

3. On 10 February 2021 you failed to observe that an unknown patient's own Bisoprolol medication had expired and/or endeavoured to administer it.

4. On 11 February 2021 you mistook Spironolactone to be Digoxin.

5. On or around 25 February 2021, on one or more occasions, made medication errors in that you:
    a. Were going to administer Clopidogrel when Colecalciferol had been prescribed to an unknown patient;
    b. Were going to administer 250mg paracetomol when 500mg had been prescribed to an unknown patient.

6. On or around 25 February 2021, failed to observe infection control policy, in that you did not remove apron and gloves when in an unknown patient's infection barrier room.

7. On or around 26 February 2021, failed to observe that the prescription of Ferrous Sulphate to an unknown patient was due to be prescribed at 0800 hours.

8. On or around 10 March 2021, failed to administer an unknown patient's Parkinson's medication at the correct time.

9. On or around 19 October 2021, you washed Resident E whilst he was laying unsafely on the edge of his bed.

10. On or around 27 October 2021 you prepared a bacon sandwich to give to Resident D who was on a soft diet.

11. On or around 29 October 2021 you lowered the bed rails of Resident D, whilst Resident D remained in the bed.

12. Between September 2021 to December 2021 you:
    a. Attempted to feed Resident F yoghurt whilst they were lying on their back;
    b. When challenged about this by Colleague B, you said 'I know what I am doing' or words to that effect.

13. Between September to December 2021, you held and/or grabbed Resident C's arm when assisting to move them.

14. On or around 2 March 2022 you failed to assist an unknown Resident with personal care and pad changing.

15. On or around 7 March 2022 you did not provide care to an unknown resident until you had been asked to do so 3 times by Colleague C.

16. On 13 March 2022 you:
    a. Failed to provide prompt personal care to an unknown resident;
    b. Failed to complete nursing notes of the unknown resident promptly;
    c. Failed to turn an unknown resident between 08.22 and 16.28 hours;
    d. You failed to prioritise the needs of the unknown resident.

17. On 27 April 2022 failed to meet the requirements of the Observation Supervision in the following areas:
    a. Working in line with organisations core values;
    b. Engagement with residents and their families;
    c. Work in a way that promotes residents dignity and choice;
    d. Demonstrates a caring and compassionate attitude;
    e. Documentation is accurate clear and factual.

18. On or around 11 May 2022:
    a. On one or more occasion left medication on top of the medication trolley unattended and/or with the keys in the door of the medication trolley;
    b. Failed to identify a possible error in the counting of medication and/or failed to check whether the previous medication count was correct;
    c. Failed to ensure the mouthpiece of an inhaler was clean before or after use prior to administering it to a resident;
    d. Failed to follow medication administration procedures
    e. Failed to follow the covert medication agreement for Resident B, in that you:
    i. did not crush the medication before administering it to Resident B;
    ii. Did not administer the crushed medication in a cup of tea.
    f. Once resident B spat the medication out, you did not wear gloves when handling the medication.
    g. Failed to administer a patch of medication as prescribed to Resident B.

19. Between 13 December 2021 – 10 June 2022, lacked basic knowledge of medication and/or made medication administration errors.

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

That you, a registered nurse:

20. Between September 2021 – December 2021 you said to Colleague B “don’t treat me like a slave, I know how you have been treating everyone badly at Weller” or words to that effect.

21. Between 13 August 2021 to 8 November 2021 you said to Resident D:
    a. “you don’t like me is it because I am black” or words to that effect;
    b. “don’t you like me because of my skin colour” or words to that effect.

22. On or around 23 October 2021 you said to Resident D:
    a. “you don’t like me because I’m black” or words to that effect;
    b. “why don’t you like me, I love you”, whilst stroking Resident D’s face.

23. On or around 2 March 2022 ‘Sucked your lips’ when you were asked to carry out the task of the tea trolley.

24. On or around 16 March 2022 when you were asked to bath an unknown resident you stated “if you don’t want red flags you can do all our checks” or words to that effect.

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

You made a request that this case be held in private because you believed that members of your family would read about it and be unhappy, causing you embarrassment. You therefore requested that this case is not publicised on the NMC website or in a newspaper. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

Ms Higgs opposed the application on the basis that it is a public hearing and could not see any particular grounds in this case that are not present in any other case which would justify this hearing being 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 took account of your submissions and those of Ms Higgs.

While the panel empathise with the position you are in, it was of the view that the public have a right to attend NMC hearings which include the press. It also bore in mind that the NMC do not have any jurisdiction on what is published in newspapers pertaining to the NMC and its hearings.

When considering your submissions, the panel was of the view that you have not provided it with any specific grounds to justify conducting the entirety of this hearing in private.

The panel was of the view that it would revisit the application if private matters arise. However, on this occasion, the panel rejected your application.

Background

Horley Ward, East Surrey Hospital

In October 2020 you started working at the Horley Ward, East Surrey Hospital, as an overseas nurse, having previously practised in Jamaica and Nigeria.

During the initial weeks of an overseas nurse joining the hospital, a four week induction is required along with Objective Structured Clinical Examination (OSCE) exams prior to starting work on the ward. Following this a further two weeks of shadowing take place on the ward prior to the nurse being allowed to work alone. During that period, a drugs assessment is undertaken on the ward followed by an IV competency assessment which takes place off the ward at a later time.

The pass mark for each of the drugs assessments is 100%. It is alleged that you failed three of the drug assessment or drug calculation tests. It is also alleged that you failed the IV competency assessment on 3 February 2021. As a result, you were directly supervised when completing medication rounds.

On 10 February 2021 Ms 7, a practice development nurse, was supervising you completing medication rounds when she noticed that the patient's bisoprolol medication had expired. It is alleged that you had not noticed it before and had gone to administer it before Ms 7 stopped you.

On 11 February 2021 Ms 7 was again supervising you on a medication round. On that occasion it is alleged that you confused two medications, Spironolactone and Digoxin. Ms 7 had to prompt you before you realised that you had picked up the wrong medication and not the one which was due to be administered.

On 25 February 2021 it was decided that another nurse Ms 8 would supervise you during a medication round. It is alleged that during that round Ms 8 noted that you tried to administer Clopidogrel rather than Cholecalciferol. It is further alleged that you had halved a tablet of 500mg paracetamol to give to a patient who was prescribed a whole tablet of 500mg.

Whilst Ms 8 was supervising you, you attended a patient who was being barrier nursed, meaning the patient was infectious. You followed the correct procedure as regards to wearing Personal Protective Equipment (PPE). However, it is alleged that you left the

room and walked down the corridor without removing the gloves and apron. It is alleged that Ms 8 had to remind you to remove your gloves and apron as you were walking down the corridor.

Ms 8 supervised you again on 26 February 21. It is alleged that when you were checking a patient's prescription, the 12:00 and 18:00 prescriptions had been crossed off, but the 08:00 one had not been.

On 10 March 2021 Ms 7 completed a medication round with you. During that round, a patient with Parkinson's disease was due to receive his medication. It is said that the patient usually took medication with yoghurt. However, it is alleged that you did not immediately administer the medication but went to go and get a yoghurt, then put both in the patient's medication pod and moved on to the next patient.

On 6 April 2021 you handed in your notice and left with immediate effect.

Wombwell Hall

You then worked as a care assistant at Wombwell Hall nursing home between 13 August 2021 and 8 November 2021.

On 19 October 2021 you were shadowing care assistant Ms 5 whilst getting resident dressed. One resident was threatening to climb out of bed. Ms 5 allegedly told you to watch him as he is someone who had fallen out of bed previously. Ms 5 went to find assistance. When she returned, it is alleged that she found you washing the resident on the edge of the bed, in an unsafe position.

On 27 October 2021 you were shadowing carer Ms 2. Ms 2 asked you to feed a resident, noting that the resident had asked for porridge but sometimes liked to eat jam sandwiches with the crusts cut off. The resident in question was on a soft diet. It is alleged that you

prepared a bacon sandwich for the resident. When questioned by Ms 2 as to who the sandwich was for, you allegedly heard her say ‘ham sandwich’.

On 29 October 2021 Ms 2 was asked by a colleague who had fed one of the residents. The resident in question had balancing difficulties and was at risk of falling. Ms 2, knowing it was you who had fed the resident, went to the room to check and allegedly found that the resident’s bed rails had been lowered with the table placed over the top.

On an occasion between September and December of 2021 Colleague B was working alongside you. Colleague B was completing the tea time medication round when she walked past a resident’s room and allegedly saw you feeding the resident whilst she was lying flat on her back. Colleague B entered the room and allegedly advised you that it was not safe to feed the resident whilst lying down flat and explained how to reposition her prior to eating. It is alleged that you responded by saying words to the effect of ‘I know what I am doing’.

At some point between September 2021 and December 2021 Colleague B had been working with you, moving a resident from a commode to her bed. The day after the resident complained to Colleague B that you had allegedly grabbed her arm and that it was sore as a result. Colleague B looked and found a bruise to the resident’s arm.

Ms 9, the Registered Manager at Wombwell Home, set up a formal meeting where you were invited to bring a representative and given the opportunity to postpone the meeting until you could be represented. It is alleged that you declined. During the meeting you were informed that you were no longer employed by the Home as of 8 November 2021.

The Mayflower Care Home

You then worked at the Mayflower Care Home from 13 December 2021 until 13 June 2022 as a medical technician (“med-tech”), which is the equivalent of a senior carer.

On 2 March 2022 you were allegedly asked by Colleague C, also a medical technician at Mayflower, to assist a male resident with personal care and bed changing. It is alleged that you refused to do so. It is said that you were spoken to by Ms 6 about this resident and were reminded that as a senior member of staff you had a duty to manage challenging behaviour.

On 7 March 2022 you were asked, alongside another staff member, to assist a resident who had opened her bowels and had not had any pressure relief since she had got up. The resident's clothes were wet. It is alleged that you were asked three times to assist but did not do so.

On 13 March 2022 a registered nurse was working with you. it is alleged a resident was washed and dressed at 08:22 and thereafter did not receive any personal care until 16:28. The resident's son attended to visit at 16:59 and found his mother to be soaking wet and having opened her bowels. It is alleged that you were reminded of the importance of ensuring residents are clean and dry every three to four hours and that they were taken to the toilet as they were unable to take themselves. It is further alleged that you responded by saying that you had provided care but had not yet completed the notes.

On 27 April 2022 you were observed by Ms 6, in a routine observation undertaken for all staff every three months and allegedly you were found to require improvement in all areas observed.

On 11 May 2022 you were supervised by Ms 6 in administering medication. You were allocated a medication round for 12 residents, but your involvement was allegedly stopped after three residents due to Ms 6's concerns due to your medications administration practice.

On 13 May 2022 you attended a mid-probation review which led to your probation being extended for a further three months. During this time it was expected that you would make significant improvements.

During your time working at the Mayflower, it is alleged that you lacked basic knowledge of medication and made a number of administration errors.

On 13 June 2022, there is a letter discussing the outcome of the probation review. It was confirmed that your employment would be terminated as of 13 June 2022

Charges relating to misconduct

Whilst working alongside Colleague B, at Wombwell Hall Nursing Home, on a date between September and December 2021 it is alleged that you said to her ‘don’t treat me like a slave, I know how you have been treating everyone badly at Weller’.

During the time you worked at Weller House (part of Wombwell Hall Nursing Home), between 13 August 2021 and 8 November 2021, Ms 5 was working alongside you when she overheard you having a conversation with a resident. It is alleged that you said ‘you don’t like me, is it because I am black? Don’t you like me because of my skin colour?’

On or around 23 October 2021 Ms 4 was working alongside you at Wombwell Hall nursing home. Ms 4 was standing some distance away when she overheard you allegedly saying to a resident, who was cognitively impaired, ‘you don’t like me because I’m black? Why don’t you like me, I love you?’. As Ms 4 turned around she allegedly saw you stroking the resident’s face.

On or around 2 March 2022 you were working alongside Colleague C. You were asked to do to the trolley over handover and in response allegedly sucked your lips and repeated ‘what, what, what’.

On or around 16 March 2022 you were working with Colleague C. You were asked by Colleague C to bath a resident due to Colleague C being in the office on that day. You allegedly responded ‘well if you don’t want red flags you can do all our checks’.

You were then referred to the NMC due to the above allegations which the NMC say amount to a lack of competence and misconduct, such that your fitness to practice is impaired.

Decision and reasons on application to admit the witness statement of Ms 9

The panel noted that Ms 9's name was being referenced within the witness statements of multiple witnesses. It considered that Ms 9, being the Registered Manager at Wombwell Hall at the time of the events alleged, should be present to give evidence.

Ms Higgs took instructions regarding this and the NMC was able to locate Ms 9 who was willing to give evidence at this hearing.

The panel heard submissions from yourself and Ms Higgs regarding Ms 9 giving evidence.

Under Rule 31 of the Rules, the panel heard an application from Ms Higgs to allow the written statement of Ms 9 into evidence. She submitted that it is evidence that is relevant because Ms 9 was working at Wombwell Hall during the time of the allegations. She submitted that it would be fair to admit Ms 9's statement at this late stage and informed the panel that you do not oppose the application.

You confirmed that you do not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Ms 9's witness statement serious consideration. The panel noted that Ms 9's statement had been prepared in anticipation of

being used in these proceedings and contained the paragraph, ‘This statement … is true to the best of my information, knowledge and belief’ and signed by her.

The panel considered that the evidence was relevant. In terms of fairness, it bore in mind that you did not oppose the application and would have an opportunity to cross-examine the witness. In these circumstances, the panel came to the view that it would be fair to accept into evidence the written statement of Ms 9 and have her give evidence.

Decision and reasons on application to amend the charge

After closing submissions, the panel noted that there appeared to be an error in the wording of charge 7 and the heading of charge 16.

With regards to charge 7, the panel noted that the word “prescribed” appears in relation to the medication Ferrous Sulphate. It noted that the medication would have already been prescribed and was of the view that the word should be changed to “administered”.

With regards to the heading of charge 16, it considered that the date “13 March 2022” may be incorrect. It took account of the Cause for Concern Form by Ms 6, detailing the allegation, which was dated 12 March 2022.

The panel asked Ms Higgs if she had any submissions relating to the observations made by the panel.

In light of the above, the panel heard an application made by Ms Higgs, on behalf of the NMC, to amend the wording of charges 7 and the heading of charge 16.

With regards to charge 7, the proposed amendment was to change the wording of “prescribed” to “administered”. It was submitted by Ms Higgs that the proposed amendment does not change the essence of the charge. She submitted it is in the interest of justice to make the amendment.

With regards to charge 16, the proposed amendment was to change the date of “13 March 2022” to “on or around 12 March 2022”. It was submitted by Ms Higgs that the proposed amendment would provide clarity and more accurately reflect the evidence. She also submitted that there would be no prejudice to you in making the amendment.

Proposed Amendments

That you, between October 2020 and June 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse:

7. On or around 26 February 2021, failed to observe that the prescription of Ferrous Sulphate to an unknown patient was due to be ~~prescribed~~ **administered** at 0800 hours.

16. On **or around** ~~13~~ 12 March 2022 you:

You did not oppose either application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

With regards to both charges 7 and charge 16, the panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed minor amendments being allowed. It noted that you had been able to address the intended mischief of charge 7 and charge 16 when cross-examining the NMC’s witnesses and in your own evidence, as though the charges had already been amended. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on panel's proposal to amend the charge of its own volition

During deliberations, the panel noted several issues with charges 5a, 5b, 12a and 19.

The panel noted that there are spelling errors with the medications in charge 5a and 5b. With regards to charge 5a, the panel was of the view that medication "Colecalciferol" should be "Cholecalciferol". With regards to charge 5b, it was of the view that the medication "paracetomol" should be "paracetamol".

The panel also noted that with charge 12a, there is evidence of you feeding Resident F, however, there is no information before the panel to indicate exactly what you were feeding Resident F. The panel considered that removal of the word "yoghurt" from the charge could resolve this difficulty.

With regards to charge 19, the panel was of the view that the dates "13 December 2021 – 10 June 2022" were too broad. During its deliberation of the charge it noted that it could only find evidence that supported what has been alleged, in the charge, occurring on a single day, namely 11 May 2022. The panel therefore proposed that the dates in the charge be changed to reflect this.

The panel asked both parties for their submissions relating to the observations made by the panel.

In light of the above, Ms Higgs indicated that she supported the proposed amendments to the wording of charges 5a, 5b, 12a and 19. She submitted that there is no prejudice to you in making the amendments.

Proposed Amendments

That you, between October 2020 and June 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse:

5. On or around 25 February 2021, on one or more occasions, made medication errors in that you:
    a. Were going to administer Clopidogrel when ~~Colecalciferol~~ **Cholecalciferol** had been prescribed to an unknown patient;
    b. Were going to administer 250mg ~~paracetomol~~ **paracetamol** when 500mg had been prescribed to an unknown patient.

12. Between September 2021 to December 2021 you:
    a. Attempted to feed Resident F ~~yoghurt~~ whilst they were lying on their back;

19. ~~Between 13 December 2021 – 10 June 2022~~ **On or around 11 May 2022**, lacked basic knowledge of medication and/or made medication administration errors.

You did not oppose the amendments for charges 5a, 5b and 19. However, you did oppose removing the word “yoghurt” from charge 12a. You submitted that your defence to charge 12a did not alter as a result of the proposed amendment. You continue to deny the charge.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

With regards to both charges 5a and charge 5b, the panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed minor typographical amendments being allowed for these charges.

With regards to charge 19 the panel was of the view that such an amendment was in the interest of justice. The panel bore in mind that you did not object to this and was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. The amendment significantly narrowed the scope of the charge.

With regards to charge 12a, the panel noted your objection to this amendment. However, it had regard to its overarching objective to protect the public. This was a serious allegation and if the amendment was not made, there was a risk of the charge failing on a technicality. Bearing in mind that this did not alter your defence to the charge, the panel considered that the balance lay in favour of amending the charge in the interests of justice.

It was therefore appropriate to make the amendments to ensure clarity and accuracy.

Details of charge (as amended)

That you, between October 2020 and June 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse:

1. Between October – November 2020, failed 3 drug assessment and/or drug calculation test papers.

2. On 3 February 2021, failed the IV medications assessment test.

3. On 10 February 2021 you failed to observe that an unknown patient's own Bisoprolol medication had expired and/or endeavoured to administer it.

4. On 11 February 2021 you mistook Spironolactone to be Digoxin.

5. On or around 25 February 2021, on one or more occasions, made medication errors in that you:
    a. Were going to administer Clopidogrel when Cholecalciferol had been prescribed to an unknown patient;
    b. Were going to administer 250mg paracetamol when 500mg had been prescribed to an unknown patient.

6. On or around 25 February 2021, failed to observe infection control policy, in that you did not remove apron and gloves when in an unknown patient's infection barrier room.

7. On or around 26 February 2021, failed to observe that the prescription of Ferrous Sulphate to an unknown patient was due to be administered at 0800 hours.

8. On or around 10 March 2021, failed to administer an unknown patient's Parkinson's medication at the correct time.

9. On or around 19 October 2021, you washed Resident E whilst he was laying unsafely on the edge of his bed.

10. On or around 27 October 2021 you prepared a bacon sandwich to give to Resident D who was on a soft diet.

11. On or around 29 October 2021 you lowered the bed rails of Resident D, whilst Resident D remained in the bed.

12. Between September 2021 to December 2021 you:
    a. Attempted to feed Resident F whilst they were lying on their back;
    b. When challenged about this by Colleague B, you said 'I know what I am doing' or words to that effect.

13. Between September to December 2021, you held and/or grabbed Resident C's arm when assisting to move them.

14. On or around 2 March 2022 you failed to assist an unknown Resident with personal care and pad changing.

15. On or around 7 March 2022 you did not provide care to an unknown resident until you had been asked to do so 3 times by Colleague C.

16. On or around 12 March 2022 you:
    a. Failed to provide prompt personal care to an unknown resident;
    b. Failed to complete nursing notes of the unknown resident promptly;
    c. Failed to turn an unknown resident between 08.22 and 16.28 hours;
    d. You failed to prioritise the needs of the unknown resident.

17. On 27 April 2022 failed to meet the requirements of the Observation Supervision in the following areas:
    a. Working in line with organisations core values;
    b. Engagement with residents and their families;
    c. Work in a way that promotes residents dignity and choice;
    d. Demonstrates a caring and compassionate attitude;
    e. Documentation is accurate clear and factual.

18. On or around 11 May 2022:
    a. On one or more occasion left medication on top of the medication trolley unattended and/or with the keys in the door of the medication trolley;
    b. Failed to identify a possible error in the counting of medication and/or failed to check whether the previous medication count was correct;
    c. Failed to ensure the mouthpiece of an inhaler was clean before or after use prior to administering it to a resident;
    d. Failed to follow medication administration procedures

e. Failed to follow the covert medication agreement for Resident B, in that you:
i. did not crush the medication before administering it to Resident B;
ii. Did not administer the crushed medication in a cup of tea.
f. Once resident B spat the medication out, you did not wear gloves when handling the medication.
g. Failed to administer a patch of medication as prescribed to Resident B.

19. On or around 11 May 2022, lacked basic knowledge of medication and/or made medication administration errors.

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

That you, a registered nurse:

20. Between September 2021 – December 2021 you said to Colleague B “don’t treat me like a slave, I know how you have been treating everyone badly at Weller” or words to that effect.

21. Between 13 August 2021 to 8 November 2021 you said to Resident D:
a. “you don’t like me is it because I am black” or words to that effect;
b. “don’t you like me because of my skin colour” or words to that effect.

22. On or around 23 October 2021 you said to Resident D:
a. “you don’t like me because I’m black” or words to that effect;
b. “why don’t you like me, I love you”, whilst stroking Resident D’s face.

23. On or around 2 March 2022 ‘Sucked your lips’ when you were asked to carry out the task of the tea trolley.

24. On or around 16 March 2022 when you were asked to bath an unknown resident you stated “if you don’t want red flags you can do all our checks” or words to that effect.

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

Decision and reasons on facts

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

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:

- Ms 1: Ward Manager at Horley Ward;
- Ms 2: A HCA at Wombwell Hall at the relevant time.
- Ms 3: Deputy Manager at Wombwell Hall;

- Ms 4: a Nursing Assistant at Wombwell Hall at the relevant time;
- Ms 5: HCA at Wombwell Hall at the relevant time;
- Colleague B: Staff Nurse at Wombwell Hall at the relevant time.
- Ms 6: Clinical Manager at the Mayflower Care Home;
- Ms 7: Clinical Support Nurse for the Trust at the relevant time.
- Ms 8: Preceptorship Lead at the Trust at the relevant time;
- Colleague C: Medical Technician with Canford Healthcare working at Mayflower Care Home;
- Ms 9: Registered Manager at Wombwell Hall at the relevant time.

The panel also heard evidence from you under oath.

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

Charge 1

1. Between October – November 2020, failed 3 drug assessment and/or drug calculation test papers.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

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

Ms 1 in her witness statement stated:

> *'The normal process for Overseas Nurses is to have a four week induction and sit the OSCE exams before the come to us on the Ward. This four weeks includes basic training. When they come to the Ward they have another two weeks of supernumerary times where they would shadow other Staff Nurses doing the drug rounds and gain an understanding of how the Ward works in general. It is expected that after this two weeks the Nurses are able to go off on their own.*
> *An oral drugs assessment would be done on the Ward during these two weeks and they are expected to pass this. Overseas Nurses also have to complete an IV competency assessment which takes place off the Ward…Kemi took three test papers, the pass mark for these are 100% as if you make one mistake during a medication round you are likely to kill someone. Kemi failed all three test papers.'*

The panel took account of the test papers in the NMC bundle. While they were not dated, the panel noted that they are concurrent with the time you were employed at Horley Ward. The test papers showed that you scored below 100%.

The panel also bore in mind that you accepted this charge during your closing submissions.

The panel therefore found this charge proved.

Charge 2

2. On 3 February 2021, failed the IV medications assessment test.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 7 and your evidence.

The panel took account of the email Ms 7 sent to you, dated 1 February 2021, which confirmed that you had booked yourself onto the IV medications course. The panel then took account of the contemporaneous email Ms 7 sent to Ms 1, dated 4 February 2021 where the concerns around medications were initially highlighted. It stated:

> *"Kemi scored poorly in the drug calculations test, and we cannot let her attempt IV's in practice yet. She got 4/15" [sic]*

The panel also took account of a file note dated 8 February 2021 where Ms 1 discusses the above with you. It stated:

> *"When I came on duty today I received an email telling me Kemi had failed her I.V medications by a lot."*

Ms 1, in her oral evidence stated that as part of the training, nurses were put forward by senior staff to sit an IV medications assessment test once oral medications exams had been passed. Both Ms 1 and Ms 7 in their oral evidence stated you had booked yourself onto the IV test prior to having passed the oral medications assessment.

The panel also bore in mind that you accepted this charge during your closing submissions. You stated that those who had started at Horley Ward around the same time you did were booked onto the IV medications course. You stated that you booked yourself onto the course so that you could keep up with them. However, you said that by doing this you did not have the preparation time that others had.

In light of the above, the panel concluded that on 3 February 2021, you failed the IV medications assessment test.

The panel therefore found this charge proved.

Charge 3

3. On 10 February 2021 you failed to observe that an unknown patient's own Bisoprolol medication had expired and/or endeavoured to administer it.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of evidence of Ms 7 and your evidence.

Ms 7 in her witness statement stated:

> *'I completed a supervised medication round on 10 February 2021... Kemi did not notice that the patient's own Bisoprolol medication had expired and went to*

administer this. I stopped Kemi and asked her to have a look at the box. Trained nurses have to be particularly careful of expiry dates of patients own medication and stock medication…You just don't give patients expired medication, it is dangerous. Kemi's reaction when I pointed it out was "oh I didn't see that""

Ms 7 reiterated this in her oral evidence.

The panel took account of the contemporaneous email Ms 7 sent to Ms 1, dated 10 February 2021. which stated:

'Further to my last e-mail, following on from our conversation just now, I can confirm that I visited Horley Ward…to assess Oluwakemi Oyebisi on her or oral drugs administration…

…She correctly identified twice when the patient's own medications were past their expiry date. However she did not notice the lady in side room 5's Bisoprolol had expired, so she was prompted to use one from the ward stock.'

Ms 7, in her oral evidence also stated that she writes her reports immediately after her observations while her recollection is fresh in her mind.

In your oral evidence, the panel noted that you initially stated that you were simply comparing the medications and stated that you cannot administer medications if they are expired. However, later you stated in your cross examination of Ms 7 that you could not remember this particular day.

In your closing submissions, you appeared to accept that you did not observe that the Bisoprolol medication had expired but did not accept that you had endeavoured to administer the medication.

However, the panel preferred the evidence of Ms 7. It found consistency in her contemporaneous email, her witness statement and her oral evidence and was of the view that you would have administered Bisoprolol had Ms 7 not prevented you from doing so.

In light of the above the panel concluded, on the balance of probabilities, that on 10 February 2021 you failed to observe that an unknown patient's own Bisoprolol medication had expired and endeavoured to administer it.

The panel therefore found this charge proved.

Charge 4

4. On 11 February 2021 you mistook Spironolactone to be Digoxin.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 7 and your evidence.

Ms 7 in her witness statement stated:

> *'I supervised another medication round on 11 February 2021, Kemi had confused Spironolactone and Digoxin. Spironolactone is a potassium sparing loop diuretic which rids the body of excess water. Digoxin is cardiac medication.*
>
> *Both medications were in the patients pod [lockable cupboard next to their bed]. The MAR chart showed that Spironolactone had been discontinued. Kemi picked up the Spironolactone instead of Digoxin. I did hang back a bit to see if she would realise and correct herself but she didn't I said a few times "look at the packaging"*

and her response was "yes". I had to keep prompting and said "what is the name of the drug in your hand?" and "what is the medication you need to administer?" She needed a lot of prompting before she realised her error which, to me, was very worrying.

Spironolactone causes the blood pressure to lower by the nature of how it works. The patient required Digoxin which is cardiac medication which indicates the patient was in some sort of heart failure. Digoxin strengthens the contractility of the heart to not give this would have been dangerous for the patient.'

Ms 7 reiterated this in her oral evidence She accepted that you may have noticed the error had you been left to work it out, but she instead prompted you.

The panel took account of the contemporaneous email Ms 7 sent to Ms 1, dated 11 February 2021 where she reported the incident. She stated:

"…she seemed to get confused between Spironolactone which was not on the patient's chart, and Digoxin which was due. I'm not sure why she picked up the Spironolactone, anyway I prompted her and she then dispensed the Digoxin correctly. It would be fair to say she may have realised her mistake, had I not questioned her, but I did not wait to see if that was the case."

The panel noted that in your oral evidence, you stated you picked up two medication packets to compare and that you were just checking them. You said that the name of the medications were similar and you were not going to administer Spironolactone. However, it bore in mind that when you were cross examining Ms 7, you stated that you could not recall the incident.

The panel preferred the evidence of Ms 7. It bore in mind that she was observing at the time and considered her evidence to be consistent and she provided a more plausible explanation of what occurred. Ms 7's evidence is also supported by the contemporaneous email she sent to Ms 1.

In light of the above, the panel concluded, on the balance of probabilities, that on 11 February 2021 you mistook Spironolactone to be Digoxin.

The panel therefore found this charge proved.

Charge 5a

5. On or around 25 February 2021, on one or more occasions, made medication errors in that you:
    a. Were going to administer Clopidogrel when Cholecalciferol had been prescribed to an unknown patient;

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 8 and your evidence.

Ms 8 in her witness statement stated:

> *"On 25 February 2021, I contacted [Ms 1] to report two potential drug errors made by the registrant during two drug rounds on that day which I had supervised."*

The panel noted that Ms 8's recollection of events is not clear in her witness statement, in relation to this charge. However it noted that, in her oral evidence she stated she would have recorded her observations in an email in a timely manner. It took account of the contemporaneous email sent by Ms 8 to Ms 1, dated 25 February 2021 where she recorded her observations of you on that day. It stated:

“During the 0800 drug round. Colecalciferol was prescribed for the patient. Kemi read the drug chart appropriately then preceded to take and check Clopidogrel reading the box as though it was, what had been prescribed. She then went to administer Clopidogrel. At this point I stopped her and told her to read the prescription carefully. We then discussed what both drugs were. She could correctly tell me what they were.”

Ms 8, in her oral evidence, was not very clear in her recollection of events. However, she recalled that she had to intervene and stop you from administering the incorrect medication.

Ms 1 corroborated this, in her witness statement, when she stated:

“01 March 2021 File Note [Ms 7] thought it may be better for another PDN to supervise Kemi and have a fresh pair of eyes so [Ms 8] completed a medication round on 25 February 2021 and two potential errors were picked up.

Kemi had tried to administer Clopidogrel rather than the prescribed Colecaliferol. Clopidogrel is a medication for the heart whereas Colecaliferol is a form of Vitamin D so they are very different medications...”

The panel noted that you stated you could not recall the incident.

The panel preferred the evidence of Ms 8. It was of the view that her evidence was consistent with the contemporaneous note she made at the time. The panel had no information before it to suggest that Ms 8 fabricated her observations of you.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 25 February 2021, on one or more occasions, you made medication errors in that

you were going to administer Clopidogrel when Cholecalciferol had been prescribed to an unknown patient.

The panel therefore found this sub-charge proved.

Charge 5b

5. On or around 25 February 2021, on one or more occasions, made medication errors in that you:
    b. Were going to administer 250mg paracetamol when 500mg had been prescribed to an unknown patient.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 8 and your evidence.

Ms 8 in her witness statement stated:

> *"On 25 February 2021, I contacted [Ms 1] to report two potential drug errors made by the registrant during two drug rounds on that day which I had supervised."*

As above the panel noted that Ms 8's recollection of events is not clear in her witness statement, in relation to this charge. However it noted that, in her oral evidence she stated she would have recorded her observations in an email in a timely manner. It took account of the contemporaneous email sent by Ms 8 to Ms 1, dated 25 February 2021 where she recorded her observations of you on that day. It stated:

"During the 1200 drug round. Paracetamol 500mg was prescribed for a patient. She checked the prescription correctly and chose the correct medication, but then broke the tablet in half (250mg) and placed the other half back in the box. Therefore under dosing the patient. I highlighted this to her and then she reopened the paracetamol box and took the 2nd half out. She had already correctly administered paracetamol this morning."

Ms 1 corroborated this in her witness statement which stated:

"The second concern raised was that Kemi almost under dosed a patient of paracetamol. The tablet was 500mg tablet and the prescription was for 500mg however Kemi split the tablet in half therefore only half the dose [250mg] would have been given. The risk to the patient would be not having the prescribed pain relief."

You stated that you could recall this day vividly. You said that the 500mg paracetamol broke in half inside the blister pack. You said that you noticed this and took the other half out of the blister pack yourself.

However, the panel bore in mind that Ms 8, in her oral evidence stated that if you would have said at the time that half the paracetamol broke inside the blister back, she would have detailed this in the email. However, this did not happen.

The panel preferred the evidence of Ms 8. It was of the view that her evidence was consistent with the contemporaneous documentation she made at the time. The panel had no information before it to suggest that Ms 8 fabricated her observations of you.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 25 February 2021, on one or more occasions, made medication errors in that you were going to administer 250mg paracetamol when 500mg had been prescribed to an unknown patient.

The panel therefore found this charge proved.

Charge 6

6. On or around 25 February 2021, failed to observe infection control policy, in that you did not remove apron and gloves when in an unknown patient's infection barrier room.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 8 and your evidence.

The panel noted that Ms 8's recollection of events is not clear in her witness statement, in relation to this charge. However it noted that, in her oral evidence she stated she would have recorded her observations in an email in a timely manner. It took account of the contemporaneous email sent by Ms 8 to Ms 1, dated 25 February 2021 where she recorded her observations of you on that day. It stated:

> *"We were in a side room with a barrier nursed patient. She correctly put on apron and gloves and proceeded to administer the patients medication correctly. On realising she needed a spoon, she left the room at began to walk up the corridor to the kitchen, taking her gloves off en-route. I had to call her back in and ask her to remove the apron, to place the gloves and apron in the clinical waste bin, then go and wash her hands. As per infection control policy."*

The panel noted that this was corroborated in the witness statement of Ms 1, where she stated:

"[Ms 8] also highlighted that Kemi attended a barrier nursed patient which meant they were infectious. She followed the correct procedure with PPE however she realised she didn't have a spoon and walked out of the room with her apron and gloves on and walked down the corridor. [Ms 8] had to call her back to take off the apron and gloves in the room where the patient was to then go out and when she returned had to put new apron and gloves on.

I do not recall what was specifically wrong with this patient but it probably was not Covid-19 as were rarely have anyone on our ward. It could have been diarrhoea, norovirus, shingles anything that is a risk to others." [sic]

The panel noted that when you were cross examining Ms 8 you stated that you could not recall the incident. However, under cross examination it you appeared to accept this charge when you stated that you had removed the gloves and apron when you were walking in the corridor.

The panel preferred the evidence of Ms 8. It was of the view that her evidence was consistent with the contemporaneous note she made at the time. The panel had no information before it to suggest that Ms 8 fabricated her observations of you.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 25 February 2021, failed to observe infection control policy, in that you did not remove apron and gloves when in an unknown patient's infection barrier room, prior to leaving the room.

The panel therefore found this charge proved.

Charge 7

7. On or around 26 February 2021, failed to observe that the prescription of Ferrous Sulphate to an unknown patient was due to be administered at 0800 hours.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 8 and your evidence.

The panel noted that Ms 8's recollection of events is not clear in her witness statement, in relation to this charge. However it noted that, in her oral evidence she stated she would have recorded her observations in an email in a timely manner. It took account of the contemporaneous email sent by Ms 8 to Ms 1, dated 26 February 2021 where she recorded her observations of you on that day. It stated:

> *"Ferrous Sulphate that originally been prescribed TDs, 0800, 1200 & 1800. The doctors had recently crossed through the 1200 and 1800 dose.*
>
> *Kemi checked the prescription and it said it had been crossed off and moved on to the next prescription. I told Kemi to look again and then had to explain and ensure her that the 0800 had not been crossed." [sic]*

Ms 1 corroborated this in her witness statement which stated:

> *"[Ms 8] supervised Kemi on the following shift on 26 February 2021…[Ms 8] raised that Kemi almost missed a dose of Ferrous Sulphate which had been prescribed three times a day but the doctor had crossed off two doses..."*

The panel noted that you appear to accept that you had seen the Ferrous Sulphate prescription had been crossed off but had not noticed that it had then been reinstated with a prescription for a single dose.

The panel accepted the evidence of Ms 8. It was of the view that her evidence was consistent with the contemporaneous note she made at the time. The panel had no information before it to suggest that Ms 8 fabricated her observations of you.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 26 February 2021, failed to observe that the administration of Ferrous Sulphate to an unknown patient was due to be administered at 0800 hours.

The panel therefore found this charge proved.

Charge 8

8. On or around 10 March 2021, failed to administer an unknown patient's Parkinson's medication at the correct time.

This charge is found proved.

The allegation in this charge relates to your time at Horley Ward, East Surrey Hospital where you were employed as a registered nurse.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 7 and your evidence.

Ms 7 in her witness statement stated:

> *"I supervised another medication round on 10 March 2021 this was the most worrying for me. We had a patient who was recently diagnosed with Parkinson's disease and had been prescribed Parkinson medication, I do not recall the specific medication name. I asked Kemi if she knew what the medication was and she said "no" so I explained it to her…*

After I explained all this to Kemi she tipped out all the patients medication that was due and said the patient liked to have their medication with a yoghurt. I said this was fine. She locked the drugs away and went to get a yoghurt. Bearing in mind we just had a conversation about the importance of timing, Kemi came back with the yoghurt and instead of administering straight away she put it on the side and went to move on to the next patient."

The panel noted that Ms 7 reiterated this in her oral evidence. She stated that another nurse had been in the room at the time of this incident. This other nurse noticed the error and offered to assist in administering the medication.

The panel took account of the contemporaneous email sent by Ms 7 to Ms 1, dated 10 March 2021 where she recorded her observations of you on that day. It stated:

"3B required Parkinson's medication at 08.00. When I asked her what particular rule of administration must be observed when giving Parkinson's medication, she did not know. I then explained the importance of the patient receiving it absolutely on time.

Despite me just informing her of this rule, she then explained that the patient usually takes their medication with yoghurt, and so she put all the tablets into the patients locker, saying she would go back and give it with the yoghurt. I thought she would and then immediately go and get a yoghurt, but she moved on to the next patients medications in 3C." [sic]

The panel also noted that Ms 7's account is corroborated in the witness statement of Ms 1 which stated:

"…feedback from [Ms 7] explained that there was a Patient who had Parkinson's and she discussed with Kemi the importance of giving their medication on time as this is very important for the patient as if this is missed it can affect everything, their

speech, gate, everything. So it is really important their meds are given on time. However this patient liked to take their medication with a yoghurt and instead of going to get the yoghurt straight away Kemi dispensed the medication and left them on the side and moved on to the next patient despite just having the conversation with [Ms 7] about the importance of administering the medications on time."

The panel noted that in your oral evidence, you stated that you accepted the medication was put in the pod which was next to the patient's locker. You then stated that you went away and got yoghurt and put that in the pod then returned to the medication trolley. This evidence from you appeared to corroborate Ms 7's oral evidence. However you then stated that you thought the other nurse was going to administer the medication which is why you walked away.

The panel also noted that in your reflective piece, dated 28 April 2021, you stated:

"Working with the Practice Development Nurses (PDNs) I began medication rounds with the PDNs I had a Parkinson patient who was had Sinemet, for 8 am, when I got to this patient I dispensed the medication and placed it back into the pod and moved over to the next patient, with the intent to come back to her after my medication rounds as it takes a while to get her to take her tablet and I needed to get her yogurt to take her tablet. The PDNs prompted me as to why I returned the medication to the pod and I explained to her. She explained that I needed to give the medication as it is time sensitive and should be give at the right time. She explained they are to be prioritized when on medication rounds, I should have at least giving the Parkinson medications and then keep the rest for a later time and as it takes me longer time to finish one patient medication round. At this point she asked another nurse to attend to the medications and allowed me to proceed with the next patient." [sic]

The panel noted that this appeared to accept the evidence given by Ms 7.

The panel preferred the evidence of Ms 7. It was of the view that her evidence was consistent with the contemporaneous note she made at the time. The panel had no information before it to suggest that Ms 7 fabricated her observations of you. Ms 7 was clear that she only instructed the other nurse to administer the medication once it was clear that you were moving onto the next patient.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 10 March 2021, you failed to administer an unknown patient's Parkinson's medication at the correct time.

The panel therefore found this charge proved.

Charge 9

9. On or around 19 October 2021, you washed Resident E whilst he was laying unsafely on the edge of his bed.

This charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 5, Ms 9 and your evidence.

The panel bore in mind that during this period, Ms 9 confirmed that you were working as a healthcare assistant shadowing Ms 5. in her witness statement Ms 5 stated:

"…Resident E, I do not remember the resident's surname…kept trying to get out of his bed, I was about to start personal care on a different resident so I asked Kemi to watch him whilst I went to find my colleagues to help. When I came back with my colleagues, I do not remember their names, Kemi was washing this Resident and he was laying right on the edge of the bed and the bed was positioned very high so there was a risk of him falling out. Luckily he did not fall.

It is possible that Kemi misheard me say wash him when I said watch him. There was no issue with Kemi washing the resident in bed it was more the laying on the edge of the bed up very high and the risk of falling.

I asked Kemi to step back and my colleague and I made sure he was safe in his bed and lowered the bed down, I then left my colleagues with him."

Ms 5 reiterated this in her oral evidence.

The panel took account of the contemporaneous email sent by Ms 5, dated 19 October 2021 where she reported the incident to Ms 9. It stated:

"I had an incident where a resident was threatening to climb out of bed, (I was just about to start personal care on another resident) I rushed to residents room. I told Kemi to stay and watch him as he is known to fall out of bed and I would get another colleague to help us, when I came back with a colleague she was washing resident and he was unsafely on the edge of bed so we quickly intervened." [sic]

In your oral evidence, you stated that you never washed a resident directly unless you were being supervised. The panel noted that in your closing submissions you stated, *"From the integrity of my heart I will clearly state that this incident never happened."*

The panel preferred the evidence of Ms 5. It was of the view that her evidence was clear, consistent and plausible. The panel also bore in mind that it appeared that Ms 5 had no

animosity towards you. It noted that her aforementioned local statement was prefaced with the following:

> *"Can I first start this statement by saying what a lovely person Kemi is! She has shown kindness & also compassion with their residents" [sic]*

In light of the above, the panel concluded, on the balance of probabilities, that on or around 19 October 2021, you washed Resident E whilst he was laying unsafely on the edge of his bed.

The panel therefore found this charge proved.

Charge 10

10. On or around 27 October 2021 you prepared a bacon sandwich to give to Resident D who was on a soft diet.

This charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

Ms 2 in her witness statement stated:

> *"Kemi was shadowing me and I asked her to give Resident D her breakfast, I said to her that Resident D had asked for porridge but sometimes liked to eat a jam*

sandwich without the crust. I later saw Kemi walking out with a bacon sandwich, I asked who the sandwich was for and she said Resident's name. I explained that Resident D asked for porridge and that she was also on a soft diet. Kemi's response to me was that I said she liked a ham sandwich that's why she was going to give her bacon. I said no she liked a jam sandwich with the crusts off, it is possible Kemi misheard when I said jam and thought I said ham.

Kemi was quite defensive at first as she said I had told her she could have ham, she also said that Resident D asked for bacon.

The risk to Resident D was choking but I stopped Kemi so Resident D did not get the bacon sandwich and did not choke."

Ms 5 reiterated this in her oral evidence. She also stated she had provided you with a note detailing which of the residents had what for breakfast. She said that you were not asked to serve lunch or supper, but that you were allowed to serve breakfast yourself. Ms 5 also confirmed that she saw you coming out of the kitchen with a bacon sandwich.

The panel reminded itself that to find this charge proved it would have to find evidence that demonstrated that you prepared a bacon sandwich.

The panel took account of the contemporaneous written statement of Ms 2, dated 27 October 2021, to Ms 3 which stated:

"Kemi was assisting with breakfast service. Kemi asked if she could prepare Resident D breakfast. I told Kemi that Resident D asked for porridge. Kemi then went to do the breakfast as I entered the kitchen Kemi came out with a bacon sandwich" [sic]

The panel took account of another contemporaneous written statement of Ms 2, dated 29 October 2021, to Ms 3 which stated:

I wrote out on a piece of paper rooms one to twenty with their names and what they like and the ones that like to change every so often so they need to be ask, so can we had an understanding of what to do, Kemi said she had an understanding what I had done and went about making Tea's and Coffee's, As I came out of the kitchen Kemi had a bacon sandwich which I asked who it was for she will replied [Resident D]…Kemi was assisting " [sic]

You stated that you were under the supervision of Ms 2, and you were given the bacon sandwich to give to Resident D. You stated that you did not serve any meals, you were just "dishing them out", in other words distributing them after they had been prepared by other members of staff. You said that you just took what you were given and you did not know what the residents ate. You said that you knew that Resident D could not chew and would not have given this resident a bacon sandwich.

The panel preferred the evidence of Ms 2. It was of the view that her evidence was consistent and corroborated by the contemporaneous documentation. It also noted that Ms 3 confirmed receiving Ms 2's written statement in her witness statement.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 27 October 2021 you prepared a bacon sandwich to give to Resident D who was on a soft diet.

The panel therefore found this charge proved.

Charge 11

11. On or around 29 October 2021 you lowered the bed rails of Resident D, whilst Resident D remained in the bed.

This charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence Ms 2 and your evidence.

Ms 2 in her witness statement stated:

> *"I was in the kitchen and [previous colleague, Nursing Assistant] called and asked me who gave Resident D their breakfast, I responded saying that Kemi had. [A colleague] called me along to Resident D's room and I saw that the left side bed rails were down and the table was over the top. Kemi had raised the bed higher to reach the table and lowered the bed rail, she should have lowered the table and never lowered the bed rails.*
>
> *Resident D has balance issues and could have fallen out the bed and the bed was higher than normal. Resident D did not fall out of the bed.*
>
> *I spoke to Kemi about this and she said she would not do this again. She did not come across defensive or anything, she just said she would not do it again."*

Ms 2 reiterated this in her oral evidence.

The panel took account of the contemporaneous written statement of Ms 2, dated 29 October 2021, to Ms 3 which stated:

> *"Kemi had served breakfast to Resident D. [A colleague] explained that Resident D safety bed rails was left down [the colleague] and myself made sure that the bedrails was in place and safe, then I approached Kemi to ask her if she had*

disengaged the bedrails, Kemi said yes because the table wouldn't go over the bedrails. I explained that it is not safe to leave bedrails down when a resident is in bed as it posses a falls risk." [sic]

The panel also took account of Resident D's Bedrail risk assessment and consent form which confirmed that Resident D was at risk of falling out of the bed and therefore the bedrails should have been engaged.

When you cross examined Ms 2, you put to her that you had washed Resident D and lowered the bedrail. Ms 2, in response, stated that you were not washing the resident, you were feeding him breakfast. She then stated that you had raised the bed and lowered the bedrail.

In your closing submissions you stated:

"In this case, I never had any discussion with [Ms 5] regarding the issue of bed rail and I was not the only one who attended to the resident at that time so, this discussion did not happen between [Ms 5] and me."

The panel preferred the evidence of Ms 2. It was of the view that her evidence was consistent and was corroborated by the contemporaneous documentation. It also noted that Ms 3 confirmed receiving Ms 2's written statement in her witness statement. The panel also bore in mind that it appeared that Colleague B had no animosity towards you. It noted that her written statement stated the following:

"I feel I need to add, that prior to any of these points I harbour no ill feelings against Kemi. Nor do I think I am trying to put her down, but I feel need to speak up about the safety of those in my care…"

The panel further noted that it seemed that at the time, you admitted this incident to Ms 2.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 29 October 2021 you lowered the bed rails of Resident D, whilst Resident D remained in the bed.

The panel therefore found this charge proved.

Charge 12a

12. Between September 2021 to December 2021 you:
    a. Attempted to feed Resident F whilst they were lying on their back;

This sub-charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Colleague B and your evidence.

Colleague B in her witness statement stated:

> *"Kemi was in Resident F's room, I think I was doing my tea time medication round and I walked passed Resident F's room and saw Kemi trying to feed Resident F whilst lying flat on her back in bed. I stepped in the room straight away and told Kemi that she should not be feeding whilst lying flat as she could choke. I did say this in front of Resident F as I was very concerned. I did try and say it in a nice way but I felt that Kemi thought I was picking on her but I was not."*

Colleague B reiterated this in her oral evidence. She stated that she was doing a medication round, looked inside the room you were in and what she saw shocked her to the point that she had to intervene immediately. She spoke about how she checked Resident F's mouth and said she reported the incident straightaway. She said that while there may have been a pillow, she recalls seeing Resident F flat on her back.

The panel took account of the contemporaneous written statement of Colleague B, dated 1 November 2021, to Ms 9 which stated:

> *"Kemi has on occasion being found to have compromised the safety of the residence by assisting the resident with her meal. The Resident F was lying down in bed instead of being sat upright which caused great concern as resident F is high choking risk. When I corrected Kemi about two, she was not happy that I advised or reminded her of the incident."*

You stated that you would never have done this and the incident did not happen. In your closing submissions you stated:

> *"Naturally I know no one can eat while laying down so, I will not in any way feed someone, especially someone who is 100 years old while lying down. Because I know the risk and complication of choking and aspiration. With all sincerity this did not occur." [sic]*

The panel preferred the evidence of Colleague B. It bore in mind that she was a direct witness to the incident and was of the view that her evidence was consistent with contemporaneous documentation and more plausible than your general denial that you would have done this. She had provided detail of her reaction to what she saw and her intervention. It also noted that Ms 9 confirmed receiving Colleague B's written statement.

In light of the above, the panel concluded, on the balance of probabilities, that between September 2021 to December 2021 you attempted to feed Resident F whilst they were lying on their back.

The panel therefore found this charge proved.

Charge 12b

12. Between September 2021 to December 2021 you:
    b. When challenged about this by Colleague B, you said 'I know what I am doing' or words to that effect.

This sub-charge is found not proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Colleague B and your evidence.

Colleague B in her witness statement stated:

> *"I explained to Kemi that should be sat up and repositioned before eating. Kemi's response was something like "I know what I am doing", I cannot recall specifically what she said. I felt resistance from her again she was not happy and not keen on being corrected. Again I raised this with Unit Manager...I raised to [Unit Manager] that I felt it was not safe for Kemi to be left on her own, I was concerned if she was not supervised we ran the risk of Residents being put at harm."*

The panel bore in mind that Colleague B's oral evidence was not clear when recalling this incident and Colleague B was candid about this. It also bore in mind that she said in her witness statement above *"I cannot recall specifically what she said."*

The panel took account of the contemporaneous written statement of Colleague B, dated 1 November 2021, to Ms 9. However, it noted that there is no mention of the words you allegedly used when Colleague B challenged you regarding your actions described in charge 12a. The panel considered that these words, or similar words, would have been memorable and if they had been used Colleague B would be likely to have recorded them at the time.

In light of this, the panel reminded itself that it is for the NMC to prove the charge. It noted that the NMC has not provided the panel with any contemporaneous evidence to support this charge with regards to your words. It reminded itself that the NMC relied solely on the evidence of Colleague B. The panel does not believe that she was trying to mislead the panel. However, the panel noted that the NMC had not provided the panel with information that shows that you did what has been alleged in this charge. This charge is not supported by any other documentation before the panel.

The panel therefore concluded that the NMC had not provided the panel with sufficient evidence to find this charge proved.

Charge 13

13. Between September to December 2021, you held and/or grabbed Resident C's arm when assisting to move them.

This charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC's position is that while you were not employed as

a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Colleague B and your evidence.

Colleague B in her witness statement stated:

> *"I do not recall which side I was on and which side Kemi was on. I had one arm under Resident C's armpit and the other arm behind her back to support her. I was more concentrating on her legs than watching what Kemi was doing at the time but I did see her gripping Resident C with her fingertips.*
>
> *Resident C is compos mentis and has capacity. The following day she called me and complained to me that her arm was very sore from the day before. I asked her what had happened and she told me that when myself and Kemi, she referred to Kemi as "the other lady" as she did not know who she was, had moved her from the commode to the bed Kemi had grabbed her by the arm whilst doing so and it was sore. Resident C showed me her arm, I cannot recall if this was the left or right, but I saw a slight bruising that looked like a finger mark and she said it was sore. I apologised to Resident C and said I would speak to Kemi about it. Resident C was quite upset about it and asked that Kemi didn't go into her room anymore or attend to her personal care. I offered her pain relief but she was already on Co-Codamol for her leg injury and she said she was fine."*

Colleague B reiterated this in her oral evidence.

The panel took account of the contemporaneous written statement of Colleague B, dated 1 November 2021, to Ms 9 which stated:

“Kemi is not mindful of her actions especially when she is assisting residents to transfer from the chair to the bed Resident C suffered a left sore arm when Kemi applied too much pressure by trying to lift Resident C into a standing position by grabbing Resident C upper arm. I again corrected Kemi after the incident, outside of Resident C room and she was not happy about it she stormed off.” [sic]

The panel noted that there appears to be discrepancies between Colleague B’s witness statement and her contemporaneous written statement. It noted that while she mentioned bruising in the witness statement, this did not appear in her written statement.

When you cross examined Colleague B, she stated that the incident occurred before Christmas and said that Resident C has full capacity. She said that the Resident C told her you were “a bit rough” and then Colleague B told Resident C that she would speak to you.

In your closing submissions you stated:

“Regarding this, I never worked with [Colleague B] to lift any resident in all truthfulness.”

The panel preferred the evidence of Colleague B. It bore in mind that she was in the room when the incident occurred and had given a detailed account of both the incident and her conversation with the resident the next day. The panel was of the view that her evidence was broadly consistent with the contemporaneous documentation. It noted that absence of reference to bruising in the original note could simply be that the bruise appeared later. The panel could see no reason why Colleague B would have fabricated her account. Ms 9 confirmed receiving Colleague B’s written statement.

In light of the above, the panel concluded, on the balance of probabilities, that between September to December 2021, you held and/or grabbed Resident C’s arm when assisting to move them.

The panel therefore found this charge proved.

Charge 14

14. On or around 2 March 2022 you failed to assist an unknown Resident with personal care and pad changing.

This charge is found proved.

The allegation in this charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of evidence of Ms 6, Colleague C and your evidence.

Colleague C in her witness statement stated:

> *"On 2 March 2022, I wrote a statement, which I gave to [Ms 6], regarding the Registrant's refusal to assist a male client with personal care that day."*

The panel took account of the contemporaneous written statement of Colleague C, dated 2 March 2022, to Ms 6 which stated:

> *"Kemi has refused to assist a male client with personal care and pad changing I have explained before its how you approach him but still refuses to do him" [sic]*

Colleague C in her oral evidence stated that the resident was sensitive around personal care and required extra thought and care. She explained that she would ensure to tell everyone that he needed to be treated with quiet and calmness.

Ms 6 corroborated the fact that she received the written statement and confirmed that she spoke to you about this:

> *"…on 02 March 2022 [Colleague C], a Med Tech, wrote a statement stating that…Kemi also refused to assist a male client with personal care and pad changing. I discussed this with Kemi as part of the ongoing general discussions with her. Kemi's response was that the Resident was aggressive. As a senior member of staff I reminded her that she has to manage these behaviours. Kemi did not complete this task another Carer did straight away so there was no harm to the resident."*

In your closing submissions you stated:

> *"In this case, I do not wait to be told before I carry out my duty, I do what am supposed to do at the appropriate time because I know the implication of pressure ulcer when a resident is left in a wet pad so, this did not happen."*

The panel preferred the evidence of Colleague C. It bore in mind that she was a direct witness to the incident occurred and was of the view that her evidence consistent with the contemporaneous documentation. It also noted that Ms 6 confirmed receiving Colleague C's written statement. It appears that when Ms 6 spoke to you about the incident, you did not deny it but gave an explanation that the resident was aggressive.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 2 March 2022 you failed to assist an unknown Resident with personal care and pad changing.

The panel therefore found this charge proved.

Charge 15

15. On or around 7 March 2022 you did not provide care to an unknown resident until you had been asked to do so 3 times by Colleague C.

This charge is found proved.

The allegation in this charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of evidence of Ms 6, Colleague C and your evidence.

Colleague C in her witness statement stated:

> *"On 7 March 2022, I wrote a statement, which I gave to [Ms 6], regarding the Registrant being asked 3 times to assist a client who had opened their bowels."*

The panel took account of the contemporaneous written statement of Colleague C, dated 7 March 2022, to Ms 6 which stated:

> *"Kemi and…were asked 3 times to assist….due to having her bowels open and due to not having any pressure relife [sic] since she had got up and her clothes were wet. Carer…asked them once – 14.00 then myself asked them twice – 14.35 & 15.15."*

Ms 6 corroborated the fact that she received the written statement and confirmed that she spoke to you about this:

“On 07 March 2022 [Colleague C] raised that she asked Kemi and another staff member
three times to assist a resident due to her having opened her bowels and not had any pressure relief since she had got up and her clothes were wet. Kemi did complete this care but it was after a prolonged period of time, this was more about Kemi not being able to identify resident’s needs at the time. This was discussed with Kemi, all concerns were discussed with Kemi and she had a vacant, vague response each time. In this instance Kemi said that another resident needed something else, she was not able to prioritise. The risk to the resident here is about privacy, dignity, skin integrity and general wellbeing. This resident could not verbalise her needs or how she was feeling but she was able to portray this in her behaviour this could have escalated into a challenge which could have put herself or others at risk. There was also a risk to others in that there was an unpleasant smell.”

In your cross examination of Ms 6, it was established that there was another carer in the room during the incident. You also stated that there was never a day that you refused to change anybody.

The panel preferred the evidence of Colleague C. It bore in mind that she was a direct witness to the incident and was of the view that her evidence was consistent with the contemporaneous documentation. It also noted that Ms 6 confirmed receiving Colleague C’s written statement. It appears that when Ms 6 spoke to you about this incident, you did not deny it but offered the explanation that you had been providing care to another resident.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 7 March 2022 you did not provide care to an unknown resident until you had been asked to do so 3 times by Colleague C.

The panel therefore found this charge proved.

Charge 16

16. On or around 12 March 2022 you:
    a. Failed to provide prompt personal care to an unknown resident;
    b. Failed to complete nursing notes of the unknown resident promptly;
    c. Failed to turn an unknown resident between 08.22 and 16.28 hours;
    d. You failed to prioritise the needs of the unknown resident.

These sub-charges are found not proved.

The allegation in these sub-charges relates to your time Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel considered each of these charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"Another staff member [Ms 10] who is a Registered Nurse completed a Cause for Concern Form on 13 March 2022….A resident was washed and dressed at 08:22 then did not have any personal care until 16:28 where her pad was changed but she was not turned. This resident's son came to visit at 16:59 and the resident was soaking wet and had opened her bowels. [Ms 10] spoke to Kemi about this and why it is important to make sure Residents are clean and dry every 3-4 hours and to take this Resident to the toilet as they were unable to take themselves. This was another instance of Kemi not being able to prioritise and identify the severity of needs of resident's. Again her response was quite vacant she said she was busy.*

Kemi said she had provided care but not yet completed the notes, this is a concern as with documentation there needs to be an accurate time frame. Again the risk to the Resident here relates to privacy, dignity, skin integrity, general wellbeing and their right to care."

The panel noted that it had no direct evidence in relation to this charge. There was no witness evidence (either written or oral) from Ms 10. All that was available was the hearsay evidence in Ms 10's contemporaneous "cause for concern form". However this evidence was vague and tenuous. Ther was no information about the patient's identity, or the context or circumstances of the alleged failure to provide personal care. There was no other corroborating documentation or evidence.

The panel bore in mind that the charges refer to a failure on your part. For the panel to find these sub-charges proved, there needs to be a duty. In light of this, the panel reminded itself that it is for the NMC to establish both a duty and a failure in order to prove the charge.

With regards to charge 16a, the panel took account of the Cause for Concern Form dated 12 March 2022 completed by Ms 10, and an MCM (Mobile Care Monitoring) care notes form. This person-centred software note has the resident's name redacted but has many icon entries which appeared to have been made by you from 08:19 to 17:15 on 12 March 2022. Under the heading "Action Taken (Reported to and when)" Ms 10 has stated:

"I spoke to Oluwakemi about not doing any personal care on…why it is important to make sure that…is clean and dry every 3-4 hours…"

However, upon looking at this form and MCM care notes form, the panel could not find evidence to support that personal care was not given. Further, as the charge refers to an unknown patient, the panel could not be certain who these documents relate to. While they may refer to the same resident, it was of the view that the information provided is not clear. Nevertheless, the panel does not have any information before it to ascertain what

the needs of the unknown patient were in order to determine whether or not you failed to provide care for it.

Although the resident was reported as wet by a relative who visited at 16:59, there was no evidence to indicate when or for how long the resident had been in that state, or whether is was attributable to any failure by you or indeed anybody else to provide personal care.

In relation to charge 16a and 16b the panel therefore considered that there was insufficient evidence to establish either the alleged failure to provide prompt personal care or to complete nursing notes promptly.

With regards to charge 16c, the panel noted that the MCM care notes shows that you have recorded the following at 08:57:

> "Checked sitting in the lounge awake, no concerns."

Then at 16:28, you have recorded the following:

> *"Help with walking, needed a lot of help, was assisted to move, transferred to the lounge"*

In between these two recordings, the panel noted that there are more references to this unknown resident being in the lounge. As a result, the panel considered that you would not be required to turn a resident who was sitting in the lounge. There was therefore insufficient evidence to establish either the duty or the failure alleged at charge 16c.

With regards to 16d, again the panel do not have any information before it to establish what the needs for this unknown resident were. Therefore, it could not determine whether you failed to prioritise these needs.

The panel therefore concluded that the NMC had not provided the panel with sufficient evidence to find these sub-charges proved.

Charge 17a and 17e

17. On 27 April 2022 failed to meet the requirements of the Observation Supervision in the following areas:
    a. Working in line with organisations core values;
    e. Documentation is accurate clear and factual.

These sub-charges are found not proved.

The allegations in these sub-charges relates to your time Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"I completed an Observational Supervision Form on 27 April 2022 with Kemi, she required improvement in all areas observed. This is standard for the whole workforce and usually takes place once every three months. It ensures correct practices. The recent observation form…Kemi required improvement on all areas I observed including:*
>
> *- Working in line with organisations core values"*

The panel took account of the contemporaneous Observational Supervision Form dated 27 April 2022. Under the heading “Practice/Standards being observed” there is a sub-heading entitled "Works in line with organisations Core Values.” Additionally, under the heading “Comments on observed areas of practice” Ms 6 recorded:

> *“Kemi did not promote family, commitment or good care through the lack of communication with the resident.”*

The panel bore in mind that for the NMC to prove this charge, it would have to establish that you failed to work in line with the organisations core values. However, the panel noted that it did not have the organisations core values before it in order to measure from.

Therefore, while it appears from the entry made by Ms 6 that she considered that you failed in this regard, the panel did not have the core values to compare the practice you delivered in order to determine whether or how you had indeed failed them. It was unclear what, if anything, was alleged beyond what is already set out in sub-charges 17b to 17d. The panel therefore found 17a not proved.

With regards charge 17e, the panel took account of the contemporaneous Observational Supervision Form dated 27 April 2022. Under the heading “Practice/Standards being observed” there is a sub-heading entitled "Documentation is accurate, clear and factual.” Additionally, under the heading “Comments on observed areas of practice” Ms 6 recorded:

> *“Although Kemi did document the intervention (by pushing buttons), this was not personalised and did not show what the resident was able to do for themselves, what assistance was required.”*

Additionally, under the heading “Supervision Comments” Ms 6 recorded:

“Documentation following this intervention with a resident does not show personalisation and did not take note of the resident’s ability to meet some of their own needs or that choice was being offered.”

The panel bore in mind that the charge relates to a failure pertaining to documentation being accurate, clear and factual. However, the notes from Ms 6 appears to suggest that your failure refers to your documentation not being personalised. The panel did not have any evidence before it to demonstrate expected standards of documentation. There was no evidence to show that what you recorded was not “clear, accurate and factual”. At its highest the evidence suggested that your notes were insufficiently detailed. Whilst it might be good practice to include more detail, the evidence did not support a finding that the document was not clear, accurate or factual.

The panel therefore concluded that the NMC had not provided the panel with sufficient evidence to find this charge proved.

Charge 17b, 17c and 17d

17. On 27 April 2022 failed to meet the requirements of the Observation Supervision in the following areas:
    b. Engagement with residents and their families;
    c. Work in a way that promotes residents dignity and choice;
    d. Demonstrates a caring and compassionate attitude;

These sub-charges are found proved.

The allegations in these sub-charges relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"I completed an Observational Supervision Form on 27 April 2022 with Kemi, she required improvement in all areas observed. This is standard for the whole workforce and usually takes place once every three months. It ensures correct practices. The recent observation form…Kemi required improvement on all areas I observed including:*
>
> *- Engagement with residents and their families*
> *- Works in a way that promotes residents dignity and choice.*
> *- Demonstrates a caring and compassionate attitude"*
> *- Documentation is accurate clear and factual.*

With regards to charge 17b, 17c and 17d Ms 6 in her witness statement stated:

> *"Kemi demonstrated a lack of communication to residents and their families. I witnessed Kemi approach a resident did not verbally engage with the resident and placed her arm under the arm of the resident and began walking down the corridor…"*

The panel took account of the contemporaneous Observational Supervision Form dated 27 April 2022. Under the heading "Practice/Standards being observed" there is a sub-heading entitled "Engagement with Residents and their families" Additionally, under the heading "Comments on observed areas of practice" Ms 6 recorded:

“Kemi was observed approaching a resident in the corridor, Kemi did not verbally engage with the resident, Kemi placed her arm under the arm of the resident and began walking down the corridor.”

The panel was of the view that the concern Ms 6 has raised, regarding this sub-charge, is specifically about verbal engagement with a single resident. It noted that while there was no family involved, it appears that Ms 6’s observations of you were enough to establish that you failed to demonstrate this particular standard by your actions on this one occasion.

With regards to 17c and 17d, Ms 6 in her witness statement stated:

“I witnessed Kemi approach a resident did not verbally engage with the resident and placed her arm under the arm of the resident and began walking down the corridor Kemi did not inform the resident on where they were going and what was happening and did not give the resident any choice. The lack of engagement meant she did not demonstrate a caring or compassionate attitude. Kemi needs to ensure that she verbally communicates with residents, explains why she has approached them and an explanation of what is going to happen or where she needs the resident to go and why. Kemi should offer a supportive hand. Not just place her arm under the resident’s arm and start walking. This can increase the risk of falls for residents as well as damage to their skin integrity.”

The panel took account of the contemporaneous Observational Supervision Form dated 27 April 2022. Under the heading “Practice/Standards being observed” there is a sub-heading entitled "Works in a way which promotes Resident’s dignity and choice." Additionally, under the heading “Comments on observed areas of practice” Ms 6 recorded:

“Kemi did not inform the resident on where they were going and what was happening, Kemi did not give any choice to the resident.”

With regards to 17d, the panel took account of the contemporaneous Observational Supervision Form dated 27 April 2022. Under the heading “Practice/Standards being observed” there is a sub-heading entitled "Demonstrates a caring and compassionate attitude towards Residents.” Additionally, under the heading “Comments on observed areas of practice” Ms 6 recorded:

> *“Due to the lack of engagement Kemi did not demonstrate a caring or compassionate attitude.”*

The panel was of the view that if you are not providing the resident with a choice as to where they are going, then it considered that this could be seen as a failure to promote a resident’s dignity or choice. Additionally, this would also result in a failure to a demonstrate a caring and compassionate attitude.

In respect of all these sub-charges, the panel preferred the evidence of Ms 6. It bore in mind that she was she was direct witness to your contact with this resident on this occasion and was of the view that her witness statement is consistent with her contemporaneous Observational Supervision Form. The panel had no information before it to suggest that Ms 6 fabricated her observations of you.

In light of the above, the panel concluded, on the balance of probabilities, that sub-charges 17b, 17c and 17d occurred as alleged in relation to your interaction with a resident on the day of the observation supervision.

The panel therefore found these sub-charges proved.

Charge 18a

18. On or around 11 May 2022:

a. On one or more occasion left medication on top of the medication trolley unattended and/or with the keys in the door of the medication trolley;

This sub-charge is found proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"The opportunity was given to Kemi on the 11th May to administer medication supervised, during this period Kemi was deemed not to be safe in ensuring the correct medication administration procedures were followed.*
>
> *Due to concerns raised Kemi was stopped after the third resident. No harm was caused to any resident as I was watching very closely and stopped immediately anything that could have caused risk. The concerns noted were; several times the medication trolley was left open with the keys in the door in the corridor whilst she entered a resident's room. On one occasion she entered a residents room and closed the residents door behind he leaving the trolley open, not supervised and she couldn't see whether any resident entered the area. The risk here is residents/other unqualified staff could access the medications which could result in harm. Kemi also left medication on top of the medication trolley several times and walked away out of eyesight of the trolley again not ensuring the safety of residents as she could not see whether a resident had accessed the medication."*

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

> *"Several times leaving the medication trolley open with the keys in the door in the corridor whilst you entered a resident's room, on one occasion you entered a resident's room and closed the door behind you leaving the trolley open and not supervised nor could you see whether any resident entered the area.*
>
> *You left medication on top of the medication trolley several times and walked away out of eyesight of the trolley, again not ensuring the safety of the residents as you could not see whether a resident accessed the medication."*

The panel also took account of your probation review meeting dated 10 June 2022 which was attended by Ms 6. It stated:

> *"During the mid-probation review meeting we discussed how we were going to improve on these areas and put a plan in place. Following that meeting [Ms 6] planned in medication competency and stepping up into the role of leading the unit. On 11th May 2022, [Ms 6] started your medication competency…other concerns were leaving the medication trolley open, leaving the key in the trolley."*

The panel had no reason to doubt the veracity of the file note or the probation review meeting.

When you cross examined Ms 6, you stated that it was your practice to lock the medication trolley and put the keys in your pocket however Ms 6 stated that she would have recorded this in her observations had you done so.

In your closing submissions you stated:

“I do not agree with this allegation because I never left the cupboard on the corridor unlocked when I go to administer medication because I know the rules governing medication administration and safety. Knowing the population we care for that some are often confuse, I always ensure I lock the cupboard so that nobody injects [sic] medication accidentally.”

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to this incident and was of the view that her witness statement is consistent with her contemporaneous file note and the probation review meeting notes. The panel had no information before it to suggest that Ms 6 fabricated her observations of you.

The panel also bore in mind that it had asked Ms 6 if you had a false sense of security because she was observing you. Ms 6 denied this stating she told you to conduct the drug round as if she was not here.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 11 May 2022 on one or more occasion you left medication on top of the medication trolley unattended and/or with the keys in the door of the medication trolley.

The panel therefore found this sub-charge proved.

Charge 18b

18. On or around 11 May 2022:
    b. Failed to identify a possible error in the counting of medication and/or failed to check whether the previous medication count was correct;

This sub-charge is found not proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"A further concern that Kemi was unable to identify a possible error in the counting of medications or double check whether the previous counts were correct. Kemi did not identify there was an empty box, not signed on the MAR and was unaware of the process to follow. Kemi also did not know what the medication was for."*

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

> *"You were unable to identify a possible error in the counting of the medication, or double checked whether previous counts were correct."*

The panel took account of the MAR chart in relation to this charge. However, with regards to the failure to identify a possible error in the counting of medication, the panel noted that it had no evidence to support this other than what is in Ms 6's witness statement. On the MAR chart there is a note that states:

> *"Kemi did not identify there was an empty box (not signed) on MAR's and unaware of process to following"*

The panel considered that the evidence to support this allegation was vague and tenuous. It appeared from the MAR chart that you counted the remaining medication in the packet and recorded a figure on the MAR chart as a running balance. It appeared that you did not record the amount of mediation in the box before your administration of the dose. However, that was also true of entries made on the chart by other people. It was not clear from the available evidence what the significance of the empty space on the chart was or whether the expected procedure had been explained to you before you undertook this medication round. This was the first time since you joined Mayflower that you had made any part in the administration of medications and there was no evidence that you had received any training at Mayflower. No medication policy has been produced to the panel.

The panel bore in mind that it is for the NMC to prove this charge, but it concluded that the NMC had not provided the panel with sufficient evidence to find this sub-charge proved.

Charge 18c

18. On or around 11 May 2022:
    c. Failed to ensure the mouthpiece of an inhaler was clean before or after use prior to administering it to a resident;

This charge is found proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

"Kemi also administered an inhaler but did not ensure the mouthpiece was clean

before or after use. Kemi should have ensured that the mouthpiece was clean to ensure an effective dose of medication is administered. Also, this ensures that all food pieces around the mouthpiece is removed."

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

"You administered an inhaler but did not ensure the mouthpiece was clean before or after use."

The panel had no reason to doubt the veracity of the observations recorded in the file note. It also took account of the inhaler prescription which confirmed that the resident required the inhaler.

Your position, in cross examination and in your oral evidence, was that there was a cap on the inhaler which you removed to administer to the resident. Once administered you placed the cap back on. However, the panel considered that this did not mean that the inhaler was clean.

In your closing submissions you stated:

"As for the inhaler not been wiped before administering that is not true. I ensure that I followed the relevant medication procedure according to the Home policy so, all those allegations were not discussed with me before sending to NMC."

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to this incident and was of the view that her witness statement is consistent with her contemporaneous file note. The panel had no information before it to suggest that Ms 6 fabricated her observations of your clinical practice.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 11 May 2022 you failed to ensure the mouthpiece of an inhaler was clean before or after use prior to administering it to a resident;

The panel therefore found this sub-charge proved.

Charge 18d

18. On or around 11 May 2022:
    d. Failed to follow medication administration procedures

This sub-charge is found not proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel reminded itself that it is for the NMC to prove the charge. It noted that a number of specific allegations are made in the other sub-charges of charge 18. However, 18d is a generalised allegation which appears to add nothing further to those specific allegation. There was no evidence of any other specific alleged failure to follow medication administration procedures.

The panel was of the view that this charge was too vague and too broad and that there was no evidence to support it.

The panel therefore found this sub-charge not proved.

Charge 18e(i) and 18 e(ii)

18. On or around 11 May 2022:

    e. Failed to follow the covert medication agreement for Resident B, in that you:

        i. did not crush the medication before administering it to Resident B;

        ii. Did not administer the crushed medication in a cup of tea.

These sub-charges are found proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel considered each of these parts of the sub-charge separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"Another concern was a resident was under a covert medication agreement which was filed with the MAR chart…Kemi made the decision to place the tablets into a pot of rice pudding for ease of swallowing…Kemi had not followed the special instructions highlighted on the MAR that clearly stated for medication to be crushed into a cup of tea as this was the residents preferred drink. Kemi then proceeded to crush the tablet that she had in her hand to re-administer to the resident."*

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

"You tried to administer medication to a resident that is under a covert medication agreement, although you made a decision to place the tablets into a pot of rice pudding for ease of swallowing the tablets remained whole…You had not followed the special instructions which was highlighted on the residents MAR's paperwork that clearly stated for the medication to be crushed into a cup of tea as this was the residents preferred drink. You then proceeded to crush the tablet that you had in your hand to readminister to the resident."

The panel had no reason to doubt the veracity of the file note. The panel also took account of the Covert Medication Administration Agreement. Under the heading "How will they be administering the medication? (For example, mixed in yoghurt)" it is noted:

"Crushed and placed in a cup of tea"

In cross examination you said that you could not recall how the residents take their medication and therefore you could not recall this incident.

In your closing submissions you stated:

"This allegation did not happen."

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to this incident and was of the view that her witness statement is consistent with her contemporaneous file note. The panel had no information before it to suggest that Ms 6 fabricated her observations of your practice.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 11 May 2022 you failed to follow the covert medication agreement for Resident B, in that you did not crush the medication before administering it to Resident B and did not administer the crushed medication in a cup of tea.

The panel therefore found this sub-charge proved in its entirety.

Charge 18f

18. On or around 11 May 2022:
    f. Once resident B spat the medication out, you did not wear gloves when handling the medication.

This charge is found proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

> *"… the resident spat the medication out. I then saw Kemi with the tablet in her hand with no gloves on returning to the medication trolley."*

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

> *"You tried to administer medication to a resident that is under a covert medication agreement, although you made a decision to place the tablets into a pot of rice pudding for ease of swallowing the tablets remained whole, due to this the resident spat the medication out, you then was found with the tablet in your hand (with no gloves) whilst returning to the medication trolley."*

The panel had no reason to doubt the veracity of the file note.

In your oral evidence you stated that you did not recall this incident.

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to this incident and was of the view that her witness statement is consistent with her contemporaneous file note. The panel had no information before it to suggest that Ms 6 fabricated her observations of your practice.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 11 May 2022, once resident B spat the medication out, you did not wear gloves when handling the medication.

The panel therefore found this sub-charge proved.

Charge 18g

18. On or around 11 May 2022:
    g. Failed to administer a patch of medication as prescribed to Resident B.

This charge is found proved.

The allegation in this sub-charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

“Kemi also did not read the MAR correctly and did not administer a patch medication as prescribed. Kemi did not acknowledge the patch was due to be administered. The risk in relation to non-administration is that the resident would experience excess salivation.”

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. She stated:

“You did not read the MAR’s correctly and due to this did not administer a prescribed medication (patch).”

The panel had no reason to doubt the veracity of the file note. It also took account of the MAR chart for Resident B which confirmed that the patch of medication was prescribed.

In your closing submissions you stated:

“On this submission, while administering medication she stopped me half way and took over the medication administration so, I do not know what happened after then.”

In your cross examination of Ms 6 you appeared to suggest that you could not administer this medication because it was a controlled drug and required a registered nurse to administer it. However, it was apparent from the evidence that this was not a controlled medication and was due to be administered.

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to this incident and was of the view that her witness statement is consistent with her contemporaneous file note. The panel had no information before it to suggest that Ms 6 fabricated her observations of your practice.

In light of the above, the panel concluded, on the balance of probabilities, that on or around 11 May 2022 you failed to administer a patch of medication as prescribed to Resident B.

The panel therefore found this sub-charge proved.

Charge 19

19. On or around 11 May 2022, lacked basic knowledge of medication and/or made medication administration errors."

This charge is found proved.

The allegation in this charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC's position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6 and your evidence.

Ms 6 in her witness statement stated:

> *"Kemi lacked basic knowledge of any medication. She was able to state some basic vitamins but not the rationale for prescribing. Kemi was not aware of medication including Olanzapine, Kemadrin or any other non-vitamin medication that she was administering. The risks of not having basic knowledge is that there is an increased risk of medication errors, including not being able to ensure that the prescription is correct, ie time of day, the strength of the medication, contraindications with other medications, understanding of the residents health conditions, or how to support*

the resident in knowing what medication they are taking and why. Day to day she is not showing the basic skills that we would expect from everybody in the Home. I honestly would not feel comfortable with her administering medications at this point."

Ms 6 reiterated this in her oral evidence.

The panel took account of the contemporaneous file note, dated 11 May 2022, by Ms 6 where she recorded her observations of you on this day. It stated:

"Discussion had in relation to your understanding of medication – at time of administering you was unaware of the medication being administered (apart from vitamins although not the rationale for the prescription)."

The panel had no reason to doubt the veracity of the file note.

In your closing submissions you stated:

"On this submission, I do not agree that I lack basic knowledge of nursing, in all my Nursing career there have not been any record of any mistake of putting my patient at risk. I ensure safety and following the guidelines of nursing profession and also according to the rules of the organization I work with."

The panel preferred the evidence of Ms 6. It bore in mind that she was a direct witness to the incident and was of the view that her evidence was more plausible.

In light of the above, the panel concluded, on the balance of probabilities, that at the time of the medication round on or around 11 May 2022, you lacked basic knowledge of medication and/or made medication administration errors.

The panel therefore found this charge proved.

Charge 20

20. Between September 2021 – December 2021 you said to Colleague B “don’t treat me like a slave, I know how you have been treating everyone badly at Weller” or words to that effect.

This charge is found proved.

The allegation in this charge relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Colleague B and your evidence.

Colleague B in her witness statement stated:

> *“There was an incident where Kemi was inappropriate and she had a go at me. I was very upset, she made a comment that I was treating her like a slave, I could not imagine where this came from we are both overseas nurses and both women of colour. Her using the race issue with me was not fair. I think as I raised the two concerns Kemi took this personally.”*

Colleague B reiterated this in her oral evidence. The panel bore in mind that she was adamant that you had said this.

The panel took account of the contemporaneous written statement, dated 1 November 2021, Colleague B sent to Ms 9. It stated:

“Kemi and I had an argument when we were getting the supper time trolley, Kemi raised the issue of Race when she out of the blue said to me ‘don't treat me like a slave, I know how you have been treating everyone badly at Weller.’ Too which I replied ‘Excuse me, but don't you dare use the race issue with me, because we are both women of colour and for you too accuse me of such, is an immature and unprofessional. I hardly speak to you apart from work tasks, if you are not happy with me come on then you are welcome to speak to [Ms 11] about it.”

In assessing the evidence, the panel bore in mind that this written statement, dated 1 November 2021, is referring to a single incident of an alleged comment made sometime in October 2021.

In your oral evidence, you stated that this did not happen.

The panel preferred the evidence of Colleague B. While the aspect of you “treating everyone badly at Weller” was not in Colleague B’s witness statement, it was of the view that her evidence was broadly consistent. The panel also bore in mind that it appeared that Colleague B had no animosity towards you. It noted that her written statement stated the following:

“I feel I need to add, that prior to any of these points I harbour no ill feelings against Kemi. Nor do I think I am trying to put her down, but I feel need to speak up about the safety of those in my care…”

In light of the above, the panel concluded, on the balance of probabilities, that between September 2021 – December 2021 you said to Colleague B “don’t treat me like a slave, I know how you have been treating everyone badly at Weller” or words to that effect.

The panel therefore found this charge proved.

Charge 21a and 21b

21. Between 13 August 2021 to 8 November 2021 you said to Resident D:
    a. “you don’t like me is it because I am black” or words to that effect;
    b. “don’t you like me because of my skin colour” or words to that effect.

These sub-charges are found proved.

The allegations in these sub-charges relates to your time at Wombwell Hall where you were employed as a care assistant. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel considered each of these charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 5 and your evidence.

Ms 5 in her witness statement stated:

> *“This incident occurred in [Resident D] who I will refer to in this statement as Resident D’s room and [Ms 11] was present. I heard Kemi say to Resident D “you don’t like me is it because I am black” and “don’t you like me because of my skin colour”. I felt it was not my place to say anything at the time and [Ms 11] dealt with it. This was very inappropriate as Resident D could get confused. I felt that if Kemi was saying something like that I did not want Resident D to be tarred with being racist when she is not.”*

Ms 5 reiterated this in her oral evidence. She was adamant that you had said this.

The panel took account of Ms 5’s written statement, dated 19 January 2021. It bore in mind that this was written for the NMC and not contemporaneously. It stated:

“Myself and my unit manager head Kemi talking to resident saying ‘you don’t like me, it is because I am black’ & ‘Don’t you like me because of my skin colour. When this conversations was taking place myself and [Ms 11] were about to give the resident [D] personal care and Kemi was shadowing us.’”

In your oral evidence, you did not deny saying the words alleged. Your evidence was that you said it in response to Resident D saying to you that she did not like you because you were black. You said that you did not take it personally when Resident D said this to you because you knew that she had dementia.

The panel bore in mind that both you and Ms 5 mention that the Unit Manager Ms 11 was present during this incident. However, she had not attended to give evidence at this hearing nor had she provided a formal witness statement.

In considering the evidence before it, the panel preferred the evidence of Ms 5. It was of the view that her evidence was consistent. The panel also bore in mind that it appeared that Ms 5 had no animosity towards you. It reminded itself that Ms 5, in her oral evidence, spoke about you positively. In her witness statement she stated:

“I think Kemi is very lovely but I felt she lacked understanding of instructions and did not quite grasp what you were saying to her.”

In light of the above, the panel concluded, on the balance of probabilities, that between 13 August 2021 to 8 November 2021 you said to Resident D “you don’t like me is it because I am black” or words to that effect and “don’t you like me because of my skin colour” or words to that effect.

The panel therefore find these sub-charges proved.

Charge 22

22. On or around 23 October 2021 you said to Resident D:
    a. “you don’t like me because I’m black” or words to that effect;
    b. “why don’t you like me, I love you”, whilst stroking Resident D’s face.

This charge is found proved.

The allegations in these sub-charges relate to your time at Wombwell Hall where you were employed as a care assistant. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

The panel considered each of these charges separately but as the evidence in relation to each is similar and relates to the same incident, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 4 and your evidence.

Ms 4 in her witness statement stated:

> *“I remember I was standing in the lounge a bit away from Kemi and Resident D doing the medications. Resident D was very quiet and would only really speak when prompted. I had my back to them and I was alerted when I heard Kemi say “you don’t like be because I’m black?” As I turned around I saw Kemi stroking Resident D’s face saying “why don’t you like me, I love you”. There was no animosity and seemed quite friendly but the comment was inappropriate. I did not hear if Resident D said anything in response as she spoke quietly and I was not very close.”*

Ms 4 reiterated this in her oral evidence. She was adamant that you had said this. She stated that although Resident D could respond she did not really initiate conversation.

The panel took account of Ms 4's contemporaneous written statement, dated 23 October 2021. It stated:

> *"On this day, I was in the lounge administering medication. I was alerted to a conversation between Kemi and Resident D. The conversation I had heard was Kemi saying "You don't like me because I am black?" As I turned around Kemi was close to Resident D stroking her face saying "why don't you like me – I love you." I called Kemi over and briefly said that was not acceptable." [sic]*

In your oral evidence, you denied saying "love". You stated that you had said "Why don't you like me, I like you." You also denied stroking Resident D's face while saying this. As with the previous charge, your evidence was that you used those words in response to Resident D telling you that she did not like you because you were black.

In considering the evidence before it, the panel preferred the evidence of Ms 4. It was of the view that her evidence was consistent. The panel also bore in mind that it appeared that Ms 4 had no animosity towards you. It also bore in mind that in her witness statement she stated:

> *"Kemi was not defensive when I spoke to her, she did try and put it across to me that there was no nastiness behind it, which I agreed with but I said the issue was engaging in that conversation."*

Ms 4 reiterated this in her oral evidence. The panel accepted that there was no malice behind the words said to Resident D.

Nevertheless, the panel concluded, on the balance of probabilities, that on or around 23 October 2021 you said to Resident D "you don't like me because I'm black" or words to that effect and "why don't you like me, I love you", whilst stroking Resident D's face.

The panel therefore find these sub-charges proved.

Charge 23

23. On or around 2 March 2022 ‘Sucked your lips’ when you were asked to carry out the task of the tea trolley.

This charge is found not proved.

The allegation in this charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6, Colleague C and your evidence.

Ms 6 in her witness statement stated:

> *“…on 02 March 2022 [Colleague C], a Med Tech, wrote a statement stating that when Kemi was asked to do the tea trolley over handover she “sucked her lips”…”*

Ms 6, in her witness statement, refers to the contemporaneous written statement of Colleague C, dated 2 March 2022. It stated:

> *“When Kemi was asked to do the tea trolley over handover she sucked her lips in and kept saying what what what I said she was to do the tea trolley she sucked her lips in again.”*

Colleague C, in her oral evidence, changed her evidence and said that some people describe it as “sucking your teeth”.

In your oral evidence, you denied doing anything that could be considered “sucking your lips” or “sucking your teeth”. You stated that you lick your lips because they get dry. You said it is not rude rather is it is something that you do.

The panel reminded itself that it is for the NMC to prove the charge. It bore in mind that this alleged incident was not witnessed by anybody else other than Colleague C. It reminded itself that the NMC relied solely on the contemporaneous written statement of Colleague C. The panel does not believe that she was trying to mislead the panel. However, it did consider that her evidence changed when she gave oral evidence.

The panel bore in mind that you emphatically denied this charge and said that you would not “suck your teeth to demean anyone”. You said that you have dry lips and which you lick to moisten them. You said that this may have been interpreted incorrectly.

The panel was aware that in some cultures, sucking ones teeth can be used a gesture to indicate disrespect. However, Colleague C had not demonstrated the gesture and had only in her oral evidence used the description “sucking her teeth” for the first time, having at the time referred to it as “sucked in her lips”. The panel considered that the evidence was too tenuis to prove on the balance of probabilities that this was anything other than the action you described as moistening your lips. It considered it possible that Colleague C may have misinterpreted this action.

This charge is not supported by any other documentation before the panel.

The panel therefore concluded that the NMC had not provided the panel with sufficient evidence to find this charge proved.

Charge 24

24. On or around 16 March 2022 when you were asked to bath an unknown resident you stated “if you don’t want red flags you can do all our checks” or words to that effect.

This charge is found proved.

The allegation in this charge relates to your time at Mayflower Care Home where you were employed as a med-tech. The NMC’s position is that while you were not employed as a registered nurse, you were still on the NMC register and therefore still required to act in accordance with the NMC Code.

In reaching this decision, the panel took account of the evidence of Ms 6, Colleague C and your evidence.

Colleague C in her witness statement stated:

> *“On 16 March 2022, I wrote a statement which I gave to [Ms 6] regarding the Registrant being asked if they could bathe a client and the Registrant stated “if you don’t want red flags you can do all our checks.”*

The panel took account of Colleague C’s contemporaneous written statement, dated 16 March 2022. It stated:

> *“I was handing over to the workers what was happening today and asked Kemi and …if they could bath…today as it was not down to me as I was in office today. Kemi replied well if you don’t want red flags you can do all our checks. I said I have my own work to do.”*

Ms 6 confirmed receipt of the concern in her witness statement when she stated:

[Colleague C] raised another concern on 16 March 2022 that when Kemi was asked to bath a resident and Kemi's response was "if you don't want red flags you can do all our checks". Red flags are something on our computerised care planning, we can input "planned care actions" which are prompts to help staff. We understand people can get busy and little things can get forgotten but if something is missed this would be flagged and is something we monitor. This is what Kemi means by "red flags". Kemi did bathe the resident, [Colleague C] is very experienced in the role and is proactive and can prioritise which is what I would expect of someone in that position. No harm came to the Resident but again there was a risk related to privacy, dignity, skin integrity.

In your oral evidence, you denied saying this and stated that you would not say something like this to your senior.

The panel preferred the evidence of Colleague C. It was of the view that her evidence was consistent and was supported by contemporaneous documentation. It considered it plausible that you could have made such a comment if you were being asked to do a task, but knew that you had other personal care tasks in respect of other residents which were due and which were therefore likely to trigger a warning on the computer system if they were not done.

The panel concluded, on the balance of probabilities, that on or around 16 March 2022 when you were asked to bath an unknown resident you stated "if you don't want red flags you can do all our checks" or words to that effect.

The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved in respect of charges 1, 2, 3, 4, 5a, 5b, 6, 7, 8, 9, 10, 11, 12a, 13, 14, 15, 17b, 17c, 17d, 18a, 18c, 18ei, 18eii, 18f, 18g and 19 amount to a lack of competence and whether the charges found proved in respect of charges 20, 21a, 21b, 22a, 22b and 24 amount to misconduct and, if so, whether your fitness to practise is currently impaired by reason of lack of competence and/or misconduct. 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.

NMC submissions

Ms Higgs provided the panel with written submissions which the panel have read. It stated:

'1. It is submitted that the Registrant's fitness to practice is impaired as a result of

a lack of competence in respect of charges 1, 2, 3, 4, 5a, 5b, 6, 7, 8, 9, 10, 11, 12a, 13, 14, 15, 17b, 17c, 17d, 18a, 18c, 18ei, 18eii, 18f, 18g and 19 and misconduct in respect of charges 20, 21a, 21b, 22a, 22b and 24.

The Law

Lack of competence

2. The current guidance (Document FTP-2b in the NMC Fitness to Practise Library) is as follows.

"We recognise that nurses and midwives sometimes make mistakes or errors of judgement. Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse or midwife. Substandard care that calls into question a nurse or midwife's competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of the nurse or midwife's work, which could put patients at risk, For instance when a nurse or midwife demonstrates a lack of knowledge, skill or judgment showing they are incapable of safe and effective practice.
3. In McDermott v Health and Care Professions Council [2017] EWHC 2899 (Admin), the court confirmed that the context in which poor performance is alleged to have taken place may be taken into account and that lack of competence must be serious.

Misconduct

4. Lord Clyde described misconduct in Roylance v GMC (No.2) [2000] 1 A.C. 311: "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

5. It has been repeatedly confirmed that the misconduct must be 'serious'. See e.g. Aremu v Health and Care Professions Council [2018] EWHC 978 (Admin).

Impairment

6. Dame Janet Smith's description of impairment in her fifth report from the Shipman enquiry, endorsed in CHRE v NMC, Grant [2011] EWHC 927 (Admin) at §76, includes situations in which a Registrant's misconduct is found to be impair their fitness to practice in the sense that he/she

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 […] profession into disrepute[.]

7. The attitude of the registrant is relevant to the question of whether their fitness to practice is currently impaired Nicholas-Pillai v GMC [2009] EWHC 1048.

Submissions

Lack of Competence

Charges 1-8

8. It is submitted that the conduct covered by charges 1-8, taken together, involve a serious departure from the NMC Professional standards of practice and behaviour for nurses, midwives and nursing associates ('the Code'). The relevant sections of the Code are set out below:

[Ms Higgs listed parts of the Code she deemed relevant]

It is submitted that the panel should have regard to the following factors in relation to seriousness:

a. The charges all (except 6) relate to medication errors, which should be looked at in the round when considering the Registrant's competence and deciding overall whether they are serious. It is submitted that this in and of itself suggests that there is a high risk of repetition.

b. The Registrant received training for a number of weeks prior to starting her role on a supernumery basis, having worked as a nurse previously for a significant number of years. In her evidence she suggested that the reason she had difficulties was due to the different medication names and machinery. However, the Registrant was provided with significant training whenever she needed, which was accepted by her within her evidence.

c. No harm was caused to the patients as the Registrant was supervised at all times. However, it is the risk of harm that should be considered.

i. Prescribing the wrong medication, expired medication or medication not dispensed at the correct time could have a significant impact upon patients and their symptoms.

ii. In relation to charge 6, the risk is that infection could have been spread to vulnerable patients in the hospital, or vulnerable patient being kept away from the main hospital population due to their own safety.

d. That the Registrant made admissions within her closing submissions as to some of these charges, which the panel may consider shows some insight. However, she

did not accept others of the charges which the panel may consider shows a lack of insight. Although of course, in and of itself that does not amount to impairment.

e. That in relation to charges 1 and 2, the Registrant did pass the assessments at a later stage.

f. The Registrant's reflective statement and various training certificates received since, along with her employer's reference.

g. That the Registrant has not since that role had the opportunity of working as a registered nurse and has therefore not had the opportunity (other than on 11 May 2022) to administer medication.

Charges 9, 10, 11, 12a and 13

10. It is submitted that the below sections of the Code apply to these charges:

[Ms Higgs listed parts of the Code she deemed relevant]

In relation to seriousness, it is submitted that the panel should consider the following:

a. That the residents were elderly and therefore more vulnerable than other patients may be, some with dementia.

b. The risk of harm caused, despite no physical harm having been caused.

i. In relation to charge 9, the resident was a fall risk and had been threatening to get out of bed. He could have fallen, which as an elderly resident could have had serious consequences.

ii. In relation to charge 10, that the resident had no teeth and therefore was unable to eat the food and would be a potential hoke hazard. It is submitted that this is particularly serious in light of the vulnerable residents within the home.

iii. In relation to charge 11, that the resident was a fall risk and could have fallen and, as above, could have suffered injuries as a result.

iv. In relation to charge 12a, the resident could have choked as a result of lying down whilst eating although thankfully no harm a caused as [Colleague B] intervened.

v. In relation to charge 13, harm was caused in that the resident reported the incident the following day to [Colleague B]. It is submitted that it is particularly important that elderly residents are handled with care.

c. It is submitted that again, taking the charges together, they amount to a serious lack of competence in that there were multiple issues raised each putting vulnerable residents at risk of serious harm and that there is, in light of the number of incidents, a high risk of repetition.

d. That the Registrant denied these charges, which the panel may consider shows a lack of insight. Albeit, in itself, maintaining a denial cannot be grounds for impairment.

e. The Registrant's training completed since the events, along with her reflections and employer's reference. Charges 14, 15, 17b, 17c, 17d, 18a, 18c, 18ei, 18eii, 18f, 18g, 19

12. It is submitted that the below sections of the Code apply to these charges:

[Ms Higgs listed parts of the Code she deemed relevant]

13. In relation to seriousness, it is submitted that the panel should consider the following:

a. That the risk of harm could have been serious in relation to each incident if other staff members had not been present or intervened:

i. In relation to charges 14-15, the patient's dignity is put at risk, along with health consequences of not being attended to.

ii. In relation to charges 17b-d, it is important that the residents are communicated with properly and that they are treated with care and respect. The actions observed by [Ms 6] could have led to the patient being harmed by falling over, or as a result of the contact. It is submitted this is consistent with the behaviour of the Registrant within charge 13, which again suggests a high risk of repetition. Not informing a patient where they are going, risks their dignity and the behaviour spoken of does not support the resident's right to dignity and does not show a caring and compassionate attitude as is expected of a registered nurse.

iii. In relation to charges 18 a, c and e-g and 19, it is submitted that again these suggest a lack of competence in regards to medication which, as with charges 1-8, suggest a lack of competence in regards to medication administration and puts residents at risk of serious harm and provides a real risk of repetition.

1. Leaving the trolley accessible to residents, some of whom were mobile, could lead to serious consequences;

2. Failing to clean the inhaler, could have meant the correct dose was not properly administered again with a potential for serious consequences;

3. Failing to adhere to the covert medication agreement puts patients at risk of being suspicious as to eating and drinking and could lead to them not taking medication.
Further, not putting gloves on to retrieve the medication risks spreading infection to vulnerable residents.

4. As above, failing to administer medication could lead to serious consequences for residents.

iv. The fact that the Registrant did not admit these charges may be considered to show a lack of insight.

v. The Registrant's evidence, reflection, training certificates and reference.

Misconduct

Charges 20, 21a, 21b, 22a, 22b and 24.

14. It is submitted that the following sections of the Code apply to these charges:

[Ms Higgs listed parts of the Code she deemed relevant]

15. It is submitted that the panel should have regard to the following in regards to seriousness:

a. That the residents were vulnerable, primarily suffering from dementia.

b. That in relation to charges 21 and 22 the Registrant should not have made the comments she did particularly in light of the resident not having capacity. It is not in line with the Code and what is expected of a nurse as a professional. The fact that this occurred on more than one occasion suggests a real risk of repetition.

c. The suggested attitudinal issues suggested by that have been staff members at different places of work and the likely impact of that on the ability for cohesive working.

d. That the Registrant denied some of the charges, which the panel may decide shows a lack of insight.

e. The panel will take into account, as with the other charges, mitigation as set out by the Registrant in her reflective statements, training certificates and reference.

Insight/Remediation

16. The panel will consider the Registrant's evidence, reflective statement, training certificates and reference. The certificates are dated in late 2021, prior to a number of charges. Therefore, although the Registrant seemingly did not successfully allow the Registrant to fully remediate.

17. The Registrant is currently employed as a health care assistant, as per her employer's reference, at JCM Michael Groups Care. Her employer states within the reference that she has undertaken mandatory training and refreshers, however it is unclear what those were. She does state that the Registrant scored the highest on medication competency which the panel will consider. She is also described as having a can-do attitude and that she goes above and beyond.

18. It would be fair to observe also that very little is known clearly about the Registrant's account as to the charges that she denied, as she denied them primarily on the basis that she denied that they happened or could not recall them having happened. Maintaining a denial cannot of course be grounds for impairment in and of itself. On balance, the panel may conclude there is some limited evidence of insight.

19. The Registrant has been subject to an Interim Conditions of Practice Order, which has limited the way in which she is able to work and she has not practised as a registered nurse since working at the Horley Ward. It is unclear from her employer's letter what her current work involves and to what extent she has had the opportunity to remediate. It is therefore submitted, that there is insufficient evidence to suggest that Registrant has fully remediated and as a result that her fitness to practice remains impaired.'

Your Submissions

You submitted that some of the charges are not true. You submitted that you have regret that some of the charges happened. You asked for leniency from the panel.

You submitted that you are willing to go through training to address your shortcomings. You submitted that you are overwhelmed with the NMC process and have no further submissions.

In response to questions from the panel, you said that you are unable to undertake training presently due to [PRIVATE] but you are willing to enrol and undertake training pertaining to the charges that it found proved.

You told the panel that you are trying your best to get a position as a registered nurse, however your opportunities are restricted due to the current interim conditions of practice order. You said that if you do get a job as a registered nurse, you will be able to address your shortcomings.

You told the panel that you currently work for a care agency and are currently working in the community four days a week. You said that you are assigned to go to different houses and care for the clients in their house. You told the panel that most of the clients are elderly and you provide personal care which includes washing them, doing their laundry

and providing them with meals. You also said that you dispense medication to them when it is due. You said that the medication had already been prescribed and sorted in blister packs. You said that you call NHS 111 or the district nurse if you come across anything unusual. In your current work assignment, you work double handed with another carer.

With regards to charge 6 you said that this occurred out of nervousness due to how you were treated at Horley Ward, East Surrey Hospital. You said that if you saw another nurse do this, you would let the nurse know that this is not right and correct her.

You told the panel that you want to return to nursing in the future. You said that your nursing career has taken you from Nigeria to Jamaica. You love nursing and it is unfortunate that these incidents happened.

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

Decision and reasons on lack of competence

When determining whether charges 1, 2, 3, 4, 5a, 5b, 6, 7, 8, 9, 10, 11, 12a, 13, 14, 15, 17b, 17c, 17d, 18a, 18c, 18ei, 18eii, 18f, 18g and 19 amount, individually or collectively to a lack of competence, the panel had regard to the terms of the Code. In particular, the panel considered following standards are engaged in this case:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel bore in mind, when reaching its decision, in relation to lack of competence, that at the time you were not always employed as a registered nurse at times when the failings occurred. However, you were still a registered nurse during those periods and it took the

view you should be judged by the standards of competence of the average registered nurse and not by any higher or more demanding standard.

The facts found proved involved failures in relation to:

- Medication knowledge;
- Medication administration knowledge, skills and judgment;
- Infection control;
- Safe and timely provision of personal care;
- Movement and handling techniques;
- Communication, including issues around patient dignity and choice; and
- The recognition, assessment and judgment of risk.

With regards to charge 1, the panel bore in mind that you had to achieve 100% on the oral drug administration assessments. It further bore in mind that you have been a registered nurse for many years and had been supported through the overseas nurse programme. However, despite this you failed the drug assessment tests three times. In light of this, the panel was satisfied you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, the panel determined that your performance demonstrated a lack of competence.

With regards to charge 2, the panel bore in mind that it heard evidence that you should have completed the oral medication assessment before being nominated by your manager to undertake the IV medication assessment. You did this on your volition and as a result undertook and failed the IV medication assessment. Your decision to undertake the test prematurely showed a lack of judgment and a lack of awareness of the limitations of your knowledge. In light of this, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, the panel determined that your performance demonstrated a lack of competence.

With regards to charge 3, the panel noted that a colleague pointed out to you that the Bisoprolol had expired before you were going to administer it. The panel was of the view that, on its own this single medication error would not amount to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. The panel was of the view that this did not amount to a lack of competence.

The panel was of the view that charge 4 was serious as it related to mistaking two different medications that had different purposes and effects. It was of the view that this was a failure to demonstrate the standards of knowledge, skill, and judgement required pertaining to the administration of medication. This is because of the very different nature of the names and the actions of Spironolactone and Digoxin and the different effects they each may have had. However, the panel was of the view that while this single medication error could have resulted in serious harm, it would not on its own as a one-off incident amount to a lack of competence.

With regards to charge 5a, the panel was of the view that this was another near miss incident. However, it was of the view that as a one-off medication error, did not amount to a lack of competence.

With regards to charge 5b, the panel was of the view that potentially administering 250mg of paracetamol rather than 500mg of paracetamol was an underdose, not a serious error in this case. The panel was of the view that on its own as a one-off medication error, did not amount to a lack of competence.

With regards to charge 6, the panel bore in mind that this occurred during the height of the coronavirus pandemic when there was heightened public awareness of the significance of infection control. The panel was of the view that infection control is a basic nursing skill that you should have been aware of. It concluded that this amounts to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. However, it noted that while this was serious, your

failure to observe infection control policy was a one-off incident. It concluded that this did not amount to a lack of competence.

With regards to charge 7, the panel was of the view that while this was a medications error, it was a one-off incident and not enough to demonstrate a lack of competence.

With regards to charge 8, it was of the view that timing is essential for any medication. It took account of the circumstances. It heard evidence from Ms 7 that she told you about the importance of timing for this particular medication immediately before this incident occurred. Despite this, it appears you ignored the advice you were given when you failed to administer the Parkinson's medication despite bringing it out with the yoghurt. You moved onto another patient without administering it.

The panel was satisfied that this amounted to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this single incident was sufficiently serious that it amounted to a lack of competence.

The panel noted that your actions described in charges 1 to 8 took place from October 2020 to March 2021. It was of the view that the various incidents in these charges reflected a fair sample of your practice at the Trust. It bore in mind that Ms 1, in her evidence, stated that you did not achieve competence in the administration of oral medication while employed by the Trust. You were directly supervised when undertaking this task. In all the circumstances, the panel determined that cumulatively your performance in charges 1 to 8 demonstrated a lack of competence.

With regards to charge 9, the panel bore in mind that you were new to the unit. You may have washed Resident E because you thought you had been instructed to do so by mistaking "watch him" for "wash him". The panel noted that you washed him on the edge of the bed despite the resident being at risk of falls and that this was unsafe practice. It also bore in mind that upon seeing your actions, Ms 5 felt obligated to report this to

management. The panel was of the view that a nurse of your experience should have approached this patient with care and that this was a failing in basic risk assessment skills. The panel was satisfied that your actions in this charge amounted to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this amounted to a lack of competence.

With regards to charge 10, the panel bore in mind that Resident D was on a soft diet because he could not chew food. It was of the view that the *preparation* of a bacon sandwich to give to Resident D, by itself, did not amount to a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. You appeared to have been new in the unit and it is possible that when you reached the patient you may have realised your error and not given the food despite having prepared it. As a result, it was of the view that this single instance of failing to identify risk did not amount to a lack of competence.

With regards to charge 11, the panel bore in mind that you had been on this unit for over a week at this stage. It noted that you lowered the bedrails for Resident D, who was at risk of falls, in order to feed him and then left him unsupervised with the bedrails lowered. It was of the view that the risk of injury for Resident D was significant and this amounted to a failure to recognise and assess risk. In light of this, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this did amount to a lack of competence.

With regards to charge 12a, the panel bore in mind that it appeared Resident F was on a pureed diet and was particularly frail. It was of the view that it would not expect a registered nurse to feed any resident while she was on her back because of the risk of choking. Again, this was a significant failure in the basic task of recognising and assessing risk. In light of this, the panel was satisfied that you failed to demonstrate the standards of

knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this did amount to a lack of competence.

With regards to charge 13, the panel was of the view that it was not good practice to grip a resident's arm while helping them to mobilise. However, the panel was of the view that this was a one-off incident of poor moving and handling practice and did not, on its own, amount to a lack of competence.

With regards to charge 14, the panel bore in mind that you stated that you did not want to provide personal care for this resident because he was known to get very agitated and "kick off". It heard evidence that you were asked to do it and you would be expected to manage challenging behaviour and provide essential care. The panel was of the view that a refusal to provide what was expected was a one-off incident. Although it showed lack of judgment in relation to the risks associated with not providing personal care, on its own this did not amount to a lack of competence.

With regards to charge 15, the panel was of the view that you knew the resident had been incontinent, and you should have been aware of the potential indignity and the risk to the resident's skin integrity this posed. Despite being told three times over the course of over an hour, you failed to provide him with care. In light of this, the panel was satisfied that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this represented a lack of judgment in relation to risk, despite repeated reminders, and did amount to a lack of competence.

With regards to charge 17b, 17c and 17d, the panel was of the view that engagement with residents and their families, working in a way that promotes residents' dignity and choice and demonstrating a caring and compassionate attitude were basic requirements expected of a registered nurse. By failing to meet these requirements, during this single interaction with a resident, it was satisfied that you failed to demonstrate the standards of

knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this did amount to a lack of competence.

With regards to charge 18a, the panel bore in mind that you were being observed. Despite this, you left medication on top of the medication trolley unattended in a care home, put residents at risk of accidental ingestion of medication. Additionally, you also left the keys in the door of the medication trolley. The panel determined that this demonstrated poor medication administration practice and a serious failure to recognise risk. The panel was of the view that you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this did amount to a lack of competence.

With regards to charge 18c, the panel was of the view that your actions were not good practice. While it was of the view that you should have ensured that the inhaler was clean, it was not satisfied that this was a failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. It was of the view that this single instance of poor medication practice did not, on its own, amount to a lack of competence.

With regards to 18e(i) and 18e(ii), it bore in mind that the fact that there was a covert medication agreement in place means there was a recognised risk to the resident. The agreement clearly stated that Resident B’s medication needed to be crushed and put into to tea before being administered. The panel was of the view that your failure to adhere to the covert medication agreement put in place to ensure the safety of the resident is a clear failure to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this single failing involved basic failures to follow medication procedure and to recognise risk, and did amount to a lack of competence.

With regards to 18f, the panel was of the view that it would expect a registered nurse to implement basic infection control procedures. It would not expect you to pick up

medication that had been spat out by a resident without something to protect yourself, namely gloves. However, it was of the view that handling medication in such circumstances was a risk at the point of picking the medication up, only to yourself. The panel was satisfied that this was a one-off failure in infection control procedures and on its own did not amount to a lack of competence.

With regards to 18g, the panel was of the view that your failure to administer a patch of medication prescribed to Resident B was a one-off medication error which did not, on its own, amount to a lack of competence.

With regards to charge 19 the panel bore in mind that in oral evidence Ms 6, who was observing you, asked you questions about the medication you lacked basic medication knowledge and did not seem to understand what they were. It further bore in mind that within 90 minutes you made seven medication errors in one day, involving a range of different types of medication and different types of error. The panel was of the view that by your actions on that day, viewed collectively, you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a registered nurse. As a result, it was of the view that this did amount to a lack of competence.

The panel noted that, viewed individually, a number of the incidents referred to in charges 9 to 19 did not reach the level of lack of competence. However, viewed collectively, they demonstrated a number of different failings and a pattern of poor practice on multiple occasions in different settings, involving a range of basic nursing skills. Viewed collectively the panel therefore concluded that these charges, just as was the case with charges 1 to 8, demonstrated a lack of knowledge, skill and judgment which was serious enough to be a lack of competence.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was significantly below the standard expected of the average registered nurse acting in your role.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on misconduct

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

When determining whether charges 20, 21a, 21b, 22a, 22b and 24 amount to misconduct, the panel had regard to the terms of the Code.

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

With regards to charge 20, the panel was of the view that what you said to Colleague B was not professional or respectful especially considering that she was your manager. While Colleague B appeared to interpreted the term you used, “treat me like a slave”, as a racial slur, the panel was of the view that it was not necessarily racially motivated or intended to have racial connotations. While the panel considered what you said to be inappropriate, it was of the view that it was a one-off incident made in private and while unprofessional it would not be considered deplorable by fellow practitioners. It concluded that charge 20 did not amount to misconduct.

With regard to charges 21a and 21b, the panel bore in mind that Resident D had dementia and therefore lacked capacity. It also bore in mind that you stated that Resident D shouted at you and said “I hate you”. It was of the view that your response was not what would be expected from a registered nurse. Challenging a resident who lacked capacity in such a manner shows a lack of compassion, care and communication skills.

In light of the above, the panel determined that your actions in charge 21 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 22a the panel was of the view that the words you said were inappropriate considering Resident D’s lack of capacity. As with charge 21a, the panel was of the view that this demonstrated a significant lack of care, compassion and

understanding and would be considered deplorable by fellow practitioners. Further, with regards to charge 22b, the panel also concluded that the words you said while stroking Resident D's face were inappropriate and fell well below the standard expected of a registered nurse.

While the panel considered that there may not have been any malice or ill intent pertaining to both sub-charges, it was of the view that your actions in charge 22 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

With regards to charge 24, the panel was not persuaded that this amounted to misconduct. While it may have been interpreted as being impolite, the panel was of the view that your comments appeared to be more of a statement of fact in response to being asked to do a task when you knew that you had other time sensitive tasks which were due to be done. It was of the view that it was a one-off incident and would not be considered deplorable by fellow practitioners.

The panel therefore decided that charges 21a, 21b, 22a and 22b in this case amounted to a sufficiently serious departure from the appropriate standards that they amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide whether as a result of the lack of competence and/or 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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* (use full citation if not already used) 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) *...'*

For reasons already set out above, the panel considered that limbs a, b and c were engaged by your lack of competence and misconduct in this case.

The panel found that although the risk of harm to patients and residents was minimised as you were being directly supervised, you had in the past acted so as to put patients at unwarranted risk of harm as a result of your lack of competence.

The panel determined that your failings breached fundamental tenets of nursing practice and that your misconduct is liable to bring the nursing profession into disrepute. The panel was of the view that the way you spoke to Resident D, who was living with dementia, lacked kindness and compassion which the panel found to be a breach of a fundamental tenet. It was of the view that you also breached a fundamental tenet of the profession by failing to demonstrate the level of knowledge skill and judgement to deliver safe care. It considered that these matters were also liable to bring the profession into disrepute.

The panel however recognised that it had to make a current assessment of your fitness to practice, which involved not only taking account of past misconduct but also what has happened since the misconduct came to light. It also had regard to whether the lack of competence identified is easily remediable.

The panel referred to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and lack of competence and considered whether you had provided evidence of insight and remorse.

The panel bore in mind the categories of failing which have been identified in this case which the panel considered had been identified by a fair sample as set out in the various charges. These failings cover a broad range of basic nursing practice, including:

- Medication knowledge;
- Medication administration knowledge, skills and judgment;
- Infection control;
- Safe and timely provision of personal care;
- Movement and handling techniques;
- Communication, including issues around patient dignity and choice; and
- The recognition, assessment and judgment of risk.

In theory, the concerns identified in this case are capable of being addressed. The panel bore in mind that several former colleagues described you as a lovely and caring person. However addressing the concerns would require you to recognise them, reflect on them, and develop insight into what you did and into how you could avoid making the same mistakes again.

Regarding insight, the panel bore in mind that in your oral evidence, you still stated that some of the charges found proved did not happen. It took account of your undated reflective statement where you stated:

> *'Having worked as a nurse for long time, I have never had communication issues, coming here I was told by line manager that colleagues have reported that I have communication issues and attitude, one explained that I am harsh and rush patient, but this is not true and I believe my colleague must be mistaken in what he/she saw, this is evident from the reports of all PDNs who supervised me and staff nurse Juby whom I have worked most shifts with have to say about me and relationship with patient. In as much as I don't believe I have communication issues, I felt it must the different cultures and what each gesture means to all. I must say it is difficult communicating as I feel watched, scrutinized, judged, and sidelined by some colleagues. For this purpose, my defense mechanism was to ignore them and do what I need to, and report to the nurse or NIC of the shift.'*

The panel noted that you do not believe you have any communication issues. It further noted that the way you deal with this is to simply ignore your colleagues. The panel found this concerning.

The panel noted that the above reflective statement only covers your time at the Horley Ward, East Surrey Hospital and not your time at Wombwell Hall or Mayflower. Nevertheless, the panel was of the view that your subsequent reflections do not address the areas of concern identified by the panel.

In your oral evidence, there was limited recognition of the impact your misconduct and lack of competence had on patients, colleagues and the nursing profession.

In light of the above, the panel determined that you had limited insight.

The panel was satisfied that the misconduct and lack of competence in this case is capable of being addressed. However, it bore in mind that the areas of concern highlighted by the panel had been identified by your employers before. Additionally, support was put in place and attempts had been made to address these areas of concern over an extended period of time. Despite this, the failings continued across a number of settings. There appeared to be recurring issues, which you have not yet recognised, in relation to your judgement and your ability to retain and apply what you have learned or been told. The panel acknowledged that the pandemic would have presented challenges in training, and that you found it difficult when you were being scrutinized. However it noted that you appeared not to have been able to work with those who were supporting you to improve your practice to the extent required.

The panel carefully considered the evidence before it in determining whether or not you had taken steps to strengthen your practice. The panel took into account the evidence of training you have provided. It noted that this is mandatory training and you have not undertaken any additional, targeted training or learning relevant to the areas of concern identified in your competence.

During your oral evidence you stated that you would be willing to undertake training, but you were currently restricted financially. Nevertheless, the panel was of the view that you have failed to demonstrate how you have implemented your training in your current practice and what you have learned.

The panel also saw a reference from your current employer attesting to your current satisfactory practice. The panel bore in mind that you are currently working as a care assistant for an agency.

The panel bore in mind that you have been a nurse for many years and despite this it appears there are still many areas of basic nursing practice that you have been unable to demonstrate to the required standard. Such areas include safely assisting a resident with meals, safe medications management and administration, using safe movement and handling techniques and risk assessment. The panel was of the view that these failings were yet to be addressed.

The panel is of the view that, based on the lack of evidence that you have strengthened your practice in the areas of concern identified by the panel, there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel was satisfied that, having regard to the nature of the misconduct and lack of competence in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* if a finding of current impairment were

not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

Having regard to all of the above, the panel was satisfied on grounds of both public protection and the wider public interest 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 two years. 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 Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Higgs provided the panel with written submissions which the panel have read. It stated:

1. *'The purpose of any sanction is to protect the public and uphold the reputation of the profession.*

2. *The panel should consider the full range of available sanctions and find a fair balance between the nurse, midwife or nursing associate's rights and the overarching objectives of public protection and maintaining confidence in the profession. Any sanction must be proportionate and necessary, rather than punitive and should not go further than necessary to meet that objective.*

3. *Sanction is always a matter for the panel, which is never bound by the NMC's assessment of seriousness or submission as to the appropriate degree of restriction. The guidance documents referred to below are intended to assist, but are not binding.*

4. *The NMC suggests in this case the that a conditions of practice order is appropriate, and necessary to maintain public confidence in the profession and for the protection of the public. The length of the order sought is 24 months.*

Submissions

5. *There is considerable overlap between the NMC's submissions regarding lack of competence and misconduct and on the rationale for the sanction bid in this case.*

The following submissions are made.

6. *The NMC Guidance SAN-1 in relation to factors to consider before deciding on sanctions sets out a non exhaustive list of aggravating factors and of mitigating factors.*
7. *It is submitted that the following aggravating factors apply:*

[Ms Higgs listed the aggravating features that apply to this case]

8. *It is submitted that the following mitigating factors apply:*

[Ms Higgs listed the mitigating features that apply to this case]

9. *A striking off order or suspension order would not allow the Registrant the opportunity to improve her practice or to improve her competence. Further, despite there being evidence of some attitudinal problems it is submitted that they do not appear to be deep seated and the Registrant's current employer suggests that she*

has a good attitude, a sentiment which was averred by some of the witnesses the panel have heard from. Therefore, it is submitted that a striking off order or suspension order would be disproportionate and inappropriate in the circumstances.

10. *It is submitted that a conditions of practice order would allow the Registrant the opportunity to become competent and to work on her attitudinal problems whilst her practice is restricted. It is submitted that a conditions of practice order is proportionate in the circumstances and appropriate conditions could adequately protect the public from the risk of harm.*

11. *It is submitted that it would be appropriate to mirror the current conditions of practice order's conditions, which are proportionate and allow the Registrant to work whilst addressing the risks presented in this case.*

[Ms Higgs placed your current interim conditions of practice here]

12. *An interim conditions of practice order is in place for a sufficient period of time such that a new order is not sought at this stage.'*

Your submissions

You said that you would try to take courses to address the shortcomings in your practice and will try to improve.

Decision and reasons on sanction

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

SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into areas identified by the panel;
- A pattern of issues relating to conduct and competence over a period of time;
- Issues with clinical practice which put patients at risk of suffering harm;

The panel also took into account the following mitigating features:

- Evidence of your reflections and some developing understanding of the problem and attempts to address it (in relation to a number of the charges);
- Personal mitigation you had recently moved to a new country and were working with unfamiliar medication and equipment at the Trust.
- Personal mitigation – [PRIVATE];
- Personal mitigation – [PRIVATE];
- Remorse in relation to some of the admitted charges;
- All the incidents occurred during unique and challenging circumstances, namely the coronavirus pandemic, which may have impacted on your training and put clinical staff under increased pressure, affecting the amount of support available to you.

The panel first considered whether to take no action but concluded that this would be inappropriate. The panel bore in mind the seriousness of the case and the fact that it had identified continuing risk with your practice. It was of the view that taking no further action would not protect the public. Further, it would not address the scope of the misconduct or the lack of competence. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case and the fact that it had identified continuing risk with

your practice, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that the issues of competence and conduct in this case were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel found that your fitness to practice was impaired and that there remains a risk to the public. However, the panel took into account the mitigating factors. It noted that it found no evidence of harmful deep-seated personality or attitudinal problems. The panel also bore in mind that it had identified areas of your practice that requires improvement and needs to be addressed, including both the competence issues and the poor communication with patients reflected in the conduct charges. It took account of the submissions you made and are encouraged by your willingness to address these areas in your practice so that you can return to safe practice as a registered nurse.

The panel was of the view that conditions of practice would be the least restrictive sanction that the panel could impose that would protect the public and eventually return you safely to unrestricted practice. It also considered that conditions of practice would be in your best interests as it would allow you to continue to develop your competence and confidence and allow you to fully remediate the concerns regarding your practice.

The panel considered that an informed member of the public armed with the full facts of this case would be satisfied that the public interest would not be undermined by you being allowed to continue practising and that patients would be adequately protected with the implementation of conditions of practice.

The panel determined that it would be possible to formulate workable and measurable conditions of practice which would address the failings highlighted in this case.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order. It considered that a period of two years would be required for you to find employment, make the necessary improvements to your practice and provide evidence of safe practice.

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case at this time.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will protect the public and mark the seriousness of the issues identified in this case. It will also send to the public and the profession a clear message about the standards of practice required of a registered nurse, thereby maintaining public confidence in the profession.

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 only work for one substantive employer.
>
> 2. When undertaking medicines management and administration, you must be directly observed by another registered nurse, until deemed competent to do so independently by another registered nurse.
>
> 3. At all other times when you are working as a registered nurse, you must ensure that you are supervised by another registered nurse. Such supervision means working at all times on the same shift as, but not directly observed by, another registered nurse. You must be under such supervision until deemed competent to work independently by another registered nurse.
>
> 4. You must work with a line manager, supervisor, mentor or their nominated deputy to create a Personal Development Plan (PDP) that will help you address the areas of concern raised in your practice, with particular regard to;
>
> - Effective and appropriate communication with patients and colleagues;
> - Medication knowledge and management;
> - Infection control;
> - Safe and timely provision of personal care;
> - Movement and handling techniques; and
> - The recognition, assessment and judgment of risk.

5. You must provide a report from your line manager, supervisor, mentor or their nominated deputy to the NMC before any review of your case. This report must comment on your progress with your PDP, with particular regard to;

- Effective and appropriate communication with patients and colleagues;
- Medication knowledge and management;
- Infection control;
- Safe and timely provision of personal care;
- Movement and handling techniques; and
- The recognition, assessment and judgment of risk.

6. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.
b) Giving your case officer your employer's contact details.

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

a) Telling your case officer within seven days of accepting any course of study.
b) Giving your case officer the name and contact details of the organisation offering that course of study.

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

a) Any organisation or person you work for.
b) Any employers you apply to for work (at the time of application).
c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.
b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any current or future employer.
b) Any educational establishment.
c) Any other person(s) involved in your retraining and/or supervision required by these conditions.'

The period of this order is for two years.

Before the order expires, a panel will hold a review hearing to see how well 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.

Any future panel reviewing this case would be assisted, whether or not you have been working in a nursing role, by:

- Your continued engagement with NMC and your attendance, in person, via video link or telephone at the review hearing;
- A comprehensive reflective piece addressing your reflection on the proven charges in this case. This should include what went wrong and why, the impact on patients, colleagues and the profession, what you have learned and how you will avoid any repetition. It should also include your reflection on the following issues of concern in your clinical practice:

    - Effective and appropriate communication with patients and colleagues;
    - Medication knowledge and management;
    - Infection control;
    - Safe and timely provision of personal care;
    - Movement and handling techniques; and
    - The recognition, assessment and judgment of risk.
- Recent references and testimonials from any work undertaken whether it be paid or voluntary;
- Evidence of any study or training undertaken relevant to the identified failings.

This will be confirmed to you in writing.

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 Ms Higgs. Given the panel's findings in relation to sanction she submitted that only an interim conditions of practice order for a period of 18 months will be sufficient to protect the public. She also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

You did not oppose the application.

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.

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.

That concludes this determination.