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
Tuesday 17 October 2023 – Friday 20 October 2023
Monday 23 October 2023 – Wednesday 25 October 2023

Virtual Hearing

Name of Registrant:	**Amanda Claire Wood**
NMC PIN	04C0378W
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (May 2007)
Relevant Location:	Cheshire West and Chester, and Wrexham
Type of case:	Misconduct
Panel members:	John Kelly (Chair, Lay member) Jillian Claire Rashid (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	John Bromley-Davenport KC (2 – 6 October 2023) Paul Hester (9 – 20 October 2023) Graeme Dalgleish (23 – 25 October 2023)
Hearings Coordinator:	Charis Benefo
Nursing and Midwifery Council:	Represented by Scott Clair, Case Presenter
Ms Wood:	Not present and unrepresented
Facts proved by admission:	Charges 10, 12b, 16a and 17
Facts proved:	Charges 1, 2, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 5a)i, 5a)ii, 6a)i, 6a)ii, 7, 8a, 8b, 9a, 9b, 9c, 9d, 11, 14a, 14b, 14c, 15, 16b and 19 (in respect of charges 8b, 9b and 9d)

Facts not proved:	Charges 4, 12a, 13, 18 and 19 (in respect of charges 12a, 12b, 13 and 18)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Preliminary matters relating to the schedule of charges

At the outset of the hearing, the panel identified a number of issues relating to the charges placed before it. The panel noted that this hearing had been called in respect of two separate Nursing and Midwifery Council (NMC) case references relating to alleged events in 2018 and 2020. However, the schedule of charges before the panel only contained charges relating to the 2018 NMC case reference. The panel was provided with a Committee Bundle which contained charges relating to the 2020 NMC case reference, separate to the main schedule of charges. It had not been provided with a final schedule of charges consolidating both case references.

The panel noted that on 24 August 2023, Ms Wood had been sent, as part of the Notice of Hearing, the following charges relating to the 2018 NMC case reference:

'*That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):*

1) *On 19 February 2018, did not administer a Sevodyne Patch to a Resident at the Care Home.*
2) *On 20 February 2018, did not administer a Matrifen Patch to a Resident at the Care Home.*
3) *On 28 April 2018:*
   a) *Did not administer a Desunin tablet to Resident C at 08:00.*
   b) *Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Desunin tablet at 08:00.*
   c) *Did not administer a Folic Acid tablet to Resident C at 08:00.*
   d) *Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Folic Acid tablet at 08:00.*
   e) *Did not administer a Levothyroxine tablet to Resident C at 08:00.*
   f) *Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00.*

g) Did not administer a Levothyroxine tablet to Resident D at 08:00

h) Inaccurately signed/recorded on Resident D's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00.

4) Your actions in Charges 3 b, d, f & h were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients.

5) On 27 April 2018 in relation to Patient E, who was prescribed Cetirizine to be administered at only 08:00:

a) Incorrectly administered Cetirizine to Patient E at:

(i) 13:00;

(ii) 18:00.

6) On 28 April 2018 in relation to Patient E, who was prescribed Cetirizine to be administered at only 08:00:

a) Incorrectly administered Cetirizine to Patient E at:

(i) 13:00;

(ii) 18:00.

7) On 18 April 2018 after identifying/recording that Patient F was at a risk of suffering from deep vein thrombosis, did not escalate Patient F's condition to the out of hours GP.

And in light of the above your fitness to practise is impaired by reason of your misconduct.'

The panel also noted that on 14 September 2023, Ms Wood had again been sent the charges relating to the 2018 NMC case reference, along with those set out below relating to the 2020 NMC case reference:

'*That you a registered nurse whilst employed at Penybyrn Care Home;*

1) In or around the evening of 2 April 2020;

a) Did not administer one or more of the prescribed medication to Resident A as listed in schedule 1.

b) Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart.

2) On 3 April 2020;

a) In or around the morning, did not administer one or more prescribed medication to Resident A as listed in schedule 2.

b) Inaccurately signed/recorded that you had administered the medication listed in schedule 2, on Resident A's MAR Chart.

c) In or around the evening, did not administer one or more prescribed medication to Resident A as listed in schedule 1.

d) Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart.

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home;

3) Around June 2020 and July 2020 inaccurately stated in your application form to the Old Vicarage Nursing Home, that your reasons for leaving or wishing to leave your employment at Penybyrn Care Home was due to 'Management/Staff Issues'

4) You actions in charge 3 above were dishonest in that you sought to conceal your dismissal at Penybyrn Park Care Home from the Old Vicarage Nursing Home.

5) On 5 September 2020;

a) Inaccurately signed/recorded that you had administered Bisporolol to Resident B.

b) Inaccurately signed/recorded that you had administered Clopidogrel to Resident C.

6) On 6 September 2020 inaccurately signed/recorded that you had administered Bisporolol to Resident B.

7) On 19 August 2020 did not use appropriate handling techniques/equipment when moving Resident E, in that you;

a) Did not wait for a stand aid.

b) Instructed Colleague Y to manually lift Resident E onto a chair, without a stand aid.

c) Manually lifted Resident E onto a chair, without a stand aid.

8) Your actions in one or more of charges 7 a), 7 b), and 7 c) above resulted in Resident E slipping onto the floor/a chair.

9) On 26 August 2020 after being instructed by Dr X to stop the administration/prescription of Zopiclone to Resident E;

a) Did not cross out the Zopiclone on Resident E's MAR Chart.

b) Did not take appropriate steps to ensure that Resident E was not administered Zopiclone.

10) Your omission in one or more of charge 9 a) & 9 b) above led to Resident E being incorrectly administered Zopiclone on one or more occasion between 26 August 2020 and 3 September 2020.

11) On 31 August 2020 inaccurately signed/recorded that you had administered Tegretol to Resident D.

12) Your actions in one or more charges 1 b), 2 b), 2 d), 5 a), 5 b), 6 & 11 were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients.

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

Schedule 1

1) Vimpat 50mg

2)Lamotrigine 200mg

3) Lamotrigine 25mg

4) Simvastatin 20mg

5) Tegretol 200mg

6) Tegretol 400mg

Schedule 2

1) Folic Acid 5mg

2) Vimpat 50mg

3) Lamotrigine 25mg

4) Omeprazole 20mg

5) Tegretol 200mg

6) Tegretol 400mg'

The panel identified some overlaps in the numbering of charges which could cause confusion, and some typographical errors which required correction.

In addition, the panel had regard to charges 1 and 2 relating to the 2018 NMC case reference which alleged:

'*That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):*

1) *On 19 February 2018, did not administer a Sevodyne Patch to a Resident at the Care Home.*
2) *On 20 February 2018, did not administer a Matrifen Patch to a Resident at the Care Home.*

...'

The panel was concerned that these charges, as worded, did not adequately reflect the potential extent and therefore gravity of the alleged mischief, namely that Ms Wood had a responsibility or duty to administer medication to a resident, but did not do so.

Mr Clair, on behalf of the NMC, informed the panel that the NMC would prepare an updated draft schedule to consolidate all charges, and correct any typographical and spelling errors. Mr Clair also indicated that the NMC would provide an updated schedule of anonymity to assist the panel.

Mr Clair subsequently provided a revised schedule of charges and a schedule of anonymity. The revised schedule of charges included amended identifiers for care home residents, and amended the wording of charges 1 and 2 relating to the 2018 NMC case reference. In addition, the NMC made changes to the wording of 11 other charges in the schedule consistent with those made to charges 1 and 2 in the 2018 NMC case reference.

The panel accepted the advice of the legal assessor.

The panel considered the revised schedule of charges and schedule of anonymity, and was satisfied that these documents provided clarity on the events which gave rise to the charges from the two NMC case references. In addition, the panel was satisfied that the amended wording of the charges better reflected the mischief alleged in those charges.

The panel noted that Ms Wood was not present nor represented at this hearing. Further, the panel noted that the two sets of charges had now been consolidated into a revised schedule, together with changes to charges 1, 2, 3a, 3c, 3e, 3g, 5, 6, 8a, 9a, 9c, 16a and 16b.

The panel gave careful regard to the merits of this case and the fairness to the proceedings. The panel carefully considered the nature and extent of the consolidation and the changes to the above charges in the context of any prejudice to Ms Wood and the proceedings generally. The panel decided that Ms Wood was served with both sets of charges within two separate Notices of Hearing. The panel could find no prejudice in the consolidation of the two sets of charges. The panel went on to consider the changes to the above listed charges and decided that they did not substantively alter the factual allegations contained within the original two sets of charges. Accordingly, the panel decided, having regard to the merits of the case, that there would be no prejudice to Ms Wood, at this stage of the hearing, in allowing consolidation and the changes to the above charges.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Wood was not in attendance and that two Notice of Hearing letters had been sent to her registered email address by secure email on 24 August 2023 and 14 September 2023.

Mr Clair reminded the panel that this hearing had been called in respect of two NMC case references, which had not been formally conjoined to date. He stated that the first Notice of Hearing letter (sent on 24 August 2023) referred to both NMC case references but only set out the charges in respect of the 2018 NMC case reference. The second Notice of Hearing letter (sent on 14 September 2023) set out the charges in respect of both NMC case references.

Mr Clair acknowledged that the second Notice of Hearing letter had been served during the 28-day notice period for this hearing. He referred the panel to the email from the NMC Case Manager to Ms Wood on 21 September 2023 which acknowledged her indication that she did not intend to attend the hearing. The email also stated:

> '*I'd be very grateful if you could respond to me by email to answer the following questions:*
> *1. Are you happy to waive notice of hearing?*
> *2. Are you happy for the panel to proceed with the hearing in your absence?*
> *3. Are you happy for Witness 9's witness statement to be read into the record in her absence?*'

Mr Clair then referred the panel to Ms Wood's email response on 29 September 2023 which stated:

> '*Yes happy to go ahead with this.*'

Mr Clair submitted that Ms Wood had essentially confirmed that she was content to '*go ahead*' in relation to all three questions.

The panel also had regard to the telephone call note which detailed a call between the NMC Case Manager and Ms Wood on 20 September 2023. The panel noted that as part of this conversation, Ms Wood confirmed her willingness to waive the notice period.

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

Mr Clair submitted that the panel could also be satisfied that Ms Wood had waived the notice period in respect of the second Notice of Hearing letter. He submitted that if, however, the panel was not satisfied with this, then alternatively the 28-day notice period in respect of the charges for the second NMC case reference was due to expire during the course of the scheduled hearing dates (namely on 12 October 2023), and so the panel could consider "*holding over*" consideration of the second case until then.

The panel accepted the advice of the legal assessor.

The panel took into account that the two Notice of Hearing letters provided details of the allegations in respect of both NMC case references, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Wood's right to attend, be represented and call evidence, and the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Wood has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34. The panel was also satisfied that Ms Wood had waived the 28-day notice period in respect of the second Notice of Hearing letter sent on 14 September 2023.

Decision and reasons on proceeding in the absence of Ms Wood

The panel next considered whether it should proceed in the absence of Ms Wood. It had regard to Rule 21 and heard the submissions of Mr Clair who invited the panel to continue in the absence of Ms Wood.

Mr Clair referred the panel to the correspondence between Ms Wood and the NMC Case Manager on 21 September 2023 and 29 September 2023 which indicated that she was content for hearing to proceed in her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Ms Wood. In reaching this decision, the panel considered the submissions of Mr Clair, the representations from Ms Wood, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Wood;
- Ms Wood informed the NMC that she received the two Notice of Hearing letters and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Seven witnesses are due to attend to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 and 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Wood in proceeding in her absence. The evidence upon which the NMC relies has been sent to her at her registered email address, and she provided responses to the allegations. However, Ms Wood will not be able to challenge the evidence in person and will not be able to give evidence on her own behalf. In the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Wood's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Ms Wood. In coming to this conclusion, the panel carefully revisited the issues of consolidation and changes to the charges and concluded that there would be no unfairness to Ms Wood in proceeding in her absence. The panel will draw no adverse inference from Ms Wood's absence in its findings of fact.

Details of charge [as amended]

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

1) On 19 February 2018, having been required to do so, did not administer a Sevodyne Patch to a Resident at the Care Home. **[PROVED]**

2) On 20 February 2018, having been required to do so, did not administer a Matrifen Patch to a Resident at the Care Home. **[PROVED]**

3) On 28 April 2018:

   a) Having been required to do so, did not administer a Desunin tablet to Resident C at 08:00. **[PROVED]**

   b) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Desunin tablet at 08:00. **[PROVED]**

   c) Having been required to do so, did not administer a Folic Acid tablet to Resident C at 08:00. **[PROVED]**

   d) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Folic Acid tablet at 08:00. **[PROVED]**

   e) Having been required to do so, did not administer a Levothyroxine tablet to Resident C at 08:00. **[PROVED]**

   f) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00. **[PROVED]**

   g) Having been required to do so, did not administer a Levothyroxine tablet to Resident D at 08:00 **[PROVED]**

   h) Inaccurately signed/recorded on Resident D's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00. **[PROVED]**

4) Your actions in Charges 3 b, d, f & h were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients. **[NOT PROVED]**

5) On 27 April 2018 in relation to Resident E, who was prescribed Cetirizine to be administered at only 08:00 and having been required to administer that to him at that time:
   a) Incorrectly administered Cetirizine to Resident E at:
      (i) 13:00; **[PROVED]**
      (ii) 18:00. **[PROVED]**

6) On 28 April 2018 in relation to Resident E, who was prescribed Cetirizine to be administered at only 08:00 and having been required to administer that to him at that time:
   a) Incorrectly administered Cetirizine to Resident E at:
      (i) 13:00; **[PROVED]**
      (ii) 18:00. **[PROVED]**

7) On 18 April 2018 after identifying/recording that Patient F was at a risk of suffering from deep vein thrombosis, did not escalate Patient F's condition to the out of hours GP **[PROVED]**

That you a registered nurse whilst employed at Pen-y-Bryn Care Home;

8) In or around the evening of 2 April 2020;
   a) Having been required to do so, did not administer one or more of the prescribed medication to Resident A as listed in schedule 1. **[PROVED]**

   b) Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart. **[PROVED]**

9) On 3 April 2020;
    a) In or around the morning, having been required to do so, did not administer one or more prescribed medication to Resident A as listed in schedule 2. **[PROVED]**

    b) Inaccurately signed/recorded that you had administered the medication listed in schedule 2, on Resident A's MAR Chart. **[PROVED]**

    c) In or around the evening, having been required to do so, did not administer one or more prescribed medication to Resident A as listed in schedule 1. **[PROVED]**

    d) Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart. **[PROVED]**

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home;

10) Around June 2020 and July 2020 inaccurately stated in your application form to the Old Vicarage Nursing Home, that your reasons for leaving or wishing to leave your employment at Pen-y-Bryn Care Home was due to 'Management/Staff Issues' **[PROVED BY ADMISSION]**

11) Your actions in charge 10 above were dishonest in that you sought to conceal your dismissal at Pen-y-Bryn Care Home from the Old Vicarage Nursing Home. **[PROVED]**

12) On 5 September 2020;
    a) Inaccurately signed/recorded that you had administered Bisporolol to Resident B. **[NOT PROVED]**

    b) Inaccurately signed/recorded that you had administered Clopidogrel to Resident CC. **[PROVED BY ADMISSION]**

13) On 6 September 2020 inaccurately signed/recorded that you had administered Bisporolol to Resident B. **[NOT PROVED]**

14) On 19 August 2020 did not use appropriate handling techniques/equipment when moving Resident EE, in that you;

   a) Did not wait for a stand aid. **[PROVED]**

   b) Instructed Colleague Y to manually lift Resident EE onto a chair, without a stand aid. **[PROVED]**

   c) Manually lifted Resident EE onto a chair, without a stand aid. **[PROVED]**

15) Your actions in one or more of charges 14 a), 14 b), and 14 c) above resulted in Resident EE slipping onto the floor/a chair. **[PROVED]**

16) On 26 August 2020 after being instructed by Dr X to stop the administration/prescription of Zopiclone to Resident EE;

   a) Having been required to do so, did not cross out the Zopiclone on Resident EE's MAR Chart. **[PROVED BY ADMISSION]**

   b) Having been required to do so, did not take appropriate steps to ensure that Resident EE was not administered Zopiclone. **[PROVED]**

17) Your omission in one or more of charge 16 a) & 16 b) above led to Resident EE being incorrectly administered Zopiclone on one or more occasion between 26 August 2020 and 3 September 2020. **[PROVED BY ADMISSION]**

18) On 31 August 2020 inaccurately signed/recorded that you had administered Tegretol to Resident DD. **[NOT PROVED]**

19) Your actions in one or more charges 8 b), 9 b), 9 d), 12 a), 12 b), 13 & 18 were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients. **[PROVED IN RESPECT OF CHARGES 8b, 9b AND 9d; NOT PROVED IN RESPECT OF CHARGES 12a, 12b, 13 AND 18]**

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

Schedule 1

1) Vimpat 50mg
2) Lamotrigine 200mg
3) Lamotrigine 25mg
4) Simvastatin 20mg
5) Tegretol 200mg
6) Tegretol 400mg

Schedule 2

1) Folic Acid 5mg
2) Vimpat 50mg
3) Lamotrigine 25mg
4) Omeprazole 20mg
5) Tegretol 200mg
6) Tegretol 400mg

At the outset of the hearing, the panel had regard to the unsigned and undated Case Management Form (CMF) completed by Ms Wood in respect of the concerns stemming from the 2020 NMC case reference. The panel was not provided with a completed CMF in respect of the 2018 NMC case reference.

The panel took into account Ms Wood's admissions and denials on the CMF and it was satisfied that Ms Wood had made admissions to charges 10, 12b, 16a and 17.

The panel therefore found charges 10, 12b, 16a and 17 proved, by way of Ms Wood's admissions.

Background

Ms Wood first entered onto the NMC's register as an Adult Nurse on 9 May 2007.

This hearing was called to consider three separate matters regarding Ms Wood's nursing practice. The first of these matters related to a 2018 NMC case reference, and the second and third matters related to a 2020 NMC case reference.

(Case reference 067475/2018):

The NMC received a referral in respect of Ms Wood on 15 June 2018 from Pinetum Care Home. This referral alleged that between 19 February 2018 and 28 April 2018, Ms Wood made medication administration errors, and on 18 April 2018 failed to escalate a patient with suspected deep vein thrombosis (DVT) to the out of hours General Practitioner (GP).

Ms Wood commenced employment with Care UK (an employment agency) as a Senior Nurse at Pinetum Care Home on 2 January 2018.

On 15 February 2018, Ms Wood attended a probationary review meeting where she was informed that the quality and accuracy of her work, team-work and personal skills required improvement.

On 27 March 2018, Ms Wood attended an investigation meeting regarding concerns that she had omitted to administer a Sevodyne patch to a resident on 19 February 2018 and a Matrifen patch to a resident on 20 February 2018.

It is further alleged that on 28 April 2018, Ms Wood made additional medication errors. Ms Wood allegedly incorrectly administered medication to a resident. She also allegedly did not administer medication to residents when she was required to do so, and then inaccurately signed to indicate that she had administered the medication on the residents' MAR chart. It is alleged that Ms Wood acted dishonestly in that she falsified records in an attempt to conceal that she had not administered medication to one or more residents.

On 18 April 2018, following a night shift, Ms Wood allegedly handed over to colleagues on the day shift her concern that a resident may be suffering from a DVT. Concerns were raised that Ms Wood did not allegedly take urgent action during her shift to seek medical advice regarding this.

On 30 April 2018, Ms Wood attended a further probationary review meeting, during which the issues above were raised with her.

(Case reference 079574/2020):

The NMC received a second referral in respect of Ms Wood on 5 August 2020 from Pendine Park Care Organisation about concerns raised whilst she was working at Pen-y-Bryn Care Home. This referral identified alleged instances of poor medication practice, poor record keeping and poor patient care.

Ms Wood started working as a Registered Nurse at Pen-y-Bryn Care Home on 10 June 2019.

It is alleged that on 2 and 3 April 2020, having been required to do so, Ms Wood did not administer one or more of the prescribed medications to a resident at the home. She then allegedly inaccurately signed the MAR chart to indicate that she had administered the medication to the resident. It is alleged that Ms Wood acted dishonestly in that she

falsified records in an attempt to conceal that she had not administered medication to one or more residents.

On 10 April 2020, Ms Wood was informed of the allegations and suspended from Pen-y-Bryn Care Home pending an investigation into the allegations. A disciplinary meeting took place which resulted in Ms Wood's employment being terminated.

An appeal hearing was held on 3 June 2020 in Ms Wood's absence and the appeal was not upheld.

On 30 June 2020, Ms Wood applied for the role of Clinical Lead at the Old Vicarage Nursing Home and was offered a position on 1 July 2020.

Ms Wood allegedly inaccurately stated in her application form to the Old Vicarage Nursing Home that her reasons for leaving or wishing to leave her employment at Pen-y-Bryn Care Home was due to '*Management/Staff Issues*'. It is alleged that Ms Wood acted dishonestly in that she sought to conceal her dismissal from Pen-y-Bryn Park Care Home from the Old Vicarage Nursing Home.

Ms Wood started working at the Old Vicarage Nursing Home on 14 July 2020.

It is alleged that on 19 August 2020, Ms Wood did not use appropriate equipment when moving a resident.

It is also alleged that on 31 August 2020, 5 September 2020 and 6 September 2020, Ms Wood inaccurately signed MAR charts indicating that she had administered medication to residents at the home, and that in allegedly doing so, she acted dishonestly in that she did so in an attempt to conceal these alleged failures.

Ms Wood also allegedly did not take appropriate steps on 26 August 2020 to ensure that a resident was not administered Zopiclone after being instructed by the resident's doctor to stop the administration.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Clair to amend the wording of charge 15 to correct a typographical error in the anonymised name of the resident in that charge. Mr Clair indicated that charge 15, as presently worded, incorrectly referred to Resident E instead of Resident EE. It was submitted by Mr Clair that the proposed amendment would provide clarity and more accurately reflect the evidence.

> "That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):
>
> ...
>
> 15) Your actions in one or more of charges 14 a), 14 b), and 14 c) above resulted in Resident E**E** slipping onto the floor/a chair.
>
> ...
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that the amendment was in the interest of clarity and did not materially affect the meaning of the charge. The panel was satisfied that there would be no prejudice to Ms Wood 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.

Decision and reasons on applications to admit Witness 8 and Witness 9's written statements into evidence as hearsay

Having heard from all of the NMC's live witnesses, the panel heard applications made by Mr Clair under Rule 31 to allow the statements (and corresponding exhibits) of Witness 8 and Witness 9 into evidence as hearsay. At the time of the allegations in respect of Ms Wood's conduct at the Old Vicarage Nursing Home, Witness 8 was the Manager and Witness 9 worked as a Care Assistant.

Mr Clair submitted that both Witness 8 and Witness 9 had provided written statements to the NMC, which contained declarations that their content is true to the best of their knowledge and belief. Mr Clair submitted that Witness 8 and Witness 9 would not be present at this hearing and, whilst the NMC had made sufficient efforts to ensure that these witnesses were present, they were unable to attend due to [PRIVATE].

Mr Clair reminded the panel that Rule 31 permits the admission of any evidence that is relevant and fair, which in his submission did not preclude the admission of hearsay evidence. He submitted that the NMC's guidance on evidence makes clear that hearsay evidence can include a statement being placed before a panel without the maker of that statement giving oral evidence in proceedings. Mr Clair submitted that the panel had an obligation to prevent a regulatory case "*from going undercharged or under-evidenced*" in line with its overarching objective of public protection as highlighted in the case of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin).

Mr Clair referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), in which having reviewed the relevant authorities, the Deputy High Court Judge set out the following four principles:

> '*45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these:*

1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.
1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.
1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.
1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'

Mr Clair submitted that the witness statements of Witness 8 and Witness 9 were undoubtedly relevant to these proceedings in that the evidence contained in them was concerned with the matters charged. He submitted that it would not be unfair to Ms Wood to admit this evidence.

Mr Clair accepted that evidence ought not to be routinely admitted in this manner, however the current situation was one in which the NMC, despite attempts, had been unable to secure the attendance of Witness 8 and Witness 9. He submitted that in this case, it is possible to strike a fair balance by the panel considering what weight to give to the evidence of Witness 8 and Witness 9 at the end of the fact-finding stage. In addition, he reminded the panel that it had also been provided with some responses from Ms Wood, where some of the evidence with which these witnesses are concerned had been "*variously admitted and disputed*". Mr Clair therefore submitted that to some extent, Ms

Wood's own voice was before the panel in respect of these matters, albeit she had exercised her right not to formally take part in these proceedings.

Mr Clair submitted that the panel might find that there were good and cogent reasons for the unavailability of Witness 8 and Witness 9 to give oral evidence, namely [PRIVATE]. He submitted that even if the panel did not consider those to be good reasons, the absence of a good reason is not of itself sufficient reason to exclude what would otherwise be admissible and relevant evidence.

Mr Clair submitted that if Witness 8 and Witness 9's written statements were to be admitted, none of this evidence would constitute the sole and decisive evidence in relation to any of the charges before the panel. He submitted Witness 8's statement related charges 10 to 18 and Witness 9's to charge 14, which were also evidenced by a number of admissions (in the case of charges 10, 12b, 16a and 17) or by contemporaneous documents. It was Mr Clair's submission that there was therefore an independent means of testing the reliability of the evidence in the statements of Witness 8 and Witness 9.

Mr Clair submitted that Ms Wood had also effectively provided her consent for both statements and the accompanying exhibits to be admitted into evidence without the maker of those statements required to speak to them in sworn testimony in the hearing. In addition, in respect of Witness 8's evidence, Ms Wood had even agreed the contents of her statement.

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

The panel considered the applications in respect of Witness 8 and Witness 9 separately. The panel also took into account the factors which also appear at paragraph 56 of *Thorneycroft v NMC*.

The panel noted that both Witness 8 and Witness 9's statements had been prepared in anticipation of being used in these proceedings. The statements contained declarations of truth and are signed and dated by the respective witnesses. The panel took into account that Witness 8 and Witness 9's statements had been prepared in the proper format.

The panel was satisfied that Witness 8 and Witness 9's statements and exhibits are relevant as they relate directly to the charges and to Ms Wood's employment at the Old Vicarage Nursing Home. Both witnesses had worked at the home with Ms Wood during the period of the charges.

Having decided that both witnesses' statements are relevant, the panel went on to consider the question of whether it would be fair to admit each statement.

The panel noted that the admission of a statement of an absent witness should not be regarded as a routine matter. The Rules require the panel to consider the issue of fairness before admitting hearsay evidence. The panel also noted that the fact that the absence of a witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

The panel firstly considered whether there is a good and cogent reason for the non-attendance of each witness. The panel noted that this is an important factor but the absence of a good reason does not automatically result in the exclusion of the evidence.

The panel noted that both Witness 8 and Witness 9 were unable to attend the hearing to give live evidence due to [PRIVATE]. Whilst the NMC has not provided the panel with any documentary evidence in respect of [PRIVATE], the panel noted Mr Clair's submissions that the NMC has been provided with information as to the respective positions of each of the two witnesses. In these circumstances, the panel was therefore satisfied that there were good and cogent reasons for Witness 8 and Witness 9's non-attendance.

The panel carefully reviewed all of the evidence before it in relation to the charges and asked itself whether the evidence contained within Witness 8 and Witness 9's statements separately are the sole or decisive evidence in relation to those charges.

The panel decided on that review that the evidence of Witness 8 and Witness 9 separately was not the sole and decisive evidence on any of the charges. The panel was satisfied that there was evidence in relation to each of the outstanding charges from other witnesses and documents.

The panel next considered whether Ms Wood had prior notice that the witness statements were to be read. The panel noted that in two emails dated 26 September 2023 and 29 September 2023, Ms Wood did not object to Witness 8 and Witness 9's statements being read into the record in their absence.

The panel noted that the written statements of Witness 8 and Witness 9 cover a number of charges which also include the serious charges of dishonesty. In *Thorneycroft v NMC*, the seriousness of the charge must be taken into account because of the impact which an adverse finding might have on a registrant's career. The panel noted that if some or all of the charges of dishonesty are proved, this may have a significant effect upon Ms Wood's career as a registered nurse. The panel also noted that the various factors within *Thorneycroft v NMC* require a panel to make a careful balancing exercise as between all those factors. The panel carefully took into account the dishonesty charges and came to the decision that upon balancing all of the *Thorneycroft v NMC* factors, it would be fair to admit Witness 8 and Witness 9's written statements.

The panel have carefully read the responses made by Ms Wood to the charges and the proceedings generally. The panel will carefully take into account the nature and extent of any challenges which are contained within those responses when deciding on the facts and, if necessary, thereafter.

In these circumstances, the panel decided, balancing all of the relevant *Thorneycroft* factors, that it would be relevant and fair to admit the statements (and corresponding exhibits) of Witness 8 and Witness 9 into evidence. In doing so, the panel will give the appropriate weight to those statements in light of all of the evidence and the charges.

Decision and reasons on application to admit further documentation from Ms Wood on day 15 of the hearing

On day 13 of the proceedings, whilst the panel was deliberating on sanction, the hearing resumed at the request of Mr Clair. He informed the panel that the NMC had found five documents previously sent by Ms Wood to the NMC, which in his view, the panel should have had sight of at the outset of the hearing. Mr Clair apologised to the panel on behalf of the NMC. He stated that when registrants represent themselves in fitness to practice proceedings, the NMC compiles their documentation into a registrant's response bundle. He submitted that as a result of combining the documentation in Ms Wood's two NMC case references, some of the documentation she had sent to the NMC appeared to have been missed. Mr Clair submitted that the panel would need to see this documentation as it may affect the panel's decision on impairment.

Mr Clair informed the panel that this documentation comprised of:

- A context form from Ms Wood dated 1 March 2021;
- An email dated 1 June 2021 containing a character reference from Ms 1, Ms Wood's former colleague;
- A letter from CareConcepts (Appleton) Ltd dated 3 November 2021 containing an employer's reference in respect of Ms Wood's work as a nurse at Brampton Lodge;
- An email from Ms Wood dated 3 November 2021 confirming that she had returned to work as a nurse; and
- Ms Wood's CV.

Mr Clair submitted that these documents may assist Ms Wood's position and so are relevant and would not result in unfairness. He submitted that it would be appropriate to admit this documentation under Rule 31.

Mr Clair informed the panel that these documents had been sent to Ms Wood to ask if there was anything further she wished to see in relation to them, or whether she wished to submit additional documentation to the panel. He submitted that Ms Wood ought to be given a reasonable period of time to consider these documents and decide whether to engage with the proceedings, and the panel did so.

Mr Clair subsequently informed the panel that further documentation had been found in Ms Wood's case files and that the NMC wanted to complete an audit of the records to ensure that no other documents had been missed. He also stated that Ms Wood had provided a response to the NMC, indicating that she was content for the five documents to go before the panel. Ms Wood then sent further emails and documents to the NMC.

An updated registrant's response bundle was produced by the NMC and sent to Ms Wood who was given a reasonable time to respond.

On 23 October 2023, day 15 of the proceedings, Mr Clair informed the panel that there had been some further contact from Ms Wood stating:

> '*I have read the bundle.*
> *Before it goes to panel though I want a copy of all evidence I have sent you over the years and all bundles you have sent me. I have conformation of all received. This includes Hand written statements and email statements I have sent over the years. I have them so hope NMC has them also. Otherwise I deam [sic] this unfair practice and not professional. And detrimental to the case.*
> *Please put this to the panel also.*'

Mr Clair submitted that it was fair and appropriate for all of the documentation now recovered by the NMC and from Ms Wood be placed before the panel.

Mr Clair submitted that two authorities were directly relevant to this "*highly unusual situation*" where the panel was required to consider whether it could consider again its findings in respect of facts and impairment.

Mr Clair referred the panel to the decision of the United Kingdom Supreme Court in respect of the case of *In re L and another (Children) (Preliminary Finding: Power to Reverse)* [2013] UKSC 8, 1 WLR 634. He stated that this was a case in which the judge at first instance had given an oral judgement following a fact-finding hearing in the course of civil proceedings. He informed the panel that having delivered that oral judgement in November or December, the judge went on to deliver what the Supreme Court described as her '*perfected judgment*' almost two months later in the February. In that '*perfected judgment*', the judge had changed her mind about the initial decision and this judgment was subsequently sealed almost two weeks later. The finding was subsequently appealed and ultimately, the Supreme Court had to consider the question of whether, and in what circumstances, a judge who has announced their decision in civil proceedings is entitled to change their mind. Mr Clair said that the Supreme Court unanimously stated that it had '*long been the law that a judge is entitled to reverse his [or her] decision at any time before their order is drawn up and perfected*'.

Mr Clair submitted that in the civil context, the Court determined that perfecting of the order comes at the point it is sealed by the Court, after which, in the absence of any express power to vary its own previous order, the only proper route of challenge would be by means of appeal. Mr Clair stated that now, having established, that the first instance judge had the power to change her mind, the Court then observed the question of whether or not the judge ought to have exercised that power. The Supreme Court observed that the overriding objective must be to deal with the case justly and that a relevant factor as part of that exercise must be whether any party has acted upon the decision to their detriment. The Court stated that a carefully considered change of mind on the part of the

judge can be sufficient, but that every case will ultimately depend on its particular circumstances. Mr Clair highlighted that the Court went on to make clear that exceptional circumstances are not necessary.

Mr Clair submitted that by parity of reasoning with the decision in the case of *re L and another (Children) (Preliminary Finding: Power to Reverse)*, this panel's decision had not yet been perfected. He submitted that it would not become so until the decision on sanction had been made and handed down. Mr Clair submitted, on the authority of the case law, that it was therefore competent for the panel to "*reopen*" its findings as necessary and the issue was whether it would be just to do so.

Mr Clair submitted that the just course in this case was for the panel to proceed and to admit the evidence. He submitted that firstly, the information now forming part of the registrant's response bundle contained fair and relevant information in relation to Ms Wood's case. Mr Clair submitted that in particular, the registrant's response bundle contained information which may benefit Ms Wood's position and her case. He submitted that whilst it may not be entirely in the interest of the NMC, the interests of justice required this information to be before the panel.

Mr Clair submitted that the only possible prejudice was to the NMC, but the NMC had effectively "*waived*" that argument. He submitted that it would serve neither party to these proceedings, nor the public interest or the "*public purse*" for these proceedings to be abandoned on day 15 of an 18-day hearing. He reminded the panel that Ms Wood herself had indicated in correspondence the toll that continuance of these proceedings was taking upon her.

Mr Clair then referred the panel to the case of *Golden v Nursing and Midwifery Council* [2023] EWHC 619 (Admin). He highlighted Mr Justice Richie's observations, that having reviewed the relevant authorities, '*where a practitioner... fails in advance of a fitness to practise hearing to provide a bundle of documents to be relied on or witness statements for the hearing and fails to attend, the [panel] does not have to guess what the practitioner*

wants to put before the [panel] for the final hearing. Nor does the NMC have to sift through the historic case correspondence or the historic documents previously sent by the practitioner during, for instance, the interim suspension hearings... to construct files which the practitioner himself has not identified, provided or prepared for the final hearing.'

Mr Clair submitted that on the authority of *Golden v NMC*, the circumstances of this case were not so irregular to now preclude a just outcome.

Mr Clair therefore submitted that it was open to the panel to proceed, review the new documents, and consider again any findings it had made, notwithstanding the important principle of the need for finality in litigation. He submitted that proceeding with this case and avoiding further delay would be the just outcome to avoid the inherently undesirable situation whereby a case containing allegations dating back to 2018 may have to be restarted and reallocated to another panel at some future date.

The panel accepted the advice of the legal assessor who referred to the above case law and to the case of *Vodafone Limited, Vodafone UK Limited Applicants v IPCOM GMBH & CO KG* [2023] EWCA Civ 113, regarding the finality of proceedings.

The panel considered the submissions made by Mr Clair and it was mindful that both the NMC and Ms Wood were seeking, at an advanced stage in the proceedings, to provide further documentary evidence to the panel. It was submitted by Mr Clair that this evidence is relevant and that it is fair to admit it at this stage. The panel had sight of the evidence and it agreed that this evidence appeared to be relevant given that it contained information about Ms Wood's role as a nurse since the allegations, and further documentation which potentially appears to relate to her dismissal from Pen-y-Bryn Care Home and charge 11.

The panel has decided to proceed in the absence of Ms Wood and she has not attended this hearing. The NMC told Ms Wood, on 19 October 2023, that it had conducted an audit of her case files and that this documentation was all the information that it held and not already been provided to the panel. Ms Wood asked the NMC to provide to the panel

documentation that she said she had previously provided to the NMC during its investigation of the allegation and during subsequent procedure prior to this final hearing. Ms Wood asked for the panel to see all of that documentation.

The panel was mindful of the case law and the unusual circumstances in which it was now asked to admit and consider this evidence. It was being asked by both parties, after having considered facts and impairment, to admit into evidence this further information for the panel to consider.

The panel carefully considered the central issue of fairness, mindful that fairness is engaged in respect of both parties. It was also mindful of the importance of the overriding objectives of the NMC; the need to protect the public and the maintenance of public confidence in the professions. The NMC sought admission of this evidence explicitly acknowledging that it came late in the proceedings and also accepting that admission at this stage was likely to favour Ms Wood and potentially damage the NMC's case. The panel, out of an abundance of fairness, had informally handed down by email those parts of its decision relating to facts, misconduct and impairment of fitness to practise.

The panel noted the case law it has been referred to by Mr Clair and the legal assessor. In the Supreme Court case of *In re L and another (Children) (Preliminary Finding: Power to Reverse)*, the court stated that '*…the power of a judge to reverse his decision at any time before his order was drawn up and perfected by being sealed by the court was not limited to exceptional circumstances; that the overriding objective in the exercise of the power was to deal with the case in question justly.*'

In the Court of Appeal case of *Vodafone Group Plc, Vodafone Limited, Vodafone UK Limited Applicants v IPCOM GMBH & CO KG*, the court stated that '*It is the sealing of the order which matters for these purposes, because that is the stage at which the first instance court becomes functus officio (meaning that it ceases to have authority to decide the case) for most purposes and thus the stage at which considerations of finality bite.*'

As of day 15, the panel's decision making was ongoing. As at that date, no complete, final or '*perfected*' decision had yet been made. The panel was satisfied that it was not at that stage '*functus*', the final decision had not yet been made, nor had a decision been issued in a manner equivalent to the '*sealing*' of a court decision. The panel had not completed its consideration of this case. It was not being asked to '*reverse*' any part of its decision, but to consider it further in light of this new evidence. Whilst the evidence appeared to be relevant, its impact was not clear. The panel was mindful that the Supreme Court states that the overriding objective is to deal with the case justly.

The panel concluded in these circumstances, that it was fair and just to admit into evidence the further documentation provided to it on 23 October 2023, day 15 of this hearing. It noted that no party opposes that position. The panel was satisfied that its decision at this point in the case was not yet final and that it was therefore entitled to further consider its decision on facts and on impairment in light of this evidence, even at a late stage in the proceedings. The panel decided that not to do so would risk unfairness to Ms Wood and would be unjust. The panel took the view that the NMC had taken a magnanimous and fair approach in seeking the admission of this evidence whilst acknowledging its potential impact on its case.

The panel therefore decided to allow the application to admit this further evidence, albeit late, and to further consider its decision in light of that evidence. It will be for the panel to assess and weigh this evidence along with all the other evidence before it. What weight, if any, is attributed to this evidence will be a matter for the panel to decide.

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 Mr Clair on behalf of the NMC.

The panel did not draw adverse inferences from the non-attendance of Ms Wood.

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

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

- Witness 1: Home Manager at Pinetum Care Home at the relevant time;

- Witness 2: Unit Manager and Senior Carer at Pinetum Care Home at the relevant time;

- Witness 3: Registered Nurse at Pinetum Care Home at the relevant time;

- Witness 4: Responsible Individual/Director at Pendine Park, the care organisation running Pen-y-Bryn Care Home at the relevant time;

- Dr X/Witness 5: GP at Plas Ffynnon Medical Centre, where Resident EE (resident at the Old Vicarage Nursing Home) was registered as a patient;

- Witness 6: Registered General Nurse at Pen-y-Bryn Care Home at the relevant time; and

- Witness 7: Registered General Nurse at Pen-y-Bryn Care Home at the relevant time.

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

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

Charges 1 and 2

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

1) *On 19 February 2018, having been required to do so, did not administer a Sevodyne Patch to a Resident at the Care Home.*

2) *On 20 February 2018, having been required to do so, did not administer a Matrifen Patch to a Resident at the Care Home.*

These charges are found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 that Ms Wood was the nurse on duty at Pinetum Care Home on 19 February 2018 and 20 February 2018. It accepted that Ms Wood was responsible for administering medication to residents at the Home when she was on duty.

Witness 1 told the panel that the MAR chart for each resident set out which medications were to be administered, when they were administered and by whom. The MAR charts for the residents at charges 1 and 2 were not provided to the panel. However, it heard from Witness 1 and Witness 3 that Ms Wood was required to administer the Sevodyne Patch to

a resident on 19 February 2018, and a Matrifen Patch to another resident on 20 February 2018, but on examination, the MAR charts for these residents did not indicate that the patches had been administered.

The panel noted the written statement of Witness 1 dated 8 February 2019 which stated:

> '*At around this time one of the other nurses was doing a medication order and raised concerns to me that Amanda hadn't administered a Sevodyne patch on the 19 February 2018 and a Matrifen patch on 20 February 2018...*
>
> *These residents have patches that routinely need to be changed on set days. On the day that a patch is due to be changed the box is outlined on the MAR chart. Amanda had not signed the MAR charts and on counting the patches it was evident that they had not been administered.*
>
> *An investigation was carried out and a statement was taken from Amanda. On 27 March 2018 I brought Amanda in to a disciplinary outcome meeting to discuss the patches and she was apologetic. During the investigation the deputy manager asked Amanda why this had happened she said that on 19 February 2018 she was stuck with a service user for two hours who was complaining of pain and she was concerned about them. Amanda said that she hadn't changed the patch on 20 February 2018 as had started the medication round but just forgot. She said that she hadn't been interrupted or anything, and admitted it was her fault...*'

In addition, Witness 3's written statement dated 27 March 2019 stated:

> '*I discovered that the registrant had not administered Sevodyne on 19 February 2018 and Matrifen on 20 February 2018. Those medications are pain killers and were prescribed for two residents one of which was suffering from dementia and the other one had osteoporosis. I was not on the same shift with the registrant, but I*

must have followed on. I found these medication errors from the MAR charts which had no records of the above medicines being administered...

After I noticed the above errors I administered the patches of the above medications to the residents and reported the incident to the Deputy Matron. As far as I know there was no harm caused to the residents as result of the registrant's failure to administer the above medications.'

In oral evidence, Witness 3 described how she noticed that the Sevodyne Patch and Matrifen Patch had not been administered to the two residents on 19 February 2018 and 20 February 2018, as prescribed and that the MAR charts were not "*ticked*" to say they had been given. Witness 3 explained that she conducted a count of the controlled drugs and checked this with the numbers listed in the controlled drugs book. This was consistent with the medication not being given on the dates prescribed.

The panel also noted Ms Wood's account in an email to the NMC dated 29 June 2018. She stated that:

'*3. Sevodyne patch not given 19/2 as stated It was an extremely busy shift. I prioritised my care to a patient suffering acute abdominal pain. (Known problems with catheter. UTI'S and SEPSIS). I was late off shift that day due to this which I did not mind. Due to this the error occurred. But was not picked up straight away. Matrifen patch 20/2 not given I did miss by accident and when told about both I was really upset as I like to give 100% to patients in my care. I felt awfull that I had failed in my duty.*
I did do a reflective account and reassessed with meds competency.' [sic]

The panel noted that Ms Wood's account in respect of these allegations amounted to an acceptance that she did not administer the Sevodyne Patch and Matrifen Patch to the two residents on 19 February 2018 and 20 February 2018, and she provided an explanation for the omission.

The panel therefore determined, on the balance of probabilities, that having been required to do so, Ms Wood did not administer a Sevodyne Patch to a resident on 19 February 2018, and did not administer a Matrifen Patch to a resident on 20 February 2018. It found charges 1 and 2 proved.

Charges 3a, 3c, 3e and 3g

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

3) *On 28 April 2018:*
    a) *Having been required to do so, did not administer a Desunin tablet to Resident C at 08:00.*
    c) *Having been required to do so, did not administer a Folic Acid tablet to Resident C at 08:00.*
    e) *Having been required to do so, did not administer a Levothyroxine tablet to Resident C at 08:00.*
    g) *Having been required to do so, did not administer a Levothyroxine tablet to Resident D at 08:00.*

These charges are found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 that Ms Wood was the nurse on duty at Pinetum Care Home on 28 April 2018. It accepted that Ms Wood was responsible for administering medication to residents at the Home when she was on duty.

The panel noted Witness 1's written statement dated 8 February 2019, which stated:

> '*On 28 March 2018 Amanda made a number of medication errors. These was noted by one of the other staff, a senior carer named [Witness 2]. [Witness 2] is trained in medications, and noted the omissions during the next medication round*

when he saw that some of the tablets Amanda had signed as given were still in their blister packs.

[Witness 2] reported the error he had noted with the tablets to the deputy home manager who informed me of this the next day which was a Monday. We investigated by checking all the MAR sheets on the floor of the Home where Amanda had been working...

The particular medicines Amanda had signed for but not administered were for two residents. Resident C was prescribed Desunin which provides vitamin B3, Lansoprazole which controls stomach acid, and Levothyroxine which regulates the thyroid's thyroxin levels.

Resident D was also prescribed Levothyroxine.'

The panel also noted Witness 1's supplementary written statement dated 9 March 2022 which clarified that reference to '*28 March 2018*' in her initial written statement was incorrect and that it should read '*On 28 April 2018 Amanda made a number of medication errors*'. In addition, the supplementary written statement clarified that her initial reference to '*Lansoprazole*' in respect of Resident C was incorrect and that it should read '*Folic Acid*'.

The panel took into account the evidence of Witness 2 in his written statement dated 3 April 2019 which stated:

'*With regard to the registrant's medication administration errors on 28 March 2018 I discovered this incident because part of my job was gap analysis. When I did morning medication round I found out that the tablets the registrant should have administered to the residents were still in the blister pack, but they had been signed off by the registrant on MARs as administered. The registrant failed to administer the tablets which she documented as if she had given them to the residents. I then*

took photocopies of the MARS and the blister packets and showed the copies to my then Deputy Manager... I explained to her what had happened.

The medications which were missed due the registrant's oversight were needed to be administered for a reason...'

Witness 2 confirmed in oral evidence that his reference to 28 March 2018 in the written statement was an error. The MAR charts along with the medication blister packs for each resident confirmed the correct date in question was, in fact, 28 April 2018. Witness 2 was unable to provide further clarification as to how the date error occurred.

The panel had regard to Resident C's MAR chart for the period 23 April 2018 to 10 May 2018. It took into account that Resident C was prescribed Desunin tablets (one to be taken daily), Folic Acid tablets (one to be taken daily) and Levothyroxine tablets (one to be taken in the morning at least 30 minutes before breakfast). The panel also noted the entries on the MAR chart which indicated that each of these medications were being administered to Resident C at 08:00 every day from 23 April 2018.

The panel also noted Resident D's MAR chart for the period 23 April 2018 to 10 May 2018. It took into account that Resident D was prescribed Levothyroxine tablets (one to be taken each morning). The panel had sight of the entries on the MAR chart which indicated that this medication was being administered to Resident D at 08:00 every day from 23 April 2018.

The panel was satisfied that based on their MAR charts, Ms Wood was required to administer Desunin, Folic Acid and Levothyroxine to Resident C, and Levothyroxine to Resident D on 28 April 2018 at 08:00.

The panel had regard to the photocopies of Resident C's blister packs for Desunin, Folic Acid and Levothyroxine. The blister packs were labelled and dated 13 April 2018. Witness

1 told the panel that this was the date on which the pharmacy prepared the blister packs, ready for the four-week medication cycle starting on 23 April 2018.

The panel noted that the Levothyroxine blister pack showed that the tablet which was to be given to Resident C on 28 April 2018 (namely the tablet in the '*Sat*', '*week 1*' blister) was present when the photocopy was taken by Witness 2. In addition, the Desunin blister pack showed that the tablet which was to be given to Resident C on 28 April 2018 (namely the tablet in the '*Sat*', '*week 1*' blister) was present when the photocopy was taken by Witness 2.

The panel noted that the photocopy of Resident C's Folic Acid blister pack did not show the tablet for '*Sat*', '*week 1*'. However, it considered that some of the other tablets in the blister packs were also not clear due to the possibility that a photocopy of a plastic blister pack might not clearly show all of the tablets present. Witness 2 confirmed in live evidence that the Folic Acid tablet was definitely still in the blister pack when he discovered the error and he would not have photocopied it had the tablet not been there. The panel was of the view that Witness 2 provided cogent evidence in respect of this matter. The panel was therefore satisfied that the Folic Acid tablet in the '*Sat*', '*week 1*' blister was present when the photocopy was taken by Witness 2.

In respect of Resident D, the panel had regard to the photocopy of their Levothyroxine blister packs which was also labelled and dated 13 April 2018. The panel noted that this blister pack showed that the tablet which was to be given to Resident D on 28 April 2018 (namely the tablet in the '*Sat*', '*week 1*' blister) was present when the photocopy was taken by Witness 2.

On this basis, the panel was satisfied that Ms Wood did not administer the required tablets to Resident C and Resident D on 28 April 2018 at 08:00 as they were still in the blister packs.

The panel therefore found charges 3a, 3c, 3e and 3g proved.

Charges 3b, 3d, 3f and 3h

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

3) On 28 April 2018:

b) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Desunin tablet at 08:00.

d) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Folic Acid tablet at 08:00.

f) Inaccurately signed/recorded on Resident C's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00.

h) Inaccurately signed/recorded on Resident D's MAR Chart to indicate that you had administered a Levothyroxine tablet at 08:00.

These charges are found proved.

In reaching this decision, the panel took into account its finding on charges 3a, 3c, 3e and 3g that having been required to do so, Ms Wood did not administer Desunin, Folic Acid and Levothyroxine to Resident C, and Levothyroxine to Resident D on 28 April 2018 at 08:00.

The panel had regard to Resident C and Resident D's MAR charts for the period 23 April 2018 to 10 May 2018. It noted that there were signatures under the '*28*' column at 08:00 for Desunin, Folic Acid and Levothyroxine on Resident C's MAR chart, and for Levothyroxine on Resident D's MAR chart.

Witness 1 told the panel in oral evidence that she recognised the signature in each of these entries as being that of Ms Wood, and that Ms Wood had been the nurse on duty on 28 April 2018. The panel was therefore satisfied that Ms Wood made the entries on Resident C and Resident D's MAR charts to indicate that their required medication had been administered on 28 April 2018 at 08:00.

Having already found that Ms Wood did not administer these medications to Resident C and Resident D, the panel determined that the entries on their MAR charts were inaccurate. The panel therefore found charges 3b, 3d, 3f and 3h proved.

Charge 4

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

4) *Your actions in Charges 3 b, d, f & h were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients.*

This charge is found NOT proved.

In reaching this decision, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel took into account the minutes from Ms Wood's meeting with Witness 1 at the home on 30 April 2018, which stated:

> ‘*Bigger concerns ... medication 28th April – signed for administering meds but still in blister packs – x4 meds... Asked if AW is struggling with meds. Answered no. She got interrupted and called away and is very busy – admits it’s her error. [Witness 1] expressed her concern re residents missing their medication. Asked if anything in particular disrupted her on 28th April, AW answered ... (resident) ... was shouting out + she attended him*’.

The panel noted that the minutes of this meeting had been reviewed and signed by Ms Wood on 30 April 2018.

The panel considered Ms Wood’s explanation expressed in these minutes for her conduct at charge 3 was that she made an error because she had needed to attend another resident and became busy.

The panel considered the evidence as a whole to determine whether Ms Wood had acted dishonestly. The panel considered that the medication that should have been administered to Resident C and Resident D had been left in the blister packs. In considering Ms Wood’s subjective state of mind at the time, the panel considered the likelihood of her dishonestly falsifying entries on the MAR charts but leaving the relevant medication in their blister packs to be discovered later. Taking this together with Ms Wood’s explanation that she had made an error, in the context of a busy shift, the panel considered it unlikely on balance that she dishonestly falsified the entries on the MAR charts.

The panel therefore found charge 4, on the balance of probabilities, not proved in its entirety.

Charges 5 and 6

That you, whilst employed as a Senior Nurse at Pinetum Care Home (“the Care Home”):

5) *On 27 April 2018 in relation to Resident E, who was prescribed Cetirizine to be administered at only 08:00 and having been required to administer that to him at that time:*
   a) *Incorrectly administered Cetirizine to Resident E at:*
      (i) 13:00
      (ii) 18:00

6) *On 28 April 2018 in relation to Resident E, who was prescribed Cetirizine to be administered at only 08:00 and having been required to administer that to him at that time:*
   a) *Incorrectly administered Cetirizine to Resident E at:*
      (i) 13:00
      (ii) 18:00

These charges are found proved.

In reaching this decision, the panel had regard to Resident E's MAR charts for the period 26 April 2018 to 23 May 2018. It noted that there were signatures under the '*27' and* '*28'* columns at 08:00, 13:00 and 18:00 for Cetirizine which was prescribed to be taken as '*TWO 5ml spoonfuls [sic] daily*'.

The panel took into account Witness 1's written statement dated 8 February 2019, which stated that:

> '*Resident E received three doses of Cetirizine oral liquid instead of one which is an antihistamine. This had the potential to make the resident sleepy. Resident E should have received this once at 8am; but Amanda also gave it at 1pm and 6pm.*'

In live evidence, Witness 1 explained that '*10ml*' was written next to '*08:00*' on the MAR chart to indicate that Resident E's dose of Cetirizine was to be administered at 08:00. She stated that in line with common practice at the home, '*08:00*' had also been highlighted

and colour-coded pink on the MAR chart to indicate the time it was to be administered. The panel was therefore satisfied that Resident E was prescribed Cetirizine to be administered only at 08:00 and that Ms Wood was required to administer it at that time.

The panel noted that Resident E's MAR chart was pre-printed with the times of 08:00, 13:00, 18:00 and 22:00 in the '*time dose*' column for every medication on the MAR chart. The panel considered that the 13:00 and 18:00 rows on Resident E's MAR chart for Cetirizine had not been highlighted and colour-coded according to the practice at the home, which meant that the medication was not to be administered at those times. However, Ms Wood's signature had been entered onto the MAR chart for Cetirizine at 08:00, 13:00 and 18:00 on 27 April 2018 and 28 April 2018.

The panel therefore determined that it was more likely than not that Ms Wood incorrectly administered Cetirizine to Resident E at 13:00 and 18:00, in addition to the correct dose at 08:00. It found charges 5 and 6 proved.

Charge 7

That you, whilst employed as a Senior Nurse at Pinetum Care Home ("the Care Home"):

7) *On 18 April 2018 after identifying/recording that Patient F was at a risk of suffering from deep vein thrombosis, did not escalate Patient F's condition to the out of hours GP.*

This charge is found proved.

In reaching this decision, the panel took into account the client daily record for Patient F on 18 April 2018. It noted the entry by Ms Wood at 04:57 which stated:

> '*Settled night meds given as pxs.*
> *On repositioning [Patient F] left leg very odematus [sic] still from knee down.*
> *States she has cramp tight feeling to back of calf painful when touched.*

Has popliteal and pedal pulse evidence but needs GP review to rule out DVT.'

The panel was satisfied that Ms Wood had clearly identified a potential risk of DVT and that this required escalation to a GP.

Witness 1's written statement dated 8 February 2019 stated that:

'*On 18 April 2018 Amanda came to see me in the morning just after finishing her night shift. She told me she had handed a patient over to another nurse and didn't think she had taken on what she said. I said I would check, and went to speak to the nurse. I did not have any concerns as I found the nurse had taken the correct action; but when I looked at the patient's notes it was clear that Amanda had identified concerns that they were suffering from deep vein thrombosis (DVT) at around 5am and hadn't escalated this to the out of hours GP.*'

Witness 1 told the panel in oral evidence that in a situation involving a potential DVT, Ms Wood should have contacted the out of hours GP, and in the event that they could not help, should have contacted the emergency services. She explained that the consequences of not acting quickly in such cases could lead to a number of serious complications, including death.

Ms Wood did not escalate Patient F's condition to the out of hours GP in a timely manner. The panel considered that Patient F was at risk of a DVT and this should have been seen as a potential emergency and escalated to a doctor immediately.

The panel took into account the minutes from Ms Wood's meeting with Witness 1 at the home on 30 April 2018, where Ms Wood was asked about her failure to escalate Patient F's condition to the out of hours GP. It noted her response that:

‘*...she was short-staffed + didn’t get chance + resident no longer complained of* pain*. AW stated there was [sic] only x2 carers which is the sufficient amount of staff. Asked if AW consulted other nurse – answered no.*’

The panel considered that Ms Wood’s response in the meeting indicated an acceptance that she did not escalate Patient F’s condition.

The panel therefore determined, on the balance of probabilities, that on 18 April 2018 after identifying/recording that Patient F was at a risk of suffering from a DVT, Ms Wood did not escalate Patient F’s condition to the out of hours GP, and so, found charge 7 proved.

Charges 8a, 9a and 9c

That you a registered nurse whilst employed at Pen-y-Bryn Care Home;

8) *In or around the evening of 2 April 2020;*
   a) *Having been required to do so, did not administer one or more of the prescribed medication to Resident A as listed in schedule 1*

9) *On 3 April 2020;*
   a) *In or around the morning, having been required to do so, did not administer one or more prescribed medication to Resident A as listed in schedule 2*
   c) *In or around the evening, having been required to do so, did not administer one or more prescribed medication to Resident A as listed in schedule 1.*

<u>Schedule 1</u>

1) *Vimpat 50mg*
2) *Lamotrigine 200mg*
3) *Lamotrigine 25mg*
4) *Simvastatin 20mg*
5) *Tegretol 200mg*
6) *Tegretol 400mg*

Schedule 2

1) *Folic Acid 5mg*
2) *Vimpat 50mg*
3) *Lamotrigine 25mg*
4) *Omeprazole 20mg*
5) *Tegretol 200mg*
6) *Tegretol 400mg*

These charges are found proved.

In reaching this decision, the panel took into account Resident A's MAR chart which indicated that the medication listed on Schedule 1 and Schedule 2 had been prescribed and administered. It was satisfied that there was a requirement on Ms Wood to administer the medications listed on Resident A's MAR chart on 2 April 2020 and 3 April 2020.

The panel had regard to the notes of the appeal hearing at Pen-y-Bryn Care Home on 3 June 2020 which stated:

> '*The resident was admitted to the care home on the afternoon of 20th march 2020 and a MAR chart commenced, the first dose of medication being administered that evening. The admitting nurse checked the medication in and her statement states she checked and signed the "Med Box" as evidenced by a tick and a circle on the box (appendix 2) as he could not open each of the sachets to check the drug count. Her statement records 47 sachets entered the building with the resident. One sachet was administered the evening of admission (20th March) followed by 2 sachets there after up to and including the morning of 2nd April 2020*.'

Colleague B was the admitting nurse for Resident A and the panel noted her handwritten statement dated 27 April 2020:

'I [Colleague B] – staff nurse signed in Resident A medications when he arrived at Pen-y-Bryn was checked by myself and signed for there being 47 packets of medications.'

The panel noted Witness 7's signed and undated handwritten statement which stated:

'*Incident statement regarding medication belonging to Resident A.*

Resident A's medication comes in a box containing a series of labelled pouches. Each pouch is labelled with name of person medication belongs to, day and date medication is to be administered, and time of day to be offered, e.g. morning, evening etc.

Each pouch also states which medications are within, enabling the person administering to cross reference each tablet/tablets in accordance with the Medication Administration Record.

On the morning of 4/4/20, upon dispensing Resident A's medications, I found x3 medication pouches:
Thursday 02/04/20 – evening medication
Friday 03/04/20 – morning medication
Friday 03/04/20 – evening medication

Manager informed as per procedure.'

The panel also noted Witness 7's written statement dated 20 December 2021, which stated:

'*On 4 April 2020 I remember going to the middle floor trolley to get Resident A's medication and check where he was at. This was on the middle floor trolley. This is*

when I saw that three medication pouches had medication which had not been administered...'

In oral evidence, Witness 7 confirmed that when she discovered the error, the medication pouches that had not been used were all connected to the roll in order, and so it was evident that they had not been administered.

The panel also took into account Witness 6's signed and undated handwritten statement which stated:

> *'On 04.04.2020 Nurse [Witness 7] was dispensing morning medication. [Witness 7] had a query with Resident A's medication.*
>
> *...*
>
> *I checked the roll of medication with [Witness 7]. Attached was Thursday 02/04/2020 evening packet, Friday morning 03/04/3030 packet and Friday evening 03.04.2020 packet.*'

Witness 6 and Witness 7 both confirmed in evidence that there were no spare or loose pouches in Resident A's medication box and that even if there were, they would not have been used as it was best practice to only administer the dated sequential pouches on the roll for the residents.

The panel also had regard to the photocopies of Resident A's three unopened medication pouches for the medications listed in Schedule 1 for the evenings of 2 April 2020 and 3 April 2020, and in Schedule 2 for the morning of 3 April 2020.

The panel was satisfied that Witness 6 and Witness 7 provided clear and consistent evidence about their discovery on the morning of 4 April 2020, and both nurses saw the unopened medication pouches for 2 April 2020 and 3 April 2020 which were still attached to Resident A's medication roll.

The panel took into account Ms Wood's email to the NMC dated 13 September 2020 in respect of this allegation:

> '*The medication of the patient I was dispensing to were in single pouches and on a roll.*
> *Each pouch had the patient's name, date and morning and evening written on it.*
>
> *On the said dates of allegations I supposedly did not give them to him. I took the box the roll of pouches were in. I went to takea pouch out but there were ones stuffed in box and not freely on the roll.*
> *Because the patient had the same medication every morning and the same every evening. I dispenced the loose pouches to him.*
> *As I stated to the manager in meeting. In hindsight I should of looked for right dated pouch to give. But as medication was all the same morning and evening I didnt.*
> *I apologised and stated I was only human and would never not give a patient there medication. Especially his as he was prescribed anti- seizure tablets. If I did make an error knowingly I would report it.*
>
> *A point I would also like to add is. This patient took his medication one at a time on a spoon by the nurse giving them to him. He knew exactly how many he had morning and evening. When I asked about proof he had been asked about wether he had missed any medication. Or any documentation to back this up nothing was said or given to me in evidence.*' [sic]

The panel noted that Ms Wood's account, which was not consistent with the evidence of Witness 6 and Witness 7, could not be tested in live evidence. In addition, the panel had not seen any evidence to support Ms Wood's account that she administered the required medication to Resident A from loose pouches that she claimed were not attached to the medication roll. The panel therefore gave limited weight to Ms Wood's account.

The panel preferred the consistent and cogent evidence of Witness 6 and Witness 7, who were able to provide clear information about the pouches of medication for Resident A and the fact that the pouches for the evening of 2 April 2020, the morning of 3 April 2020 and the evening of 3 April 2020 were unopened and attached to the roll on 4 April 2020.

On this basis, the panel was satisfied that, on the balance of probabilities, Ms Wood did not administer the required medication, as set out in charges 8a, 9a and 9c, to Resident A. The panel therefore found charges 8a, 9a and 9c proved.

Charges 8b, 9b and 9d

That you a registered nurse whilst employed at Pen-y-Bryn Care Home;

8) *In or around the evening of 2 April 2020;*
    b) *Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart*

9) *On 3 April 2020;*
    b) *Inaccurately signed/recorded that you had administered the medication listed in schedule 2, on Resident A's MAR Chart.*
    d) *Inaccurately signed/recorded that you had administered the medication listed in schedule 1, on Resident A's MAR Chart.*

Schedule 1

1) *Vimpat 50mg*
2) *Lamotrigine 200mg*
3) *Lamotrigine 25mg*
4) *Simvastatin 20mg*
5) *Tegretol 200mg*
6) *Tegretol 400mg*

Schedule 2

1) *Folic Acid 5mg*
2) *Vimpat 50mg*
3) *Lamotrigine 25mg*
4) *Omeprazole 20mg*
5) *Tegretol 200mg*
6) *Tegretol 400mg*

These charges are found proved.

In reaching this decision, the panel took into account its finding on charges 8a, 9a and 9c that having been required to do so, Ms Wood did not administer the medications listed in Schedule 1 for the evenings of 2 April 2020 and 3 April 2020, and in Schedule 2 for the morning of 3 April 2020 to Resident A.

The panel had regard to Resident A's MAR chart and noted that entries had been made in respect of each of the medications set out in Schedule 1 for the evening of 2 April 2020 and the evening of 3 April 2020. In addition, entries had been made in respect of each of the medications set out in Schedule 2 for the morning of 3 April 2020.

The panel noted that Ms Wood had been the nurse on duty between the evening of 2 April 2020 and the evening of 3 April 2020 and was responsible for administering medication to Resident A and recording this on the MAR chart. The panel was therefore satisfied that Ms Wood had made the entries on Resident A's MAR chart to indicate that the prescribed medications had been administered on or around the evening of 2 April 2020; on or around the morning of 3 April 2020; and on or around the evening of 3 April 2020.

Having already found that Ms Wood did not administer the required medication, as set out in charges 8a, 9a and 9c, to Resident A, the panel determined that the corresponding entries on Resident A's MAR chart were inaccurate. The panel therefore found charges 8b, 9b and 9d proved.

Charge 11

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

11) Your actions in charge 10 above were dishonest in that you sought to conceal your dismissal at Pen-y-Bryn Care Home from the Old Vicarage Nursing Home.

This charge is found proved.

In reaching this decision, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel took into account Ms Wood's admission to charge 10, namely:

> '*That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home;*
>
> 10) *Around June 2020 and July 2020 inaccurately stated in your application form to the Old Vicarage Nursing Home, that your reasons for leaving or wishing to leave your employment at Pen-y-Bryn Care Home was due to*

‘Management/Staff Issues”

The panel noted the evidence of Witness 4, the Responsible Individual/Director for Pendine Park, which was the care organisation running Pen-y-Bryn Care Home. Her written statement dated 2 August 2022 stated that:

> ‘*A disciplinary meeting took place which Ms Wood attended and a decision was taken to dismiss her.*’

The panel also had regard to the minutes of the appeal hearing at Pen-y-Bryn Care Home on 3 June 2020 which stated:

> ‘*A letter of summary dismissal was sent to Ms Wood dated 11th May 2020.*
> *E mail correspondence was received by [Witness 4] on 11th May 2020 at 15.50hrs from Ms Wood stating she would be appealing the disciplinary decision giving the following reasons –*
> *“I do not believe the evidence supports the accusations I with held medication or falsified documentation”*’

The panel saw the letter sent to Ms Wood on 11 May 2020 which confirmed the outcome of her disciplinary hearing and dismissal from Pen-y-Bryn Care Home. The panel noted that Ms Wood lodged an appeal against the decision on the same day.

The panel noted Witness 8’s written statement dated 28 October 2021 which stated:

> ‘*Amanda applied for the role of Clinical Lead in June 2020, and I offered her the position on 1 July 2020, subject to references and a DBS check, and based on a satisfactory three month probation period.*
>
> *...*

On the application form she listed her reason for leaving her previous role as "Management/Staff issues". I have since been made aware that she was dismissed from her previous role.'

The panel saw Ms Wood's application form for the role of Clinical Lead at the Old Vicarage Nursing Home which she completed and dated 30 June 2020. The panel noted that Ms Wood signed the application form almost one month after the appeal hearing at Pen-y-Bryn Care Home.

The panel noted Ms Wood's response to the allegation in an email to the NMC dated 9 September 2020, where she stated:

'*I do not agree with the allegation. Or the way I was treated by the company. Due to this I resigned via phone call as management were not being fair to me. They did not give me time to arange [sic] unison representation due to Covid 19 restrictions. I then had information sent to me regarding there decision to end my employment in a meeting I could not attend.*'

In a further email to the NMC dated 25 September 2020, Ms Wood stated:

'*Finally due to the company being not helpfull [sic] at all. I resigned in a phone call to [a colleague]. Then I received email saying I was dismissed..*'

The panel noted Ms Wood's claim set out in the email quoted above that she had resigned from Pen-y-Bryn Care Home before being dismissed. However, the panel was unable to test Ms Wood's claim, which in the panel's view was limited in detail. There was also no documentary evidence to support this account. The panel therefore gave limited weight to Ms Wood's account.

The panel considered that Ms Wood was fully aware that an investigation had taken place into her practice at Pen-y-Bryn Care Home and that she had been dismissed on 11 May

2020. In her oral evidence, Witness 4 confirmed that Ms Wood did not resign before she was dismissed.

The panel noted that Ms Wood subsequently appealed against the disciplinary decision with an appeal hearing being held in her absence on 3 June 2020. The panel determined that Ms Wood knew of the original decision to terminate her employment and the outcome of her appeal hearing when making her application for employment at the Old Vicarage Nursing Home. She therefore would have known that she ought to have disclosed her dismissal to her prospective employer.

The panel was satisfied that by the objective standards of ordinary decent people, Ms Wood's acted dishonestly by inaccurately stating in her application form to the Old Vicarage Nursing Home, that her reasons for leaving or wishing to leave her employment at Pen-y-Bryn Care Home was due to '*Management/Staff Issues*'.

The panel therefore determined that, on the balance of probabilities, whilst seeking employment/employed at Old Vicarage Nursing Home, Ms Wood's actions at charge 10 were dishonest in that she sought to conceal her dismissal at Pen-y-Bryn Care Home from the Old Vicarage Nursing Home. It found charge 11 proved.

Charges 12a and 13

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

12) On 5 September 2020;

a) Inaccurately signed/recorded that you had administered Bisporolol to Resident B.

13) On 6 September 2020 inaccurately signed/recorded that you had administered Bisporolol to Resident B.

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 8's written statement dated 28 October 2021 which stated:

> '*I conduct regular medication audits of Old Vicarage as part of my role as manager. Through an audit I conducted on 7 September 2020, I discovered that:*
>
> > *On the 5th and 6th September Amanda signed for the administration of Bisoprolol to Resident B, despite their [sic] being none available at the time (it had been recently ordered) I reviewed the ordering sheet that the Nurse completes. This stated that the medication was ordered on the 2nd September and came into the home on the 8th September signed in by ... (nurse). It is the responsibility of a registered nurse to reorder medication when they recognise that they have low stock.*'

The panel also took into account the medication ordering sheet provided by Witness 8 which had been redacted, except for one row with details relating to the ordering of Resident B's Bisporolol on 2 September 2020. This document included a handwritten annotation which stated:

> '*Sheet covered over to respect patient confidentiality as you can see Resident B's medications were ordered on 2/9/20 after a count on the MAR chart indicated that she was out of stock but signed for by AW as being administered.*'

The panel considered that whilst it had been provided with some evidence to suggest that Resident B's Bisporolol had been re-ordered on 2 September 2020, it had not been provided with Resident B's MAR chart, or any other direct documentary evidence, to support the allegation that Ms Wood had inaccurately signed/recorded that she had administered Bisporolol to Resident B on 5 September 2020 and 6 September 2020.

The panel also noted that Witness 8 was not present at the hearing to provide oral evidence in respect of these allegations.

In addition, the panel had regard to Ms Wood's response to this allegation in her unsigned and undated CMF:

> '*NO she had a box of them in her basket and new case with medication you popped out. I utilized those left in the box. As cardiac trained. I fully understand the importance of this drug.*'

The panel was not satisfied that the NMC had provided sufficient evidence to find charge 12a and 13 proved. It therefore found charge 12a and 13 not proved.

Charge 14

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

14) *On 19 August 2020 did not use appropriate handling techniques/equipment when moving Resident EE, in that you;*
    a) *Did not wait for a stand aid*
    b) *Instructed Colleague Y to manually lift Resident EE onto a chair, without a stand aid.*
    c) *Manually lifted Resident EE onto a chair, without a stand aid.*

This charge is found proved.

In reaching this decision, the panel took into account Resident EE's care plan which set out that:

‘*[Resident EE] has a history of falls prior to arriving at the old vicarage [Resident EE] is unable to mobilise. [Resident EE] had made no attempt to walk since being at the home.*
[Resident EE] requires the use of the stand aid and for 2 staff for all transfers.’

The panel was satisfied that according to Resident EE’s care plan, the only appropriate manual handling technique would have been to use the stand aid.

The panel noted the written statement of Witness 8 dated 28 October 2021 which stated:

‘*On 19 August 2020, [Colleague A] reported an incident regarding Amanda and [Resident EE]*
[Resident EE] has been receiving personal care from Senior Carer at the Home [Colleague Y] and Carer, [Witness 9]. [Witness 9] left the room to get a stand aid to help get [Resident EE] up and into her chair, and Amanda came into the room and asked [Colleague Y] if she needed help getting [Resident EE] into a chair. [Colleague Y] informed Amanda that [Witness 9] was getting a stand aid, and Amanda said that it would be quicker if they stood [Resident EE] up, and proceeded to stand [Resident EE] up. [Resident EE] slipped to the floor as her legs gave way, but did not sustain injuries. [Colleague Y] didn't speak up when Amanda came to assist as she thought a nurse knows best.

[Colleague Y] reported this to [Colleague A], who in turn reported it to me. I met with Amanda on 14 September 2020 to raise this with her and to discuss proper manual handling techniques. Amanda said that she had offered to help [Colleague Y], and that [Colleague Y] had accepted her offer of help. Amanda said that she would never knowingly stand someone who could not weight bear.’

The panel considered that Witness 8 was not present in the room at the time and that her account was that of a manager reporting on the incident. Consequently, the panel treated it with some caution.

The panel had regard to Witness 9's written statement dated 13 December 2022. It noted that Witness 9 was present in Resident EE's room before and after the incident, but did not witness the incident itself.

The panel noted that the only other person present in the room at the time (Colleague Y) had not provided live evidence in respect of this allegation as one of the NMC's witnesses in these proceedings.

However, the panel took into account the incident/accident report which had been completed by Colleague Y on 19 August 2020. This document recorded the details of the incident on the same day and stated that:

> *'Room 1 had been given personal care by [Colleague Y] and [Witness 9], [Witness 9] went to get stand-aid + then nurse came in room. Nurse asked if I needed assistance to get Room 1 into chair. I replied that [Witness 9] had gone to get stand-aid, nurse replied that it will be quicker if we stood Room 1 and she slipped to the floor.*'

The panel accepted the evidence that Witness 9 left the room to get a stand aid for Resident EE, in line with her care plan. The panel determined that Ms Wood did not wait for the stand aid, as had she done so, the incident report would not have been completed by Colleague Y.

The panel also accepted the evidence that when Ms Wood came into the room, Colleague Y told her that Witness 9 had gone to get a stand aid, but that Ms Wood replied that it would be '*quicker*' if they stood Resident EE up. The panel was satisfied that this amounted to an instruction to Colleague Y, a junior member of staff, that they should proceed to move Resident EE without waiting for the stand aid.

In the '*Managers Review*' section of the incident/accident report, following a discussion with Ms Wood, Witness 8 recorded on 14 September 2020 that:

> '*I have spoken to the nurse who holds the all wales passport for manual handling and is an assessor she said she offered to help stand once the carer said "yes" she stands, she would never knowingly stand someone who cannot weight bear.*
> *The resident had an assisted slip to the floor and was moved from a sitting position back into the chair. She never fell or had any injuries sustained.*' [sic]

The panel considered that for Resident EE to have had an '*assisted slip to the floor*', it was more likely than not that this would have taken place because she had been manually lifted by Ms Wood and Colleague Y onto a chair without a stand aid.

The panel therefore found charge 14 proved in its entirety.

Charge 15

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

15) *Your actions in one or more of charges 14 a), 14 b), and 14 c) above resulted in Resident EE slipping onto the floor/a chair.*

This charge is found proved.

In reaching this decision, the panel took into account its findings at charges 14a, 14b and 14c.

The panel was satisfied that according to Resident EE's care plan, the only appropriate manual handling technique was to use the stand aid. However it had found that Ms Wood did not use appropriate handling techniques/equipment when moving Resident EE, in that

she did not wait for a stand aid; instructed Colleague Y to manually lift Resident EE onto a chair, without a stand aid and manually lifted Resident EE onto a chair.

The panel noted Ms Wood's response to this allegation in her unsigned and undated CMF which stated:

> *'No we safety lowered her to floor as per statement'*

The panel was not provided with any such statement from Ms Wood in response to charges 14 and 15.

In the '*Managers Review*' section of the incident/accident report, following a discussion with Ms Wood, Witness 8 recorded on 14 September 2020 that:

> '*I have spoken to the nurse who holds the all wales passport for manual handling and is an assessor she said she offered to help stand once the carer said "yes" she stands, she would never knowingly stand someone who cannot weight bear.*
> *The resident had an assisted slip to the floor and was moved from a sitting position back into the chair. She never fell or had any injuries sustained.*' [sic]

The panel was satisfied that Ms Wood acknowledged that as a consequence of her actions at charge 14, Resident EE had an assisted slip to the floor and was then moved back into a chair, but did not fall or sustain any injuries.

The panel therefore determined that it was more likely than not that Ms Wood's actions at charges 14a, 14b and 14c resulted in Resident EE slipping to the floor, and found charge 15 proved.

Charge 16b

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

16) On 26 August 2020 after being instructed by Dr X to stop the administration/prescription of Zopiclone to Resident EE;

b) Having been required to do so, did not take appropriate steps to ensure that Resident EE was not administered Zopiclone.

This charge is found proved.

In reaching this decision, the panel took into account Ms Wood's admission to charge 16a, namely:

> '*That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home;*
>
> *16) On 26 August 2020 after being instructed by Dr X to stop the administration/prescription of Zopiclone to Resident EE;*
>
> a) *Having been required to do so, did not cross out the Zopiclone on Resident EE's MAR Chart.*'

The panel noted the response Ms Wood provided in her unsigned and undated CMF:

> '*Yes as I was the only Nurse on shift for over 30 residents I was very busy and forgot but did handover to night staff.*'

In her written statement dated 28 October 2021, Witness 8 stated that:

> '*It is basic nursing practice to cross medication off of the chart once the prescription has been stopped to prevent errors such as this.*'

The panel then had regard to Dr X's written statement dated 21 September 2022, which stated:

> '*[Resident EE] was prescribed medication Zopiclone 3.75mg (milligrams) nocte (nightly) from 14/10/2019 until 26/8/2020. It was stopped on the latter date but restarted again on 4/9/2020.*
>
> *On 26/8/2020 I spoke to a member of staff at the Home on the phone as [Resident EE] had ongoing confusion with no abnormalities of the blood tests, and clear urine. I was advised by the member of staff that the Zopiclone was not working for sleep, and that [Resident EE] was agitated in the evening. I cannot confirm which member of staff I spoke to, and the Medical Centre no longer has access to listen to the phone call again.*
>
> *I made the decision to change from Zopiclone (i.e. stop Zopiclone) to Lorazepam in the evenings to see if this helped the agitation.*
>
> *I therefore informed the staff member that Zopiclone should be stopped and Lorazepam 500mcg (micrograms) to be taken in the evening instead. I verbally instructed the staff member to implement this change, and prescription for the new medication given.*'

Dr X confirmed in oral evidence that she had made the decision to change Resident EE's medication to help with agitation and that she had spoken to a nurse at the Old Vicarage Nursing Home about this change. She said that her instructions were that Zopiclone was to be replaced with Lorazepam.

The panel took into account Resident EE's MAR chart commencing 17 August 2020. It noted that Zopiclone had not been crossed out on the MAR chart and there were entries

between 26 August 2020 and 3 September 2020 indicating that Zopiclone was still being administered.

The panel was satisfied that as the nurse who received the instruction from Dr X to stop the administration/prescription of Zopiclone to Resident EE on 26 August 2020, it was Ms Wood's responsibility to cross out Zopiclone from Resident EE's MAR chart on 26 August 2020. However, she did not do so and so Zopiclone was still a live medication on Resident EE's MAR chart, and was still being administered to Resident EE alongside Lorazepam.

The panel determined that Ms Wood's actions amounted to a failure to take appropriate steps to ensure that Resident EE was not administered Zopiclone. It therefore found charge 16b proved.

Charge 18

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

> *18) On 31 August 2020 inaccurately signed/recorded that you had administered Tegretol to Resident DD.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 8's written statement dated 28 October 2021, which stated:

> '*I conduct regular medication audits of Old Vicarage as part of my role as manager. Through an audit I conducted on 7 September 2020, I discovered that:*
>
> *...*
>
> *On 31 August 2020, Amanda signed for Tegretol for [Resident DD], but it was still in its pod, so I knew it had not been given. This is an anti-epileptic medication and should not be omitted.*

...

At Old Vicarage, we administer medication with a pod system which uses blister packs sent from an external pharmacy. The packs are clearly marked pre breakfast, breakfast, lunch, tea time and bedtime. The pod system is used to make it easy to identify what needs to be given. For the above errors, the medication was clearly still in the pods (with the exception of the Bisoprolol, which I knew was not in stock).'

The panel considered that this statement, although signed and containing a declaration of truth, was admitted as hearsay. As it was admitted as hearsay, the panel could determine what weight to ascribe to the statement. It noted that some of the evidence Witness 8 was reporting on amounted to multiple hearsay. The panel was not able to test Witness 8's evidence in relation to this charge, and so it was necessary to treat the evidence with caution.

The panel was not provided with photocopies of the relevant blister pack in respect of this charge, nor was there any other evidence, other than Witness 8's written statement, to support the allegation that Tegretol had not been administered to Resident DD and was left in the blister pack.

The panel had regard to Resident DD's MAR chart which indicated that Tegretol had been administered by Ms Wood on 31 August 2020. There was also an unsigned handwritten note on the MAR chart which stated '*Tegretol PR. 200mg signed to say given by AW still in pod – not given*'. However there was no indication of when this note had been made.

The panel was not satisfied that the NMC had provided sufficient evidence to discharge its burden of proof in respect of the allegation that on 31 August 2020, Ms Wood inaccurately signed/recorded that she had administered Tegretol to Resident DD. It therefore found charge 18 not proved.

Charge 19

That you, a registered nurse whilst seeking employment/employed at Old Vicarage Nursing Home:

19) Your actions in one or more charges 8 b), 9 b), 9 d), 12 a), 12 b), 13 & 18 were dishonest, in that you falsified records in an attempt to conceal that you had not administered medication to one or more patients.

This charge is found proved in respect of charges 8b, 9b and 9d.
This charge is found NOT proved in respect of charges 12a, 12b, 13 and 18.

In reaching this decision, the panel took into account its findings on charges 8b, 9b, 9d, 12a, 12b, 13 and 18.

In considering whether Ms Wood's conduct at any and/or all of charges 8b, 9b, 9d, 12a, 12b, 13 and 18 was dishonest, in that she falsified records in an attempt to conceal that she had not administered medication to one or more patients, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords*, in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

Charges 8b, 9b and 9d

The panel noted its findings on charges 8b, 9b and 9d. The panel considered Ms Wood's conduct in these charges as a whole as they related to one resident at Pen-y-Bryn Care Home on 2 April 2020 and 3 April 2020.

The panel took into account Ms Wood's email to the NMC dated 13 September 2020 in respect of this allegation:

> '*The medication of the patient I was dispensing to were in single pouches and on a roll.*
> *Each pouch had the patient's name, date and morning and evening written on it.*
>
> *On the said dates of allegations I supposedly did not give them to him. I took the box the roll of pouches were in. I went to takea pouch out but there were ones stuffed in box and not freely on the roll.*
> *Because the patient had the same medication every morning and the same every evening. I dispenced the loose pouches to him.*
> *As I stated to the manager in meeting. In hindsight I should of looked for right dated pouch to give. But as medication was all the same morning and evening I didnt.*
> *I apologised and stated I was only human and would never not give a patient there medication. Especially his as he was prescribed anti- seizure tablets. If I did make an error knowingly I would report it.*
>
> *A point I would also like to add is. This patient took his medication one at a time on a spoon by the nurse giving them to him. He knew exactly how many he had morning and evening. When I asked about proof he had been asked about wether he had missed any medication. Or any documentation to back this up nothing was said or given to me in evidence.*' [sic]

The panel noted that Ms Wood's explanation was contrary to the clear and consistent evidence from Witness 6 and Witness 7, that there were no spare or loose pouches in Resident A's medication box and that even if there were, they would not have been used as it was best practice to administer the dated sequential pouches on the roll for the residents. The panel was able to test Witness 6 and Witness 7's accounts, and accepted their evidence in relation to this matter.

The panel acknowledged that after failing to administer the required medications to Resident A on 2 April 2020 and 3 April 2020, Ms Wood left the three pouches that were due for administration on the roll, and that these were subsequently discovered by Witness 6 and Witness 7 on 4 April 2020.

The panel took into account the fact that Ms Wood's actions at charges 8 and 9 amounted to a failure to administer three sets of six medications to Resident A. Ms Wood had recorded 18 separate signatures in respect of these medications on Resident A's MAR chart.

In considering Ms Wood's subjective knowledge at the time, the panel accepted Witness 6 and Witness 7's consistent and cogent accounts that there were no loose pouches available for administration. The panel noted that the failure to administer the medication was repeated across three separate medication rounds on the evening of 2 April 2020 and the morning and evening of 3 April 2020. In these circumstances, the panel decided that, having recorded 18 signatures on Resident A's MAR chart, Ms Wood knew that she had not administered the medication as prescribed, and thereby falsely completed the records in an attempt to conceal that she had not administered the medication.

The panel was satisfied that by the objective standards of ordinary decent people, Ms Wood acted dishonestly by inaccurately signing/recording that she had administered the medication listed in Schedule 1 and Schedule 2 on Resident A's MAR Chart on 2 April 2020 and 3 April 2020.

The panel therefore determined that, on the balance of probabilities, Ms Wood’s actions at charges 8b, 9b and 9d were dishonest, in that she falsified records in an attempt to conceal that she had not administered medication to one or more patients.

Charge 12a

Having found charge 12a not proved, the panel did not find dishonesty in respect of this charge.

Charge 12b

The panel noted Ms Wood’s admission to charge 12b and her acknowledgment of the error in her unsigned and undated CMF. The panel had no evidence before it to suggest that on the balance of probabilities, Ms Wood had acted dishonestly, in that she falsified records in an attempt to conceal that she had not administered Clopidogrel to Resident CC. It therefore found no dishonesty in respect of this charge.

Charge 13

Having found charge 13 not proved, the panel did not find dishonesty in respect of this charge.

Charge 18

Having found charge 18 not proved, the panel did not find dishonesty in respect of this charge.

Fitness to practise

Having reached its determination on the facts of this case, the panel then considered whether the facts found proved amount to misconduct and, if so, whether Ms Wood’s

fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions

Mr Clair provided the panel with written submissions and then made further oral submissions.

Submissions 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.'*

Mr Clair submitted that the matters found proved involving Ms Wood's successive errors in administering medication to multiple vulnerable residents across a number of separate care homes, falsification of medical records, employing inappropriate manual handling techniques, failing to escalate a medical condition, and dishonesty in failing to disclose

information surrounding her practice to a new employer, are sufficiently serious as to constitute misconduct.

Mr Clair invited the panel to take the view that the facts found proved amounted, individually and collectively, to misconduct and fell well below the standards expected of a reasonable and competent nurse. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Clair identified the specific, relevant standards where Ms Wood's actions amounted to misconduct. He invited the panel to find that Ms Wood had breached parts 1.2, 1.4, 8.3, 10.1, 10.2, 10.3, 13.1, 13.2, 18.2, 18.3, 20.1 and 20.2 of the Code.

Submissions on impairment

Mr Clair moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Clair submitted that a finding of impairment was required on both patient protection and public interest grounds.

Mr Clair referred the panel to the test formulated by Dame Janet Smith in her Fifth Shipman Report when considering whether impairment is established or not. The test is set out in the case of *CHRE v NMC v Grant*.

Mr Clair submitted that Ms Wood's conduct, specifically in relation to medication errors, falsification of records and failing to follow appropriate manual handling techniques, put patients at unwarranted risk of harm. He submitted that significant public protection concerns remain as Ms Wood demonstrated failings in a number of fundamental areas of clinical practice. Mr Clair submitted that the most serious aspect was the dishonesty which was linked directly to Ms Wood's practice when considering the misrepresentation of medication administration and a failure to fully disclose misconduct issues and disciplinary proceedings to a prospective/new employer.

Mr Clair submitted that Ms Wood's actions brought the nursing profession into disrepute, and by making the same failures and acting dishonestly, she also breached a number of the fundamental tenets of the nursing profession to deliver care effectively and to act with honesty and integrity at all times. Mr Clair submitted that the public do not expect nurses to behave in such a manner and would be shocked to learn about what transpired in this case.

Mr Clair submitted that the panel had found that Ms Wood's conduct in respect of some of the charges was such that she acted in a dishonest manner.

In respect of whether Ms Wood has remediated her conduct and whether her fitness to practise is impaired, Mr Clair referred the panel to the guidance in the case of *Cohen v General Medical Council,* and invited the panel to take account of:

- Whether the conduct which led to the charge is easily remediable;
- Whether it has been remedied; and
- Whether it is likely to be repeated.

Mr Clair submitted that the conduct found proved in this case, including dishonesty, was difficult to remediate. He referred the panel to the NMC guidance on 'Serious concerns which are more difficult to put right' which provides that '*a small number of concerns are so serious that it may be less easy for the nurse... to put right the conduct...*'. Mr Clair

submitted that this includes concerns relating to breaching the professional duty of candour to be open and honest when things go wrong, including covering up and falsification of records; and also deliberately giving a false picture of employment history which hides clinical incidents in the past. Mr Clair submitted that these matters raise fundamental questions about Ms Wood's trustworthiness.

Mr Clair submitted that there was very limited or no evidence before the panel that Ms Wood has reflected on the conduct found proved and is now showing remorse or regret for what happened.

In considering insight, Mr Clair submitted that the evidence from the local level investigations disclosed an attitude of apathy on the part of Ms Wood. He submitted that the panel may find it rather difficult or impossible to ascertain the level of Ms Wood's insight or reflection into the concerns, given the fact that she has not fully engaged with these proceedings, and the limited information before the panel from Ms Wood herself which does not specifically address the concerns identified and does not address the issues of dishonesty at all. Mr Clair submitted that Ms Wood's failings involved a pattern of attitudinal concerns, a serious departure from expected standards and put multiple patients at risk of harm. He submitted that these matters are likely to cause risks to patients in the future if they are not addressed.

Mr Clair submitted that the panel may therefore find that the concerns have not been adequately remediated and that Ms Wood has not provided evidence of further training or current safe practice, so that there is a still a risk of repetition.

In conclusion, Mr Clair submitted that in order to protect the public, satisfy the collective need to maintain confidence in the profession, and declare and uphold proper standards of conduct and behaviour, a finding of current impairment is imperative. He submitted that members of the public would expect a regulator to act where misconduct such as that found proved in this case is found, and not to do so would undermine public confidence in the NMC as a regulator.

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

Decision and reasons on misconduct

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

The panel was of the view that Ms Wood's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Wood's 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
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

6 Always practise in line with the best available evidence
To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

8 Work co-operatively

To achieve this, you must:

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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:

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

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel appreciated that a breach or breaches of the Code do not automatically result in a finding of misconduct. The panel considered the charges which had been found proved. The panel noted that Ms Wood:

- made medication administration errors at charges 1, 2, 3a, 3c, 3e, 3g, 5a, 6a, 8a, 9a and 9c;
- inaccurately completed residents’ records at charges 3b, 3d, 3f, 3h, 8b, 9b, 9d and 12b;
- did not take appropriate steps to ensure that the administration of a resident’s medication was stopped after being instructed to do so by the resident’s doctor at charges 16a, 16b and 17;
- employed inappropriate manual handling techniques at charges 14a, 14b, 14c and 15;
- failed to refer a resident’s suspected DVT to an out of hours doctor at charge 7;
- dishonestly falsified records at charge 19 (in respect of charges 8b, 9b and 9d); and
- inaccurately completed the application for her new employer so as to dishonestly conceal her dismissal from her previous employer at charges 10 and 11.

The panel considered charges 1, 2, 3 (in its entirety), 5a, 6a, 8 (in its entirety), 9 (in its entirety), 12b, 16 (in its entirety) and 17 collectively as they related to wide-ranging concerns of poor medication management, administration and corresponding record keeping by Ms Wood. The panel noted that Ms Wood had made successive errors around administering/failing to administer medication to multiple vulnerable residents across three care homes during periods in 2018 and 2020. The panel was satisfied that the inaccurate entries made by Ms Wood in residents’ MAR charts related directly to these medication administration errors. In addition, Ms Wood did not appropriately manage a resident’s prescription after being given clear instructions by a GP.

The panel took into account that Ms Wood made medication errors at Pinetum Care Home in February 2018, shortly after she started working there and having completed and passed a medication knowledge competency assessment in January 2018. Following the February errors, the panel noted that Ms Wood undertook a repeat of this assessment on

27 February 2018. She then made further medication errors at the home in April 2018. Ms Wood subsequently went on to make further errors around medication management, administration and record-keeping between April and September 2020. The panel noted that among the medication administration errors in particular, some vulnerable residents were not given vital medication, including anti-seizure tablets and pain relief. The panel considered that Ms Wood's continual pattern of poor medication practice left residents at risk in 2018 and 2020, which in the panel's view increased the level of seriousness of her actions.

On this basis, the panel determined that Ms Wood's behaviour would be regarded as deplorable by fellow practitioners. It found that her actions at charges 1, 2, 3 (in its entirety), 5a, 6a, 8 (in its entirety), 9 (in its entirety), 12b, 16 (in its entirety) and 17, fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

The panel next considered Ms Wood's conduct at charge 7 where she did not escalate a resident's condition to the out of hours GP after identifying and recording a risk of the resident suffering a DVT. The panel noted that Ms Wood clearly identified and recorded a suspected DVT and the fact that it required escalation to a GP, but did not do so. The panel considered that as a senior nurse at Pinetum Care Home, Ms Wood was expected to have escalated the matter urgently in view of the seriousness of the potential risks and consequences to the resident if this was not done. The panel was of the view that fellow practitioners would regard Ms Wood's behaviour as deplorable. It therefore determined that Ms Wood's conduct in respect of charge 7 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Regarding Ms Wood's conduct at charges 14 (in its entirety) and 15, the panel considered that Ms Wood's behaviour stemmed from her failure to follow the recommended approach for moving and handling as detailed in the resident's care plan. It took into account that despite being told by Colleague Y that she was waiting for the stand aid, Ms Wood decided not to wait and instead instructed Colleague Y to manually lift the resident with

her. It noted that as a result of Ms Wood's actions, the resident slipped to the floor, albeit without a fall or injury. The panel noted the circumstances surrounding this incident, in particular the fact that Ms Wood was fairly new at the home and explained the reasons for her actions when questioned by management at a local level. The panel also noted that the resident did not suffer harm. The panel was not satisfied that Ms Wood's actions at charges 14 (in its entirety) and 15 were so serious as to amount to misconduct.

In relation to Ms Wood's conduct at charges 10, 11 and 19 (in respect of charges 8b, 9b and 9d), the panel noted that Ms Wood acted dishonestly in two significant areas, namely in respect of resident care and her own employment history. The panel considered that Ms Wood had a duty as a registered nurse to be open and honest, and act with integrity by informing her prospective employer at the Old Vicarage Nursing Home that she had been dismissed from Pen-y-Bryn Care Home following a local disciplinary investigation. The panel considered that Ms Wood's deliberate falsification of records in an attempt to conceal that she had not administered medication to residents was extremely serious. The panel was of the view that Ms Wood's dishonesty would be regarded as deplorable by fellow practitioners. The panel therefore found that Ms Wood's conduct at charges 10, 11 and 19 (in respect of charges 8b, 9b and 9d) fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Wood's 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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

Looking to the past, the panel determined that limbs a), b), c) and d) are engaged in this case. It found that whilst there was no evidence that residents suffered actual harm, Ms Wood's misconduct in periods during 2018 and 2020 put residents at risk of harm. Ms Wood's misconduct breached fundamental tenets of the nursing profession by failing to deliver care effectively, administer medication as prescribed and act with honesty and integrity at all times, and therefore brought its reputation into disrepute. The panel found that Ms Wood acted dishonestly and it was satisfied that confidence in the nursing profession would be undermined if it did not find charges relating to dishonesty to be serious.

The panel took into account the NMC guidance on '*Serious concerns which are more difficult to put right*' which states that '*a small number of concerns are so serious that it may be less easy for the nurse... to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening.*' The panel noted that this includes instances where a registrant is responsible for:

> '*breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, ... or otherwise contributing to a culture which suppresses openness about the safety of care*'.

The panel was satisfied that the misconduct in this case, particularly in relation to Ms Wood's medication management and administration, record-keeping and resident care errors, is capable of being addressed. The panel was of the view that whilst difficult, Ms Wood's dishonesty was not impossible to put right.

The panel considered that it had seen little evidence of insight from Ms Wood. During the investigatory process into the concerns at Pinetum Care Home in 2018, Ms Wood admitted to some of her mistakes, provided an explanation and appeared to be remorseful for her actions. However, in the panel's view this was limited. The panel noted that Ms Wood has not addressed concerns relating to dishonesty and failure to escalate the case of the resident with a suspected DVT. It considered that in other instances, Ms Wood did

not, during the course of the investigation, demonstrate ownership of the errors she made and did not acknowledge that her actions consisted of departures from expected practice. The panel saw no evidence of reflection by Ms Wood into the impact of her conduct. The panel was not provided with a reflective piece demonstrating Ms Wood's understanding of why what she did was wrong, how her actions put residents at risk of harm and how they impacted negatively on the reputation of the nursing profession. The panel had no evidence before it of how Ms Wood would manage the situation differently in the future.

On 19 October 2023, in an email to the NMC, Ms Wood stated:

> '*I have reflected fully on the case. I have empathy and a conscience.*'

However, the panel has nothing before it to demonstrate genuine insight and remorse beyond these assertions by Ms Wood.

The panel carefully considered the evidence before it in determining whether or not Ms Wood has taken steps to strengthen her practice and address the dishonesty. The panel was mindful that Ms Wood's misconduct consisted of a pattern of repeated errors in medication management, medication administration and record-keeping, and errors in other fundamental areas of nursing practice. The panel took into account that despite undertaking medication competency assessments and training in 2018, Ms Wood's practice was not strengthened and she went ahead to repeat these errors during periods in 2018 and 2020.

The panel had sight of documentation dated between October 2021 and November 2022 regarding Ms Wood's nursing role at Brampton Lodge, which she asked the NMC to provide to this panel. These included four letters from the Registered General Manager regarding Ms Wood's supervision in place at the time. The panel also saw a performance review, a Personal Development Plan (PDP) and a medication competency practical assessment all signed and dated 18 November 2021. The panel noted that this documentation was to be provided to interim order review panels considering the interim

conditions of practice order in place and accordingly, it does not make reference to the current allegations with which this panel is engaged. The panel drew no adverse inference from the fact that an interim order was in place in that period.

In the letter from the Registered General Manager of Brampton Lodge dated 29 March 2022, she stated:

> '*I have no concerns regarding her ability to administer medication, AW continues to evidence that her practise is of an excellent standard, there have been no medication issues, she has remained concise and efficient in her administration process, clearly spends time reading the medication administration records, signs all administration records appropriately, records and justifies the administration of all required medication appropriately.*
>
> *AW continues to effectively record all and any information, she maintains and reads care plans of all the residents to ensure she has a good knowledge and up to date information of residents within her care.*'

The panel noted the further letter from the Registered General Manager of Brampton Lodge dated 17 October 2022, which stated:

> '*AW remains employed at Brampton Lodge as a registered nurse, since 25/10/2021. AW has worked under the supervision of another nurse for the duration. There continues to be no issues or concerns regarding AW's nursing practise. AW continues to independently manage a unit, manage and support junior staff with another nurse in the building and has not needed any support or guidance.*
>
> *I continue have confidence in AW's ability as a registered nurse, have no concerns regarding her ability to administer medication, AW continues to evidence that her practise is of an excellent standard, there have been no medication issues, she has*

remained concise and efficient in her administration process, clearly spends time reading the medication administration records, signs all administration records appropriately, records and justifies the administration of all as required medication appropriately.

AW's continues to effectively record all and any information, she maintains and reads care plans of all the residents to ensure she has a good knowledge of residents within her care.

I continue to remain confident that AW would be able to work unsupervised in both administration of medication and as a registered nurse without supervision from another nurse. I do not feel there are any concerns that need to be addressed.'

The panel noted that none of this documentation dealt directly with the issue of dishonesty. The panel also noted that some of the documentation was not signed. The panel had no more recent information than November 2022 about whether Ms Wood is currently working as a nurse, her work place performance and what she has done since then to strengthen her nursing practice. Further, the panel has not seen any evidence or information from Ms Wood to suggest that she has since taken steps to reflect on and address the findings around dishonesty.

Regarding the regulatory concerns about medication management, administration and record keeping, the panel found that some steps were successfully taken to strengthen Ms Wood's practice in the period between October 2021 and November 2022. The panel has seen positive reports about her performance in that period, but nothing since.

In these circumstances, the panel could not conclude that it is highly unlikely that Ms Wood's misconduct would be repeated in the future. The panel concluded that Ms Wood demonstrated very limited insight and whilst there has been some strengthening of her practice, there is no evidence before the panel of what she has done in that regard in the last year. The panel therefore found that there is a real risk of repetition and that a finding

of current impairment of fitness to practise 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 determined that a finding of impairment on public interest grounds is required. This is because a well-informed member of the public would be concerned to learn that Ms Wood was dishonest and made repeated errors in fundamental areas of nursing practice. These included medication management, medication administration, record keeping, escalation of a resident with a suspected DVT and other areas of resident care, with limited evidence to show that these had been meaningfully addressed.

In addition, the panel concluded that public confidence in the profession and in the NMC as a regulator would be undermined if a finding of impairment were not made in this case. The panel determined that a finding of impairment would declare and uphold proper professional standards. It therefore also found Ms Wood's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Wood's fitness to practise is currently impaired.

Sanction

The panel considered this case carefully and decided to make a striking-off order. It directs the registrar to strike Ms Wood off the register. The effect of this order is that the NMC register will show that Ms Wood has been struck-off the register.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case, including that received on 23 October 2023 (day 15 of the hearing), and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

In the Notice of Hearing, dated 14 September 2023, the NMC advised Ms Wood that it would seek the imposition of a striking-off order if it found Ms Wood's fitness to practise currently impaired.

Mr Clair submitted that in reaching its decision, the panel may be assisted by the SG in determining what sanction, if any, ought to be imposed. He asked the panel to consider proportionality, which involves balancing the interests of the public against those of Ms Wood. Mr Clair submitted that the decision on sanction was a matter for the panel independently exercising its own judgement, and he asked the panel to consider all available sanctions, beginning with the least restrictive.

Mr Clair proposed that the following aggravating factors were present in this case:

- There were numerous failures in fundamental and basic areas of nursing practise.
- There were multiple medication administration errors made in a short period of time on more than one occasion.
- There was a risk of significant potential harm to patients who were not administered their medication.
- Ms Wood deliberately placed multiple patients at a significant risk of harm by falsifying records in relation to the non-administration of drugs.
- There was a significant risk of potential harm to a patient whose DVT was not escalated to medical colleagues.
- There was dishonesty linked to Ms Wood's clinical practise.
- There was limited evidence of remorse, insight and remediation.
- There was a pattern of misconduct across various separate employers.

Mr Clair submitted that the panel may find that there was very limited mitigation. He submitted that the panel may consider Ms Wood's engagement with the NMC to some extent, and that she appears to have sought to remediate her medication practice to some extent as mitigating factors.

Mr Clair submitted that in deciding on the appropriate sanction, it was for the panel to decide where, on the scale of seriousness, Ms Wood's conduct lies, having considered all the facts and evidence in the case. He invited the panel to consider the NMC's guidance on '*Considering sanctions for serious cases*' which notes that because honesty is of central importance to a nurse's practice, in cases involving dishonesty, it is likely that the NMC would need to take action to uphold public confidence in nurses or to promote proper professional standards. The guidance provides, therefore, that allegations of dishonesty will always be serious and that a nurse who has acted dishonestly will always be at risk of being removed from the register. Mr Clair asked the panel to take into account the forms of dishonesty which are likely to call into question whether a nurse should be allowed to remain on the register, and submitted that the following considerations were engaged in this case.

- '*deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *...*
- *vulnerable victims*
- *...*
- *direct risk to patients*
- *...*'

Mr Clair submitted that this case is too serious to take no action or impose a caution order. He submitted that Ms Wood's misconduct was not at the lower end of the spectrum, and therefore a caution order would be inappropriate in view of the seriousness of this case.

In relation to conditions of practice, Mr Clair highlighted the panel's finding that Ms Wood's behaviour in totality was not easily remediable. He submitted that it would be difficult, if not impossible, to formulate conditions that would adequately address all of the concerns. Mr Clair submitted that some aspects of Ms Wood's misconduct could not be easily addressed through retraining. Mr Clair submitted that given the panel's finding that Ms Wood had limited insight and had not demonstrated a clear understanding of the nature and extent of her misconduct, a conditions of practice order would not be appropriate, as even with conditions in place, there would still be a risk of harm to patients.

In relation to a suspension order, Mr Clair submitted that Ms Wood's behaviour could not be described as a single incident of misconduct or, in certain instances, as anything other than very serious. He submitted that the charges found proved ranged over a period of a number of years and there were several incidents, demonstrating a consistent pattern of unprofessional behaviour and misconduct, where in some cases there was repetition in a clinical context.

Mr Clair submitted that in line with the guidance, the panel concluded that Ms Wood demonstrated limited insight and no insight at all in relation to the matters of dishonesty. He reminded the panel of its finding that Ms Wood's misconduct could be said to be remediable, although she still posed a risk of repeating the behaviour as sufficient strengthening of her practice had not been demonstrated. Mr Clair submitted that Ms Wood had not provided full evidence of how she would manage similar situations differently in the future. He submitted that these factors, coupled with the serious breaches of the Code and fundamental tenets of the nursing profession, could suggest behavioural and attitudinal concerns, which would make a suspension order inappropriate.

In relation to a striking-off order, Mr Clair submitted that in light of the seriousness of Ms Wood's behaviour, the harm that was caused and the real potential for harm that could have been caused and in the absence of an explanation to the dishonesty, confidence in the profession could only be maintained if Ms Wood were removed from the register. He submitted that the panel may feel that Ms Wood's behaviour was fundamentally

incompatible with remaining on the register. He submitted that a striking-off order would be the only sanction sufficient to protect patients and members of the public, and maintain professional standards.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

- Ms Wood, as a senior nurse, was responsible for numerous failings in basic areas of nursing care.
- There was a pattern or misconduct over a period of time. Ms Wood repeated medication errors at three different care homes across two different time periods in 2018 and 2020, despite having undertaken a medication knowledge competency re-assessment in February 2018.
- Ms Wood's conduct put residents at risk of suffering serious harm.
- Ms Wood demonstrated a lack of insight into her failings.
- There was very limited reflection from Ms Wood into her failings and the impact of her misconduct on residents, colleagues or the nursing profession.
- The dishonesty in this case was linked to Ms Wood's professional practice.

The panel also took into account the following mitigating features:

- Ms Wood had taken some steps to strengthen her practice in relation to medication management, administration and record-keeping between October 2021 and November 2022.
- Ms Wood provided limited acknowledgement of her failures at the local level in respect of the 2018 concerns. The panel had regard to Ms Wood's email to the NMC dated 29 June 2018 which stated:

  '*I felt awfull [sic] that I had failed in my duty.*
  I did do a reflective account and reassessed with meds competency.'

The panel did not have the benefit of any reflective account from Ms Wood.

In considering the seriousness of Ms Wood's dishonesty, the panel had regard to the NMC guidance on '*Considering sanctions for serious cases*' which stated:

> '*Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
> - *misuse of power*
> - *vulnerable victims*
> - *personal financial gain from a breach of trust*
> - *direct risk to patients*
> - *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents in private life of nurse, midwife or nursing associate'*.

The panel considered that, save misuse of power, five of the criteria indicating that Ms Wood's dishonesty is more serious are engaged in this case; whilst none of the criteria indicating less serious dishonesty apply.

The panel determined that Ms Wood deliberately breached the professional duty of candour by covering up her medication administration errors which resulted in a direct risk to residents. It noted that the residents involved in the incidents were vulnerable. The panel found that Ms Wood benefitted financially as she was given the opportunity to earn remuneration in a job which, but for her dishonesty, she may not have had access to. The panel considered that Ms Wood's dishonesty was pre-meditated because she had time to consider and complete her application form to the Old Vicarage Nursing Home, but nevertheless dishonestly stated an incorrect reason for leaving her previous employment. In relation to her dishonesty associated with the administration of medication, the panel noted that Ms Wood made 18 signatures on a resident's MAR chart across three medication rounds to the effect that she had administered medication when in fact she had not done so.

The panel was therefore satisfied, on the guidance, that the dishonesty in this case was on the more serious side of the scale.

The panel then considered what sanction, if any, to impose in this case.

The panel considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Wood's 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 Ms Wood's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. 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 Ms Wood's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. It had regard to the SG. The panel considered that Ms Wood demonstrates a deep-seated attitudinal problem in that she has not demonstrated any understanding of the effect of her actions on residents, colleagues, and the nursing profession, and has not acknowledged her dishonesty.

The panel was of the view that there are clearly identifiable areas of Ms Wood's practice which could be addressed by way of assessment or retraining, however it noted that she had undertaken some retraining relating to medication administration in 2018 but went on to repeat her errors. The panel was mindful that Ms Wood subsequently took steps to strengthen her practice between October 2021 and November 2022. However, the panel was not provided with any information as to Ms Wood's performance and training record over the last 12 months. It had no information about Ms Wood's current circumstances. The panel considered that apart from the period referred to above, Ms Wood has not demonstrated an ongoing willingness to strengthen her practice.

The panel was of the view that it could be possible to formulate conditions. However, given the attitudinal concerns in this case and Ms Wood's lack of insight and sustained remediation to date, the panel was not satisfied that conditions of practice could be put in place that would sufficiently protect patients/residents from risk of harm.

The panel therefore determined that there are no practical or workable conditions that could be formulated. Furthermore, the panel concluded that placing conditions on Ms Wood's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *...*

The panel noted that Ms Wood's misconduct was not a single instance of misconduct and that there was evidence of a deep-seated attitudinal problem. The panel considered that whilst there was no evidence of repetition of Ms Wood's behaviour since 2020, the incidents in 2020 were a repeat of her errors in 2018. The panel was not satisfied that Ms Wood had demonstrated any insight other than providing some limited insight to the medication errors made in February 2018, and it found that she poses a significant risk of repeating her behaviour.

Ms Wood’s misconduct, as highlighted by the facts found proved, represents significant departures from the standards expected of a registered nurse. The panel found that the serious breach of fundamental tenets of the profession by Ms Wood is fundamentally incompatible with her remaining on the register.

In this particular case, the panel therefore decided that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel considered that the regulatory concerns in this case raise fundamental questions about Ms Wood’s professionalism. The panel was of the view that public confidence in the profession would be undermined if Ms Wood was not removed from the register. It was of the view that members of the public would be most concerned to learn that vulnerable residents were placed at risk of harm through medication administration errors and incorrect entries that were made on MAR charts by Ms Wood, with some of those entries being made dishonestly. In addition Ms Wood failed to escalate a patient apparently suffering from a DVT and was also dishonest in a job application form.

The panel concluded that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards because a lesser sanction would not reflect the seriousness of the misconduct in this case, nor address the ongoing risk of repetition identified by the panel.

The panel was of the view that the findings in this particular case demonstrate that Ms Wood's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Wood's actions in bringing the profession into disrepute by negatively affecting the public's view of how registered nurses conduct themselves, the panel concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that a striking-off order is necessary to maintain public confidence in the profession, and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

This will be confirmed to Ms Wood in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel 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 Ms Wood's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Clair. Given the panel's finding that Ms Wood's conduct is incompatible with remaining on the register, Mr Clair invited the

panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive striking-off order takes effect.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to ensure that Ms Wood cannot practise unrestricted before the substantive striking-off order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.