Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 3 July 2023 – Thursday 6 July 2023
Tuesday 11 July 2023
Thursday 13 July 2023 – Friday 14 July 2023
Tuesday 29 – Wednesday 30 August 2023 (In Camera)
Monday 18 September 2023 – Tuesday 19 September 2023
Thursday 21 September 2023 - Friday 22 September 2023

Virtual Hearing

Name of Registrant:	**Barbara Eckersley**
NMC PIN:	07I0528E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (February 2008)
Relevant Location:	St Helens, Merseyside
Type of case:	Misconduct
Panel members:	Ashwinder Gill (Chair, Lay member) Janet Fitzpatrick (Registrant member) David Anderson (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Nandita Khan Nitol (3 July 2023 – 11 July 2023) Charis Benefo (11 July 2023 – 14 July 2023) Sharmilla Nanan (29 August 2023 - 30 August 2023) Nandita Khan Nitol (18 September 2023 – 19 September 2023 & 21 September 2023 -22 September 2023)
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter
Mrs Eckersley:	Present and represented by Neair Maqboul, Counsel instructed by the Royal College of Nursing (RCN)
No case to answer:	Charges 11c, 13a and 13b

Facts proved by admission:	Charges 1, 2, 3, 7a, 7b)i, 7c, 7d, 7e, 7f, 7g and 7h
Facts proved:	Charges 4, 5a, 7b)ii, 8, 9a, 9b, 11a and 11b
Facts not proved:	Charges 6, 13e, 7b)iii, 10a, 10b, 10c, 10d, 12, 13c, 13d, 13e, 13f, 13g and 13h
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to adjourn the hearing under Rule 32

The original listing for this case was nine days, that has been now reduced to six by reason of panellist unavailability.

Mr Kewley, on behalf of the Nursing and Midwifery Council (NMC) acknowledged that the Royal College of Nursing (RCN) was served with proposed changes to the charges very late on Friday (30 June 2023) and this could further affect the timing of the hearing. He said that it would be unlikely that the totality of the fact stage could be concluded within the current listing.

Mr Kewley drew the panel's attention to the public interest in the expeditious disposal of the regulatory matters and the fact that two of the three live witnesses would be due to give evidence and they are family members of the two patients. Mr Kewley submitted that notwithstanding the days the panel would not sit there would still be time available where some progress could be made.

Ms Maqboul, on your behalf, submitted that due to the reduced timings of the hearing, there are real concerns about the case adjourning part heard until much later in the year. She acknowledged Mr Kewley's submissions that the case might not conclude even at the fact stage. Ms Maqboul accepted that there are relatives of the patients who would be giving evidence and that they would likely to have prepared themselves for giving their evidence this week. However, Ms Maqbool submitted that it was not acceptable that RCN was served with the application to amend charges very late on Friday and that you had just started to go through those changes this morning before the start of the hearing.

Ms Maqboul requested the panel to adjourn the hearing and relist the case with a new panel. She submitted that the these are serious charges and if the panel proceeded today, you would feel pressured and rushed to go through the amendment of the charges.

Finally, Ms Maqboul submitted that if the panel decides to proceed today, you would need considerable amount of time go through the proposed changes of the charges.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

The panel considered all the circumstances of the case. It noted the reduced timings of the hearings and the fact that the proposed application for the amendment of the charges was served late. The panel considered that the charges relate to events that occurred in 2020 and that two of the three live witnesses who are due to give evidence are relatives of the two patients. The panel determined that further delay might have an adverse effect on the ability of the witnesses to accurately recall events and that there is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair and appropriate to proceed with the hearing today. The panel determined to commence the hearing at 15:00 today and give you time to go through the proposed amendment of the charges with Ms Maqboul.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kewley to amend some of the charges to read as follows:

5) Did not ensure there were sufficient supplies of medication namely:
   a) Patient A's Rivaroxaban on 1 March 2020

6) Did not ensure there were sufficient supplies of food **for Patient B by allowing their food supplies to run out**

8) Failed to ensure personal care was provided to Patient A on some or all of the following dates: 6, 9, 10, 17 April **2020**

9) Failed to ensure oral care was provided to Patient A on:
   a) 6 April 2020
   b) 8-17 April 2020

10) When deficiencies in care were raised ~~regarding~~, failed to act on some or all of the following:

13) Failed to ~~ensure and/or~~ provide suitable care **or ensure that suitable care was provided** for Patient B in that:
   c) ~~Put a new DNAR (do not attempt resuscitation) notice~~ **Provided information to the GP for a DNAR (do not attempt resuscitation) notice to be put** in place without consulting family

   e) Did not inform their family when ~~food~~ **drink** provided **by the family** had run out.

Mr Kewley submitted that the proposed amendment mostly was to correct the typographical errors and incomplete sentences to the wording of the charges.

For charge 5, Mr Kewley submitted that the charge ended mid-sentence and that there was no date. Therefore, Mr Kewley proposed to add the words '*Patient A Rivaroxaban on 1 March 2020'* which would complete the charge and would provide clarity.

For charge 6, Mr Kewley submitted that this charge has similar errors and that it was incomplete and that it is missing a few words. Therefore, Mr Kewley proposed to add the words for '*Patient B allowing their food supplies to run out'* which would complete the charge and would provide clarity.

For charge 8, Mr Kewley submitted that this charge is missing the year and insertion of the year '*2020*' would provide clarity to the charge.

For charge 9, Mr Kewley submitted that this charge is missing the dates and insertion of the dates '*6 April'* and '*8-17 April'* would provide clarity and specificity to the charge.

For charge 10, Mr Kewley proposed the deletion of the word ‘regarding’ to provide clarity and accurately reflect the charge.

For charge 13, Mr Kewley submitted that to provide clarity and accurately reflect the charge, he proposed to add the words ‘*provide suitable care or ensure that suitable care was provided*’ and delete the words ‘to ensure and/or’.

For charge 13c, Mr Kewley submitted that the charge gives the impression it is the responsibility of a nurse to put in place a DNAR notice where in fact it is the doctor who makes the decision. Hence, Mr Kewley submitted that the insertion of the words *‘Provided information to the GP for a DNAR (do not attempt resuscitation) notice to be put’* would provide clarity and accurately reflect the charge.

For charge 13e, Mr Kewley submitted that the addition of the words ‘*drink’* and ‘*by the family’* would again provide clarity to the charge and accurately reflect the charge.

Ms Maqboul did not oppose to the application, save for the charge 13c. However, she submitted that it is a matter for that panel.

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

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

Details of charge (as amended)

That you, a registered nurse:

1) Whilst working nursing shifts between 16 – 22 April 2020 inclusive failed to wear appropriate Personal Protective Equipment ('PPE') on one or more occasion.

2) Made a dishonest statement to the Quality Director that you had 'always wore correct PPE when you had not.

3) Did not ensure suitable infection control practices were in place.

4) Did not ensure suitable signage was in place at external doors during the COVID pandemic lockdown.

5) Did not ensure there were sufficient supplies of medication namely:
   a) Patient A's Rivaroxaban on 1 March 2020.

6) Did not ensure there were sufficient supplies of food for Patient B by allowing their food supplies to run out.

7) Did not ensure appropriate nursing care was provided to Patient A between 15 March 2020 and 22 April 2020 in that:
   a) Did not conduct a risk assessment when family visits were refused.
   b) Did not provide sufficient information to paramedics and / or hospital on 7 April 2020 following a suspected stroke as you did not:
      i) Provide the required handover documents.
      ii) Inform the hospital of the previous diarrhoea.
      iii) Inform the hospital of the previous fainting.
   c) Did not ensure fluid levels were maintained.
   d) Did not ensure food intake was maintained .
   e) Did not raise dropping fluid and / or food intake levels with family and / or GP.
   f) Did not ensure toileting schedule was adhered to.
   g) Did not escalate prolonged diarrhoea with family and / or GP.
   h) Allowed medication to be missed.

8) Failed to ensure personal care was provided to Patient A on some or all of the following dates: 6, 9, 10, 17 April 2020.

9) Failed to ensure oral care was provided to Patient A on:
   a) 6 April 2020
   b) 8-17 April 2020

10) When deficiencies in care were raised, failed to act on some or all of the following:
   a) staff failure to conduct toileting plan.
   b) staff failure to conduct incontinence pad checks.
   c) Staff falsification of incontinence pad check records.
   d) Staff failure to adhere to the night monitoring plan.

11) Falsified patient records for Patient A on:
   a) 6 April 2020 by signing their MAR chart to show a lidocaine patch was administered when it was not.
   b) On or around 17 April 2020 by signing their personal care chart to show personal care had been administered when it had not.
   c) 20 April 2020 by signing their personal care chart to show personal care had been administered when it had not.

12) Failed to respect Patient A's religious beliefs upon death.

13) Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:
   a) Did not produce a care plan between May 2019 and Jan 2020
   b) Produced a care plan that lacked details concerning food and personal care requirements.
   c) Provided information to the GP for a DNAR (do not attempt resuscitation) notice to be put in place without consulting family.
   d) Did not ensure they were offered food regularly.
   e) Did not inform their family when drink provided by the family had run out.
   f) Did not inform their family regarding injuries to their foot.

g) Did not treat injuries to their foot.
h) Administered a COVID test when it was inappropriate to do so.

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

Background

You were referred to the NMC on 26 May 2020 by Witness 1, the daughter of Patient A. The NMC also received referrals relating to the same or similar issues from Witness 2, the daughter of Patient B, and from Community Integrated Care (CIC).

You were employed by CIC as a Unit Manager and worked in the Haydock Suite at Eccleston Court Care Home (the Home). The Home is a nursing home and the Eccleston Suite is the main nursing unit and Haydock unit is a dementia unit.

The referral sets out a wide range of allegations surrounding concerns about your management of the home and provision of care, your failure to wear the appropriate Personal Protective Equipment (PPE) and alleged falsification of patient records.

You allegedly failed to ensure that appropriate care was delivered to elderly residents at the Home. Patients A and B were residents at the Home. Both were elderly and vulnerable, and both were based on the Haydock unit. In 2020, you allegedly failed to adhere to infection control practices during the pandemic and compromised patients' safety by failing to wear appropriate PPE on more than one occasion. In addition, you allegedly falsified patient records. Both Witness 1 and Witness 2 allegedly raised concerns with you about a number of aspects of the care provided to Patients A and B.

Decision and reasons on application of no case to answer

Application by Ms Maqboul

The panel considered an application from Ms Maqboul that there is no case to answer in respect of charges 11b, 11c, 13a and 13b. This application was made under Rule 24(7). Ms Maqbool provided written submissions which stated:

'THE LAW

Establishing a case to answer

1. *Section 24 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 states:*

(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and—

(i) either upon the application of the registrant, or

(ii) of its own volition,

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

(8) Where an allegation is of a kind referred to in article 22(1)(a) of the Order, the Committee may decide,—

(i) either upon the application of the registrant, or

(ii) of its own volition,

to hear submissions from the parties as to whether sufficient evidence has been presented to support a finding of impairment, and shall make a determination as to whether the registrant has a case to answer as to her alleged impairment.

2. *The key case which assists in defining the term 'case to answer': R v Galbraith [1981] 1 WLR 1039 . The basic principles established in Galbraith are as follows:*

   (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

   (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

      a. Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

      b. Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.

3. *The judgement in Galbraith does not convey that if parts of the evidence support the charge then no matter what the state of the rest of the evidence it is enough to leave the matter to the jury. The evidence must be considered as a whole.*

SUBMISSIONS

Charges 11 (b) and (c) – no case to answer on the facts

4. *These charges relate to endorsement of Patient A's records rather than the administration of personal care by the Registrant. None of the relevant records found at pages 194 (ex 2: JE17) or pg 226 (ex 2: JE18) contain the registrant's signature. Further it is not clear by whom the entries have been made.*

5. *[Witness 1] did not give evidence on the discrete issue of signatures in this regard.*

6. *There is insufficient evidence upon which the panel can safely rely to find this charge proved.*

Charges 13 (a) and (b) – no case to answer on the facts

7. *The panel is not seized of any care plan relating to Patient B. The panel is therefore unable to consider this document and any purported deficiencies or gaps in information.*

8. *[Witness 2] did her best to provide evidence on the content of the care plan, however this evidence was severely lacking because she did not have sight of the document and was reliant upon what another member of staff ([Nurse 1]) had told her.*

9. *However, during her interaction with [Nurse 1], she was not shown a copy of the document and was unable to view it because [Nurse 1] was not seated at eye level.*

10. *The panel has not heard any evidence either in written form or orally from [Nurse 1].*

11. *The registrant was not the allocated nurse for Patient B nor was she the Unit Manager at the time of Patient B's admission; both of the witnesses agreed Barbara was not the Unit manager at the point of admission for their respective relative.*

12. *[Witness 3] in his evidence confirmed that compilation of the care plan was the responsibility of the Unit Manager. He agreed this would not be the Registrant's responsibility if she wasn't in this managerial post at the point of Patient B's admission.'*

Response to the application by Mr Kewley

Mr Kewley referred to the Witness statement of Witness 1, which stated that:

'It would also appear that Barbara falsified mum's personal care records, indicating that care had been undertaken on the 17 April, when it hadn't. This can be verified via the video from Mum's room, together with comparison of a photograph of the care record that I took at 19:09 hours on 17 April, when compared with a photograph of the same care record that I took at 20:13 hours on 20 April.'

Mr Kewley submitted there is a case to answer in relation to charge 11b. He referred to Witness 1's witness statement, her oral evidence and her photographs of the care plan records of Patient A dated 17 April 2020 and 20 April 2020.

Mr Kewley submitted that that there is sufficient evidence at this stage to support the charge as it can be argued that the record was blank on 17 April 2020 whereas by the 20 April 2020 the record contained the initials '*BE*'.

Mr Kewley conceded that there is no case to answer in relation to charge 11c because there is no evidence of your signature or your initials on that day.

With regards to charge 13a and 13b Mr Kewley accepted that no care plans in relation to Patient B that have been produced in evidence. Mr Kewley submitted that the NMC takes a neutral view in relation charge 13a and 13b.

Panel decision on application of no case to answer

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

With regards to charge 11b, the panel determined that there is a case to answer based on the Witness 1's evidence and photographic evidence of the records. The panel determined that there is sufficient evidence at this stage to indicate that the initials '*BE'* were entered at some point after Witness 1 left the Home on 17 April 2020.

With regards to charge 11c, the panel took account of the NMC's concession that there is no case to answer. The panel concluded that there is no evidence that you signed or initialled the record on 20 April 2020. Accordingly, the panel determined that there is insufficient evidence to support this charge.

With regards to charge 13a the panel noted that there is evidence that when Patient B was admitted to the Home, you were not the unit manager. The panel noted the evidence of Witness 3 who stated that care plans would be prepared soon after patients come into the Home. The panel also took into account that it has not been supplied with any copies of any care plan and only some unsupported hearsay evidence as to what it may have contained. Therefore, the panel determined that during the relevant period there was insufficient evidence to support the allegation that you were responsible for producing a care plan.

With regards to charge 13b, the panel noted the evidence of Witness 2 who stated that she did not have sight of the care plan or its contents during her discussion with another nurse in January 2020 or any time during Patient B's stay at the Home. Therefore, in the absence of any reliable evidence of a care plan and its contents and evidence from that other nurse, the panel determined that there is insufficient evidence to support this charge.

Accordingly, the panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charges 13a and 13b proved.

Decision and reasons on application to amend charge 11b

During the course of the panel's deliberations at the no case to answer stage, it considered that the evidence relating to the date was unclear and invited representations from the parties as to whether it would be fair to amend the charge at this stage in order to reflect the evidence by adding the words '*on or around'*.

'That you a registered nurse:

11)Falsified patient records for Patient A on:

b) **On or around** 17 April 2020 by signing their personal care chart to show personal care had been administered when it had not'

Mr Kewley submitted that the panel's proposal is technically a correct reflection of the sequence of the evidence and that it does not alter the alleged underlying misconduct at charge 11b.

Ms Maqboul objected to the application and submitted that due to stage the proceedings had reached it was a very late application. She conceded that this amendment technically does not alter the nature of the charges you face but an application at this late stage is unfair.

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

The panel determined that such an amendment was in the interest of justice. The panel was satisfied that there would be no unfairness to you and no injustice would be caused to either party by the proposed amendment because the amended charge better reflects the evidence. It was therefore appropriate to amend the charge to ensure clarity and accuracy.

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

During the course of your oral evidence, Ms Maqboul made a request that the parts of this case which involve reference to your [PRIVATE] be held in private. The application was made pursuant to Rule 19.

Mr Kewley submitted that he did not oppose the application.

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

The panel determined to hold in private the parts of this hearing that involved reference to your [PRIVATE] as and when such issues were raised, in order to protect your privacy. It was satisfied that this course was justified and that the need to protect your privacy outweighed any prejudice to the general principle of public hearings.

Preliminary matters on the withdrawal of your admission to charge 10a and 10b

At the outset of the hearing you were asked, pursuant to Rule 24(4)(a) whether you wished to make any admissions as to any of the facts on which the charges against you were based. You made admissions to the allegations at charges 1, 2, 3, 7a, 7b)i, 7c, 7d, 7e, 7f, 7g, 7h,10a and 10b.

The Chair then announced that those facts had been found proved pursuant to Rule 24(5).

Subsequently and during the course of your oral evidence under oath, you appeared to deny a failure at charges 10a and 10b as it was your evidence that you did all you could do in the circumstances.

Charges 10a and 10b alleged that:

"*That you, a registered nurse:*

10) When deficiencies in care were raised, failed to act on some or all of the following:

a) staff failure to conduct toileting plan.

b) *staff failure to conduct incontinence pad checks.*"

There was no formal mechanism in the Rules to deal with the situation when a registrant wants to withdraw, amend or qualify a Rule 24(4) admission. However, the legal assessor advised the panel that any admissions to charges must be unequivocal. He advised that in light of your evidence, it may be best to withdraw your admissions to charges 10a and 10b and treat these charges as denied, after which the panel could make its own decision on the evidence it had heard.

Ms Maqboul submitted that she agreed with the legal assessor's advice.

Mr Kewley had no objection to the legal assessor's advice.

The panel determined to allow you to withdraw your Rule 24(4) admissions to charges 10a and 10b and that in such circumstances, the Chair's Rule 24(5) announcement in respect of these charges was no longer valid or binding.

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 Kewley on behalf of the NMC, and by Ms Maqboul on your behalf.

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: Daughter of Patient A;
- Witness 2: Daughter of Patient B; and
- Witness 3: Regional Manager and Clinical Nurse Specialist for Dementia at Community Integrated Care (CIC) at the relevant time.

The panel also heard evidence from you under affirmation.

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 both the NMC and you.

In making its decision on the charges, the panel bore in mind that you were the Unit Manager at the time of the allegations. It noted your evidence that you had completed an online managerial course, although this was not specific to your particular role. The panel considered that beyond your managerial role, you still had the duties and responsibilities of a registered nurse. The panel noted that you told them that you had

no qualifications for or experience of being in a management role and you have been told at interview that you would be given support and training.

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

Charge 4

That you, a registered nurse:

4) Did not ensure suitable signage was in place at external doors during the COVID pandemic lockdown

This charge is found proved.

In reaching this decision, the panel first took into account Witness 2's oral evidence. She told the panel that she had received a phone call from you on 23 April 2020 in which you had notified her that her mother, Patient B, had tested positive for COVID-19. Her witness statement dated 5 July 2022 stated:

> '*There were no signs around the outside of the front or the porch area or doorway to advise wearing of PPE and sanitising hands. When I raised this with Barbara, when she phoned to confirm Mum was covid positive, I brought it up with her. She went and had a look, agreed and put one notice up on the external door window.*'

The panel noted your explanation that the residents at the Home removed the COVID-19 signage as you had previously found posters in residents' rooms. However, you did not dispute being prompted by Witness 2 about the lack of signage at the external doors. You accepted in oral evidence that it was your responsibility to identify that the signage was not in place at the point of entry at the Home before it had been raised by Witness 2.

Witness 3 told the panel in oral evidence that he was responsible for heading up the covid response for the operations team and with care homes. He was therefore aware of very strict and specific policies and procedures about signage during lockdown. He confirmed that there were four signs that should have been placed on the external doors and that these packs were emailed to the individual email addresses of managers including unit managers. He also confirmed that he was aware that the signs had been put up in the other parts of the Home.

In evidence, you told the panel that you did not receive the email. You accepted that you had received the internal posters but none for the external door, which you stated had been brought over by the admin team from the other unit.

The panel had sight of the two photographs of the Home's external doors which showed that there was no signage relating to the COVID-19 pandemic in place, although other posters were in place on the wall behind the external door. On this basis, the panel considered that it was unlikely that the COVID-19 signage had initially been in place at the external doors and subsequently taken down by residents or anyone else, as you had suggested.

The panel considered that you knew it was your duty to ensure suitable signage was in place at external doors during the COVID-19 pandemic lockdown. The panel determined it was likely that this signage had been emailed to you as Unit Manager, along with clear instructions on how they were to be put up, and there was clear evidence before the panel to suggest that it was more likely than not that the signage had not been put up.

The panel therefore determined, on the balance of probabilities, that you did not ensure suitable signage was in place at external doors during the COVID pandemic lockdown.

Charge 5a

That you, a registered nurse:

4) Did not ensure there were sufficient supplies of medication namely:

a) Patient A's Rivaroxaban on 1 March 2020

This charge is found proved.

In reaching this decision, the panel took into account that on 1 March 2020, you were the Unit Manager at the Home, the nurse in charge on the shift and Patient A's named nurse.

The panel had regard to Witness 1's witness statement dated 4 July 2022 which stated:

> '*At the start of 2020, we had further concerns with Mum's care that we raised directly with Barbara, who had now been promoted to the role of Unit Manager on*
> *Haydock Suite.*
>
> - *…*
> - *1 March 2020 – Mum's anticoagulant, Rivaroxaban, was allowed to run out, with little attempt made to replenish. Resulting in my sister and I having to contact the GP on 4/03/20 to request a repeat prescription, which we then collected, together with the medication.*
> - *...*'

The panel also had regard to Patient A's Medication Administration Record (MAR) chart which showed that Rivaroxaban had not been administered to Patient A on 2 and 3 March 2020. The panel considered that this was consistent with Witness 1's account that the medication had run out and that she and her sister had to request a repeat prescription and collect the medication from the pharmacy.

The panel had heard evidence from you that Patient A's prescription required transportation to the General Practitioner (GP) as Patient A had a different GP to the rest of the residents at the Home. The panel noted the overview of Patient A's medical history, which indicated that she had been prescribed Rivaroxaban as a result of having suffered an '*unprovoked massive bilateral pulmonary emboli in 2014*'. The panel was of

the view that in light of the difficulties around reordering Patient A's medication (due to her having a different GP), measures should have been put in place to ensure that adequate supplies were in place and that this important medication did not run out. As Unit Manager and named nurse for this patient, the panel determined that it was your responsibility to ensure that these processes were in place.

You told the panel in oral evidence that the nurse who noticed that the medication had run out would have been responsible for reordering it. However, you also accepted in oral evidence that it was your responsibility to check Patient A's medication supplies and ensure there were sufficient supplies of medication for her.

The panel was satisfied that as Patient A's named nurse, you were responsible for ensuring that there were sufficient supplies of her Rivaroxaban on 1 March 2020. It took into account there was no dispute that Patient A's Rivaroxaban had run out on 1 March 2020, and that it had not been administered to Patient A until it was reordered by her daughters on 4 March 2020.

The panel was therefore satisfied on the balance of probabilities that you did not ensure there were sufficient supplies of Patient A's Rivaroxaban on 1 March 2020.

Charges 6 and 13e

That you, a registered nurse:

6)Did not ensure there were sufficient supplies of food for Patient B by allowing their food supplies to run out

and

That you, a registered nurse:

13)Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

e) Did not inform their family when drink provided by the family had run

out

These charges are found not proved.

The panel considered each of these charges separately. It noted that both charges cover the same subject matter.

In reaching this decision, the panel took into account Witness 2's witness statement dated 5 July 2022 which stated:

> '*As a family, our main concern was around Mum's fluid and food intake. At the beginning of April 2020, we received a phone call to say they had called the GP, as Mum wasn't very well. The doctor diagnosed a urinary tract infection (UTI). During the call with the nurse, I questioned if Mum still had her favourite drink to assist with fluid intake, they advised it had all gone and when I asked why we hadn't been advised so we could get her more, they didn't know. When I took the juice the following day, I also took Mum's custard, yoghurts and jelly pots as we were advised that the cupboard was bare, as the food we had previously supplied, had all gone. This prompted me to ask the staff if Mum was only being fed the extra food we'd provided and nothing more. This was very worrying as we had noticed on our visits prior to lock down that it had become a regular occurrence that mum was not being offered food, she was only being fed what we called 'as & when' food daily. I raised these concerns with Barbara at the door, she was not happy at all that we had been told by the night staff of this, when she returned into the building and shut the front door we could hear her from outside, shouting at the staff asking why [Patient B] hadn't been fed food from the kitchen.*
>
> *…*
>
> *On occasions, there was nothing suitable to feed Mum so I would have packet food in the cupboard or go to the shop to purchase suitable food. We did witness many of the residents not eating their evening meals because the food was so awful. My family made and Barbara aware of this and asked if they could do something. It was promised that things would improve but again it never did. We*

never witnessed them offering alternative food to the residents. The management of CIC were very concerned and admitted they should have gone and purchased suitable food. They could see no excuse why this didn't happen.'

You told the panel that all information and communication relating to Patient B was conducted through the night staff, and that you had been instructed not to communicate with Patient B's family.

Witness 2 told the panel that her family voluntarily provided food and drink for Patient B which was kept in her cupboard as a "*top up*" to the food provided by the Home, as she was concerned that her mother was being offered food that she did not like. The panel noted that the food placed in Patient B's cupboard by her family was not her sole source of food at the Home. There was no evidence before the panel to suggest that the food provided to Patient B by the Home ran out at any stage.

The panel therefore found charge 6 not proved.

The panel was provided with no evidence that there was a duty on the Home to inform Patient B's family when food and drink supplied by the family had run out. Therefore, the panel was not satisfied that there was any duty on you to inform the family when drink had run out.

The panel therefore found charge 13e not proved.

Charge 7b)ii

That you, a registered nurse:

7) Did not ensure appropriate nursing care was provided to Patient A between 15 March 2020 and 22 April 2020 in that:

b) Did not provide sufficient information to paramedics and / or hospital on 7 April 2020 following a suspected stroke as you did not:

ii) Inform the hospital of the previous diarrhoea

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement dated 4 July 2022 which stated:

> '*The Paramedics asked Barbara for the necessary documents to take with them to A&E and I saw her hand them an A4 sized red wallet, allegedly containing key documents to assist with Mum's admission at hospital. However, upon arrival at A&E, the paramedics informed me that the envelope contained only Mum's DNR form; they were astounded at the lack of information provided by Barbara, Care Home Manager and nursing staff. This information was essential as I was not able to accompany Mum into the hospital due to Covid-19 restrictions and she would not have been able to provide any information herself due to her dementia. I am also of the opinion that Barbara failed to inform A&E about the x3 diarrhoea that mum had experienced prior to fainting on the toilet, which they should have been made aware of.*'

The panel had regard to Patient A's toileting chart for the period between 6 April 2020 and 7 April 2020. This record indicated that Patient A had three instances of a '*Type 6*' stool (which can indicate diarrhoea according to the '*Bristol Stool Chart*') prior to being taken to hospital on 7 April 2020. The panel considered that there was clear documented evidence that Patient A had Type 6 stools. This was information that you should have reviewed by checking the patient's notes yourself and shared with the paramedics.

The panel therefore concluded that on the balance of probabilities, you did not ensure appropriate nursing care was provided to Patient A in that you did not provide sufficient information to paramedics and/or the hospital on 7 April 2020 following a suspected stroke by informing them of Patient A's previous diarrhoea.

Charge 7b)iii

That you, a registered nurse:

7) Did not ensure appropriate nursing care was provided to Patient A between 15 March 2020 and 22 April 2020 in that:

b) Did not provide sufficient information to paramedics and / or hospital on 7 April 2020 following a suspected stroke as you did not:

iii) Inform the hospital of the previous fainting

This charge is found not proved.

In reaching this decision, the panel took into account Witness 1's witness statement dated 4 July 2022 which stated:

> '*At 10:19 on 7 April 2020, I received a call from Barbara; she stated she believed my mum had suffered a "massive stroke". She informed me that she had called for an ambulance and invited me to attend at the care home. I was informed that care staff had found Mum unresponsive and slumped on the toilet…*
>
> *The video from mum's room identifies Barbara at 09:23, speaking on the telephone, requesting an ambulance…*
>
> *The Paramedics asked Barbara for the necessary documents to take with them to A&E and I saw her hand them an A4 sized red wallet, allegedly containing key documents to assist with Mum's admission at hospital. However, upon arrival at A&E, the paramedics informed me that the envelope contained only Mum's DNR form; they were astounded at the lack of information provided by Barbara, Care Home Manager and nursing staff. This information was essential as I was not able to accompany Mum into the hospital due to Covid-19 restrictions and she would not have been able to provide any information herself due to her dementia…*'

The panel noted that Witness 1, in her oral evidence, confirmed that she did not hear your full telephone conversation with the ambulance service or the paramedics. Witness 1 was therefore unable to provide evidence about the complete conversation that you had with the ambulance service or paramedics. The panel also noted that it has not

been provided with any evidence from the ambulance service or hospital, nor any medical records to support this charge.

You told the panel in oral evidence that you had advised the paramedics that Patient A had been found unresponsive and did not draw a distinction between whether she had '*fainted*' or whether she was '*unresponsive*'.

The panel therefore found this charge not proved.

Charges 8, 9a and 9b

That you, a registered nurse:

8)Failed to ensure personal care was provided to Patient A on some or all of the following dates: 6, 9, 10, 17 April 2020

9)Failed to ensure oral care was provided to Patient A on:

a) 6 April 2020

b) 8-17 April 2020

These charges are found proved.

The panel considered each of these charges and sub charges separately. It considered them together for the purposes of this determination because they cover the same subject matter.

In reaching this decision, the panel took into account that in April 2020, you were the Unit Manager at the Home, the nurse in charge on the shift and Patient A's named nurse. The panel considered that given those responsibilities you had a duty to ensure that personal and oral care was provided to her.

The panel noted Witness 1's witness statement dated 4 July 2022 which stated:

> '*I also noted upon reviewing the video footage that Mum was left in bed all day on 6 April, contrary to normal routine. Mum's room remained in darkness until the*

curtains were opened at 09:28. Mum was given breakfast and lunch in bed, contrary to normal routine. She was not taken to the toilet, contrary to normal routine. The personal care chart was not completed. Pain relief patches had not been removed from her left shoulder on 5 April, thereby preventing accurate pain relief being given on 6 April. No one from the nursing home contacted us on 5 April or 6 April to notify us of any issues regarding Mum's wellbeing, nor to offer any explanation for the error in pain relief, or the sudden change to her normal routine.

…

Mum did not have false teeth; she had lovely teeth and visited the dentist regularly prior to going into Haydock Suite. We ensured that her teeth were cleaned during our visits. The records show that between 1 and 17 April 2020 she did not receive any personal care on the 6, 9, 10 and 17 April. Nor, any oral hygiene care on 6 April or between 8 and 17 April onwards. To leave an elderly, vulnerable adult without oral care for over 10 days is unacceptable.

…

On the eve of my mum's death, I could see black inside her mouth and gums. It appeared to be something rotting. However, I could not probe for fear of hurting her. I believe this black substance may be connected to the lack of oral hygiene.'

Witness 1 told the panel that in relation to oral care, when she next visited the Home and looked in her mother's mouth, she saw poor oral hygiene.

The panel had regard to Patient A's personal care record where no entries were made to indicate that personal care had been given on 6, 9, 10 and 17 April 2020. In addition, there were no entries to indicate that oral care had been given on 6 April 2020 and between 8 and 17 April 2020. There was no information before the panel to suggest that personal or oral care had been given to Patient A on those particular dates.

In oral evidence, you told the panel that you did not personally administer personal and oral care to Patient A and that this was administered by the carers.

The panel also noted the account you provided in your undated '*Reflection on my Management Failings and Documentation*' document:

> '*I failed resident A I did not check that appropriate personal care was given, yet when asked I signed to say it had been given. This has will have caused the family of resident A so much heart ache they put their loved one in my care expecting at the very least basic care. I let them down and for that I cannot apologise enough, if I was resident A family I would of expected the best for my loved one. I would not expect the person in charge to have signed to say they been assisted with personal care. If I could tell the family direct I am so sorry I now that would not be enough as I would feel the same. At times resident A had all personal care completed whilst in the bathroom and not in her room, I should of checked and documented where it was done but I didn't. I have changed I am a nurse and if I was ever in that situation ever again I would be informing everyone, I would be shouting for support. But one thing for sure I will never let myself be in such a position ever again. I will motivate, influence and support the staff and myself.*'

The panel was satisfied that you had a duty to ensure that personal and oral care was provided to Patient A, and there was clear evidence that this was not administered on the relevant dates in April 2020. You also accepted failure in respect of ensuring that personal and oral care was provided to Patient A at the time.

The panel therefore determined that on 6, 9, 10, 17 April 2020, you failed to ensure personal care was provided to Patient A, and that on 6 April 2020 and between 8 and 17 April 2020, you failed to ensure oral care was provided to Patient A. The panel found charges 8, 9a and 9b proved.

Charge 10

That you, a registered nurse:

10) When deficiencies in care were raised, failed to act on some or all of the following:
    a) staff failure to conduct toileting plan.

b) staff failure to conduct incontinence pad checks.
c) Staff falsification of incontinence pad check records
d) Staff failure to adhere to the night monitoring plan.

This charge is found not proved in its entirety.

The panel considered each sub charge separately.

In reaching this decision, the panel considered that as Unit Manager, you had a duty to act when deficiencies in care were raised to you.

Witness 1's witness statement dated 4 July 2022 which stated:

'*At the start of 2020, we had further concerns with Mum's care that we raised directly with Barbara, who had now been promoted to the role of Unit Manager on Haydock Suite.*

- *…*
- *23 February 2020 – agency staff not visually checking Mum's incontinence pad*
- *...*
- *11 March 2020 – staff failing to conduct pad checks overnight. Then when challenged, retrospectively completing the care charts with false information.*'

Witness 1 confirmed in evidence that she raised these concerns with you, and you did not dispute this account.

You told the panel that you had done everything you could to address the issues raised with you, by addressing the concerns with the carers at the Home, the Manager of the Home (Mr 1) and the Regional Manager (Ms 2). You said that you "*could not do anymore than [you were] doing*". You stated that you may have recorded these actions in your diary, however this diary was not available to the panel.

The panel has not heard any evidence to contradict your account and there was nothing before the panel to suggest that you did not raise these concerns with those listed above.

The panel therefore found all four sub charges not proved.

Charge 11a

That you, a registered nurse:
11) Falsified patient records for Patient A on:
    a) 6 April 2020 by signing their MAR chart to show a lidocaine patch was administered when it was not.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's MAR chart which showed that Patient A was prescribed '*Ralvo*' (lidocaine patches). The panel noted that the MAR chart had been signed on 6 April 2020 at 10:00 with the initials '*BE*' to show that the lidocaine patch had been administered. You accepted in oral evidence that you made this entry.

Witness 1's evidence was that when she watched the footage from her mother's room, she noticed that the lidocaine patch had not been administered and that the previous patch had been left on too long. The panel had sight of the screenshots of the footage from Patient A's room on 6 April 2020. The description on the screenshots, entered by Witness 1 who stated that she had viewed the footage, indicated that there was '*no video evidence to support that the patches were applied at any time on 6/4/20*'.

The panel had regard to the account in your undated '*Reflection on my Management Failings and Documentation*' document that:

> '*I cannot remember signing for things that had not happened or for medication but I obviously did this it was my job to ensure that everything was documented.*

…

Signing for medication not given Lidocaine patch, I cannot remember a time I have done this, but obviously at this time I did, this is a legal medical documentation and I do not know where I went wrong with this I can only think did I put it on in the bathroom ?'

In oral evidence, you initially stated that you did not have much recollection of this incident on 6 April 2020. You then went on to outline a version of events in which you recalled signing the MAR chart before the carers came back to explain to you that the lidocaine patch could not be administered. You told the panel that at that stage, you knew the lidocaine patch had not been administered, but still did not update Patient A's MAR chart to record the error. You accepted in cross-examination that you could not have known when Patient A was given the lidocaine patch when you signed the MAR chart. You also acknowledged that you should have returned to amend the record to show that an error had been made on the MAR chart.

The panel considered that your accounts in respect of this allegation were inconsistent, and that one of these accounts amounted to an acceptance of your culpability.

The panel determined that when you signed Patient A's MAR chart to show that a lidocaine patch had been administered on 6 April 2020, you knew that it had not been administered. The panel considered that by signing the MAR chart you were indicating that the lidocaine patch had been administered when in fact it had not, and this would be misleading to anyone reading the chart.

The panel therefore concluded on the balance of probabilities that on 6 April 2020, you falsified Patient A's patient records by signing her MAR chart to show a lidocaine patch was administered when it was not. Applying the standards of ordinary decent people your conduct would be seen as dishonest.

Accordingly, this charge is found proved.

Charge 11b

That you, a registered nurse:

11)Falsified patient records for Patient A on:

b) On or around 17 April 2020 by signing their personal care chart to show personal care had been administered when it had not

This charge is found proved.

In reaching this decision, the panel took into account the images of Patient A's personal care record for April 2020. The first image (which was taken at 19:09 on 17 April 2020), had no entries for 17 April 2020, indicating that no personal care had been administered that day. The second image (which was taken at 20:13 on 20 April 2020) had been signed with the initials '*BE*' for '*wash*' and '*skin checked*' for 17 April 2020. The panel accepted that Patient A's personal care record had therefore been signed between 19:09 on 17 April 2020 and 20:13 on 20 April 2020.

Witness 1 told the panel that she viewed the footage of her mother's room on 17 April 2020, and she confirmed that no personal care had been administered to her mother on that date.

The panel noted your undated '*Reflection on my Management Failings and Documentation*' document which stated:

> '*I failed resident A I did not check that appropriate personal care was given, yet when asked I signed to say it had been given. This has will have caused the family of resident A so much heart ache they put their loved one in my care expecting at the very least basic care. I let them down and for that I cannot apologise enough, if I was resident A family I would of expected the best for my loved one. I would not expect the person in charge to have signed to say they been assisted with personal care… At times resident A had all personal care completed whilst in the bathroom and not in her room, I should of checked and documented where it was done but I didn't.*'

In oral evidence you stated that you had never seen this personal care record. You accepted that your initials were '*BE*', but denied making this particular entry on Patient A's personal care record for 17 April 2020, as this entry did not match your own handwriting. This account was inconsistent with your written reflection.

The panel considered it unlikely that another member of staff would have made the entry of '*BE*' on Patient A's personal care record on or around 17 April 2020. It had heard no evidence of any staff in the Home with the initials *'BE'*. Neither had it seen or heard any suggestion of an agenda from any of the witnesses that would indicate malice towards you. The panel considered that there was no plausible or reasonable explanation as to why someone else would have falsified your initials on Patient A's personal care record. The panel determined that it was more probable that you did sign your initials on Patient A's personal care record on or around 17 April 2020.

The panel determined that when you signed Patient A's personal care chart to show that personal care had been administered on or around 17 April 2020, you knew that it had not been administered. The panel considered that signing the personal care chart suggested that it had been done, which would mislead anyone reading the chart.

The panel therefore concluded on the balance of probabilities that on or around 17 April 2020, you falsified Patient A's patient records by signing her personal care chart to show personal care had been administered when it had not. Applying the standards of ordinary decent people your conduct would be seen as dishonest.

Accordingly, this charge is found proved.

Charge 12

That you, a registered nurse:
12)Failed to respect Patient A's religious beliefs upon death

This charge is found not proved.

In reaching this decision, the panel took into account the context of the COVID-19 pandemic and national lockdown at the time of Patient A's death.

The panel noted that you were not on duty at the time of Patient A's death. It considered that there would have been other nursing staff on duty who would have had responsibility for managing the situation of Patient A's death, dealing with her religious preferences and arranging her last rites.

You told the panel that you made several attempts to get faith representatives to visit the Home during the pandemic, but the Home had been "*struggling to get people in*" even before the COVID-19 lockdown.

The panel had not been provided with any of Patient A's end of life care planning documentation, or any other clear or reliable record as to what was discussed or agreed about Patient A's wishes upon death.

The panel therefore determined that whilst you may not have arranged religious provision in preparation for Patient A's death, this did not amount to a failure to respect Patient A's religious beliefs upon death.

The panel was therefore not satisfied that the NMC had discharged its burden in respect of charge 12, and therefore found the charge not proved.

Charge 13c

That you, a registered nurse:

13) Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

c) Provided information to the GP for a DNAR (do not attempt resuscitation) notice to be put in place without consulting family.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and your oral evidence.

The panel considered the evidence of Witness 2. The panel noted that in Witness 2's oral evidence she referred to a face to face conversation where she had been asked in the corridor if her mother became seriously ill and required end of life care, would she want her mother to be taken to hospital to pass away or would she prefer her mother to stay at the Home. She confirmed that she had told you that she wanted her mother to stay in the Home, to be comfortable, in those circumstances. The panel noted that Witness 2 also stated that you had telephoned her after speaking to the doctor.

The panel took into consideration that Witness 2 received a letter, dated 7 September 2020, from the GP which states *"[Patient B] already had a DNAR when she joined our practice after moving to Eccleston Court Care home. From the notes it looks like it was put in place during a hospital stay in September 2017. I issued a new DNAR with her new address on in November 2019.It was felt that she was becoming nearer to the end of her life as she was becoming increasingly sleepy and taking less food and drink I prescribed some "just in case" meds in case she was unable to take oral medication as was in pain or agitated."*

The panel considered your evidence that you had explained to Witness 2 what a DNAR was and that *"it's only if she has a fall and breaks a bone, or if her heart stops working, then we use it. If it's anything work going into hospital and having antibiotics or having fluids, then should go. That's what happens. It's not for keeping her there and just waiting. If she can be fixed in hospital, she will go to hospital."* You said that you could not recall if this conversation took place in the corridor at the Home. You also clarified that *"apart from me having the conversation, the GP also has to speak to the families before they sign the DNR, as they have to speak to the family member."* You stated that you felt Witness 2's response to this conversation *"was like, alright, so is she expected to pass now?"* and you said *"no, it's in place in case anything happens in the future."*

The panel considered the evidence before it. It was clear from the GP's letter that a DNAR had been in place for some time before Patient B's arrival at the Home. The

panel was satisfied that a conversation had taken place between you and Patient B's family, but that there appeared to be some confusion about the purpose of the DNAR as opposed to end of life care. The panel determined that you had provided information to the GP for an updated DNAR notice to be put in place and had consulted the family before doing so. The panel therefore found this charge not proved on the balance of probabilities.

Charge 13d

That you, a registered nurse:

13) Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

d) Did not ensure they were offered food regularly

This charge is found not proved.

The panel noted that you were not the named nurse for Patient B however as Unit Manager you would have overall responsibility for making sure that Patient B was being offered food regularly.

In reaching this decision, the panel took into account Witness 2's witness statement dated 5 July 2022 which stated:

> '… *Mum didn't always take a drink or food when she was offered it, so we had requested and her GP had instructed that she should be offered both, little and often.…*
>
> *As a family, our main concern was around Mum's fluid and food intake. … This was very worrying as we had noticed on our visits prior to lock down that it had become a regular occurrence that mum was not being offered food, she was only being fed what we called 'as & when' food daily. I raised these concerns with Barbara at the door, she was not happy at all that we had been told by the night staff of this, when she returned into the building and shut the front door we could*

hear her from outside, shouting at the staff asking why [Patient B] hadn't been fed food from the kitchen.

Following this incident, we were much more vigilant about asking what Mum had eaten daily. Around 13-14 April 2020, Health Care Assistant [HC]*…, telephoned with an update…. I then asked* [HC] *what Mum had eaten that day and when* [HC] *looked at the care sheet for that day there was no entry. Mum had not been offered food, therefore she hadn't eaten or been offered fluids all that day*.'

Witness 2 told the panel that the Home was not offering food to Patient B regularly.

However, the panel has been provided with some of Patient B's food and fluid charts in February, March and April 2020 which detailed the times she was offered food and drink, what food and drink she was offered and in some instances, when she refused to accept food and drink. The panel was therefore satisfied that it was more likely than not, based on the charts provided, that Patient B was offered food regularly.

The panel also had regard to the working notes from the CIC Investigation report. It noted that on 22 January 2020, Patient B's GP had approved her being '*offered food and drink little and often*'. The CIC investigation report stated that over the following days, the records showed that staff were offering food to Patient B little and often.

The panel was therefore not satisfied that the NMC had discharged its burden of proof in relation to charge 13d. The panel therefore found this charge not proved.

Charge 13f

That you, a registered nurse:

13) Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

f) Did not inform their family regarding injuries to their foot

This charge is found not proved.

In reaching this decision, the panel took into account that there were two incidents which relate to this charge, one in January 2020 and April 2020. It took into consideration that you are not the named nurse for Patient B however it acknowledged that you were the Unit Manager.

The panel considered the evidence of Witness 2. In her NMC witness statement, she said of the first incident, *"Around 13 January 2020, my brother … visited Mum and Barbara showed him a skin lesion on Mum's foot. She explained it had been found the previous day, but we were not contacted. [He] took a photograph and sent it to me... I asked [him] to ask Barbara why the chiropodist hadn't attended to Mum when she visited the home earlier in the week, why she hadn't noticed, or been informed, of the dry scabbed skin on the bottom of Mum's foot. I also asked [him] to ask why the foot cream Mum was prescribed by the Doctor wasn't applied. Barbara had no answers."* The panel took into consideration that Witness 2's oral evidence was consistent with this account but that her evidence in respect of this incident was hearsay evidence.

In relation to the second incident Witness 2 said in her witness statement, *"Around 13-14 April 2020, Health Care Assistant [Ms 3], telephoned with an update… [Ms 3] called and advised that Mum had another small lesion on her foot. This was Tuesday evening and it had been detected over the weekend. Barbara at no time called to advise us, although we had been assured it was written in mum's file - there was no excuse for us not to have been informed."*

The panel considered the evidence before it. The panel took into consideration the wording of the charge which did not specify a timeline of when the family should be notified of Patient B's injuries. The panel bore in mind that Patient B's family had been informed of her injuries within a few days of them being discovered.

The panel therefore found this charge not proved.

Charge 13g

That you, a registered nurse:

13) Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

g) Did not treat injuries to their foot

This charge is found not proved.

The panel noted that you were the Home Manager at the time and had a responsibility for all patients in the unit. The panel took into consideration that you were not the named nurse for this patient.

The panel noted that it had not been provided with Patient B's Medical Records, Body Map and Topical Medicines Application Record.

The panel had regard to the photograph of Patient B's injury to her foot. However, it noted that there was no evidence from any independent medical or health professional detailing the nature or extent of the injury or the appropriate course of treatment. The panel also took into consideration that it did not have the Home's skincare protocols for dry skin and pressure ulcers on how this should be dealt with.

In your oral evidence you said that this appeared to be hard skin on Patient B's foot which went soft when the cream was applied and did not break. You also noted that the blackness around it had gone. You stated that you were off from work when this injury had been found on Patient B's foot.

The panel noted that Investigation Notes supported your account that cream had been applied to Patient B's foot following the injury being found.

The panel therefore determined that the NMC has not discharged its burden of proof in respect of this charge. The panel therefore found this charge not proved.

Charge 13h

That you, a registered nurse:

13)Failed to provide suitable care or ensure that suitable care was provided for Patient B in that:

h) Administered a COVID test when it was inappropriate to do so

This charge is found not proved.

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

The panel considered your evidence that you did not carry out the COVID test on Patient B and that you were unaware that Public Health England (PHE) had come to the Home as you were in a meeting. You stated that you were only told of the testing after the meeting.

The panel took into consideration the 'Notes from the meeting with Patient B's family' dated 31 July 2020 which supported your evidence. The notes record that Witness 4 told the patient's family that it was PHE who made the decision to do the COVID test. This is also supported by the 'Working Notes of the Investigation' which states *"At the time any symptoms of Coronavirus were shared with Public Health England and testing was a decision of theirs. When the service contacted PHE they indicated that they would be testing everyone in the home. In the event they only tested 7 people"*

In oral evidence Witness 2 told the panel that the family later found out *"on one of the statements and from CIC that Barbara was the one who led the test."* The panel was provided with no evidence to corroborate this.

The panel considered that there is little evidence which contradicts your corroborated account. The panel therefore found this charge not proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Kewley divided the charges into two categories. The first category related to the issues regarding dishonesty and the second category related broadly to the concerns regarding patient care.

In relation to the first category, Mr Kewley identified the specific, relevant standards where your actions amounted to misconduct.

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

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.'

In relation to the second category, Mr Kewley identified the specific, relevant standards where your actions amounted to misconduct.

'1 Treat people as individuals and uphold their dignity

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:
11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.'

Mr Kewley pointed out to the panel that the dishonesty charge of not wearing PPE and the charge relating to falsification of records engaged matters of honesty, integrity and professionalism. In relation to the dishonesty charge Mr Kewley acknowledged that you

had to work during an unprecedent time of pandemic when huge restrictions were placed on the nation. However, Mr Kewley submitted that it was difficult to comprehend the reasons behind not wearing PPE when you were caring for vulnerable residents and that there was no evidence of any shortage of resources. Further, Mr Kewley submitted that you only accepted that you did not wear PPE when images of you not wearing PPE were shown to you.

Further, Mr Kewley submitted that the charges regarding the second category concerned your delivery of care which relates to basic and fundamental aspects of nursing practice.

Therefore, in all the circumstances, Mr Kewley submitted that your conduct fell far below the standards which would be considered acceptable, and that the facts found proved amount to misconduct.

Submissions on impairment

Mr Kewley 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 (Admi). He submitted that all four limbs were engaged.

Mr Kewley submitted that your conduct breached the fundamental tenets of the nursing profession, put patients at serious risk of harm and, therefore, brought the profession's reputation into disrepute.

In relation to the dishonesty charge relating to PPE, Mr Kewley pointed out to the panel that Witness 4 in her evidence said that you put your own interest first by denying what was being put to you. Further, Mr Kewley submitted that the charges relating to dishonesty and falsification of records are indicative of attitudinal concerns and that they are rather difficult to put right. He submitted it was a matter for the panel to decide how

your conduct has impacted the reputation of the nursing profession and that there is a risk of repetition which required a finding of impairment on public protection grounds.

Mr Kewley submitted that in view of the seriousness of the case, public confidence in the profession would be undermined and a finding of impairment is required on the grounds of public interest.

Having regard to all of the above, Mr Kewley invited the panel to make a finding that your fitness to practise is currently impaired on both grounds.

Finally, Mr Kewley submitted that if the panel were to find that there is no risk of repetition, considering the dishonesty and falsification charges, the panel should find impairment on public interest alone. He submitted that it is necessary to maintain public confidence in the nursing profession and to declare and uphold the proper standards of conduct expected of those on the register.

Ms Maqboul accepted that your actions amounted to misconduct and that your fitness to practice is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000], *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2007] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

‘1 Treat people as individuals and uphold their dignity

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

7 Communicate clearly.

10 Keep clear and accurate records relevant to your practice.

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, …

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.

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

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that these breaches of the Code did amount to misconduct due to the extent of the acts and omissions on your part as you were both an experienced nurse and experienced in the protocols of the Home. The panel noted the risk of harm arising from failing to provide patient care by not prioritising the safety of vulnerable residents, including in the context of the COVID-19. The panel found that the charges which were admitted and proved included three separate instances of dishonesty, not ensuring Patient A's fluid and food intake was maintained, failure to ensure personal and oral care, not providing sufficient information to family and other health professionals and not ensuring sufficient supplies of medication were serious and would be considered deplorable by fellow professionals.

The panel, therefore, concluded that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel in its assessment, determined that the four limbs of the Grant test are applicable to this case, both in terms of past actions and potential future ramifications.

The panel determined that your failures in respect of Patient A, a vulnerable resident, potentially placed that resident at an unwarranted risk of harm. The panel determined that your misconduct had breached the fundamental tenets of the nursing profession and that your actions brought the reputation of the profession into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. The panel noted that you are a very experienced nurse and there was an expectation that you should have known what was expected of you and the responsibilities your role required.

The panel then considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin). It determined that while the misconduct in this case is difficult to remediate it is capable of remediation should you choose to recognise the gravity of the misconduct findings made against you and demonstrate sufficient and appropriate insight.

The panel went on to consider whether you remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Regarding insight, the panel considered your remediation bundle prepared in connection with this hearing. The panel was of the view that the reflective statement purports to demonstrate insight into your wrongdoing. The panel acknowledges your apology and empathy towards Patient A's family. However, it is partly undermined by the fact that there is no detailed account in relation to your acts of dishonesty and falsification. It was the panel's view that your insight remains incomplete.

The panel next considered whether you have taken steps to strengthen your practice. It took into account the positive references from your supervisors, colleagues and family members of patients for whom you have cared, with no further reported concerns. The panel noted that, although evidence of some training was provided, the most recent being August 2022, much of this did not relate to the regulatory concerns. The panel did not have any evidence of recent training and, as such, it was of the view that you have not been able to demonstrate that you have strengthened your practice. However, the panel has taken into account your evidence that you are not working at the moment and have no plans to return to nursing due to [PRIVATE].

The panel noted your limited insight into the dishonesty and falsification of records charges which related to more than one incident. The panel further noted in relation to the other charges admitted/found proven, there is limited evidence that you have sufficiently strengthened your practice. In all the circumstances, the panel considered that there is a risk of repetition should you return to practice as you remain liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession.

Having regard to your actions in this case, the panel considered that members of the public and patients would expect a nurse to provide safe and effective care to patients by managing care and keeping up to date records of medication administration. The panel therefore determined that a finding of impairment is also necessary on public interest grounds.

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

Sanction

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

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

Submissions on sanction from Mr Kewley

Mr Kewley informed the panel that in the Notice of Hearing, dated 1 June 2023, the NMC had advised you that it would seek the imposition of a striking off order if the panel found your fitness to practise currently impaired. He submitted that a Striking-off order is appropriate in light of the panel's findings, and it can properly address both the public protection and public interests.

Mr Kewley submitted that the panel will be required to make an assessment on the seriousness of the dishonesty. He further submitted that your dishonesty was at the higher end of the spectrum because you were dishonest to a colleague in the context of your failure to wear PPE during COVID, which was a key part of protecting vulnerable patients. He also submitted that you thereby prioritized your own interest, and this raised fundamental questions about your integrity. Furthermore, the dishonesty charges relating to the falsification of patient records involved you giving misleading impression to anyone reading the patient records. Accordingly, the dishonesty charges were all related to your clinical practice. Mr Kewley pointed out to the panel that your dishonesty was not a one-off incident or an isolated one.

Mr Kewley submitted that this case involved failings in relation to basic and fundamental aspects of providing care to a patient who was reliant on you to ensure that she received the care to which she was entitled. He added that the patient was to some extent left in a rather undignified position by virtue of not receiving their basic needs and fundamentals of care.

With regards to sanction, Mr Kewley submitted that pragmatically looking at this case taking no action or imposing a caution order or conditions of practise order would not be appropriate. He further submitted that a suspension order would not be sufficient in terms of public protection and public interest due to the seriousness and repetitive nature of the dishonesty charges and the panel's findings about the lack of insight at the impairment stage.

Mr Kewley acknowledged your most recent reflective piece and submitted that it is a matter for the panel to assess the level of your insight. However, he submitted that your reflective piece demonstrated late developing insight, after denying that it was your signature on the care charts. In relation to strengthening of practice, Mr Kewley submitted that the panel found limited evidence at the impairment stage and that there is ongoing risk of repetition and consequently risk of harm to the public.

Taking account of all the above, Mr Kewley submitted that your misconduct is too serious to be met with temporary removal from the register since it involves multiple

instances of dishonesty along with fundamental failings concerning provision of patient care. Therefore, Mr Kewley submitted that a suspension order would be insufficient to protect the public, but also would not mark the serious nature of the misconduct in this case.

Finally, Mr Kewley emphasized that that it is entirely a matter for the panel's own professional judgement as to what sanction meets both the public protection issues in this case and also the public interest considerations. However, he submitted that it is the NMC's view that the only appropriate sanction in this case would be of a striking off order.

Response on sanction from Ms Maqboul

Ms Maqboul submitted that ultimately it is a matter for the panel and that it is accepted by you that the panel will either be looking at a suspension or a striking-off order.

Ms Maqboul drew the panel's attention to your reflective piece and the panel's view at the impairment stage that '*it is capable of remediation should you choose to recognise the gravity of the misconduct findings made against you and demonstrate sufficient and appropriate insight'*.

Ms Maqboul submitted that you accepted that the misconduct involved vulnerable patients and that in relation to dishonesty charges there was a direct risk to patients. Ms Maqboul submitted that your conduct was less serious since your dishonesty did not involve any financial gain. She further submitted that you have shown remorse for your actions.

Ms Maqboul highlighted your career history since your qualification in 2008 and drew the panel's attention to the fact the concerns were only raised when you progressed to a management role. On that basis, Ms Maqboul submitted that the panel could safely conclude that the incidents were isolated since prior to that no concerns had been reported to the regulator regarding your practice.

Ms Maqboul submitted that you have accepted your errors and the panel's determination regarding facts and impairment. However, she requested the panel to consider the fact that the incidents happened during COVID when the country was in dealing with an unprecedented situation. Ms Maqboul conceded that you are not suited to management responsibilities.

Ms Maqboul further submitted that reflection is an on-going process and she conceded that your insight is at an early stage and that you are a very different person since the commencement of the proceedings in 2020.

Ms Maqboul asked the panel to consider suspension with a requirement to complete a further reflective piece towards the end of any suspension order for a future panel to consider how your insight might have developed.

Finally, Ms Maqboul informed the panel that due to your [PRIVATE] you have no intention to return to practise as a nurse, but it would be a great shame if you were to leave the profession with that very dark cloud of strike-off hanging over you and requested that the panel to give you a final opportunity.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Three distinct incidents of dishonesty.
- Conduct which put vulnerable patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Early admissions to some of the charges including one of the three dishonesty charges.
- Lack of staff and management support during COVID.
- Remorse and several positive testimonials which attest to your character and clinical practice.

The panel first 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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Further, you have made it very clear that [PRIVATE] will prevent you from working as a nurse again. In addition, some of the misconduct identified in this case was not of a nature that can be readily addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your 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 is satisfied that there is no evidence of a repetition of behaviour since the incident and the remaining factors are not applicable in your case.

The panel in its assessment found that your conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Particularly, the panel noted that the misconduct was not an isolated incident but a course of conduct which included failures in basic patient care along with charges relating to three separate incidents of dishonesty towards the upper end of the scale.

During the course of these proceedings, you have provided the panel with two reflective statements. One of these statements was provided prior to commencement of the hearing, the second after the finding of impairment. Although the panel acknowledges that reflection is an ongoing process it considered that your current insight is developing slowly but remains incomplete and difficult to discern. For example, in your most recent reflection regarding Charge 11a) you accept that you do not really understand why you did this. Furthermore, the panel noted in relation to Charge 11b) in your first reflective statement you stated that you could not remember signing for things that had not happened or for medication. You also stated, '*I did not check that appropriate personal care was given, yet when asked I signed to say it had been given'*. In evidence you stated that it was not your signature, however, in your most recent reflective piece you

state that you had signed the personal care record on behalf of a colleague who had gone home without completing the records. Therefore, despite giving consideration to the various accounts in your reflective statements, the panel was not satisfied that you have demonstrated complete insight.

The panel further noted the other charges which related to basic patient care. This included failures to ensure Patient A's fluid and food intake was maintained, that they received appropriate personal and oral care and that sufficient information to family and health professionals was provided. You also did not ensure that there were sufficient supplies of medication for Patient A. The panel considered that these were serious failures which would be considered deplorable by fellow professionals. Further you have told the panel that since early last year your [PRIVATE] was such that you were no longer able to practise as a nurse and therefore were not able to strengthen your practise.

Taking all of this into consideration, the panel determined that there remained a significant risk of repetition.

The panel therefore determined 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 also took account of the NMC Guidance "Considering sanctions for serious cases" which stated:

‘Cases involving dishonesty

The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone’s care.

However, because of the importance of honesty to a nurse, midwife or nursing associate’s practice, dishonesty will always be serious.

In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. 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:

- *…*
- *…*
- *vulnerable victims*
- *…*
- *direct risk to patients*
- *…’*

Notwithstanding the positive testimonials that you have provided, the panel was of the view that the findings in this particular case demonstrate that your actions were serious with a real risk of harm to patients and carry a real risk of repetition. The panel therefore determined that striking-off is the only sanction which would be sufficient to protect patients, members of the public and maintain professional standards. To allow you to remain on the NMC register as a registered nurse would undermine public confidence in the nursing profession and in the NMC as a regulatory body. With this in mind, the panel concluded that the only appropriate and proportionate sanction available to it was to impose a striking-off order. It considered that any other sanction in this case would be inadequate given this panel’s findings.

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 your actions in bringing the

profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Interim order

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

Ms Maqboul did not oppose the application.

Decision and reasons on interim order

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

The panel concluded that 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 as it concluded that to do otherwise would be incompatible with its earlier findings. 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 you are sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to you in writing.