Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 19 February – Wednesday 21 February 2024

Virtual Meeting

Name of Registrant:	**Sarah Fisher**
NMC PIN	07F0313E
Part(s) of the register:	Sub part 1: Adult nurse, level 1 (8 September 2008)
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, registrant member) Paul Hepworth (Lay member) Bryan Hume (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Rim Zambour
Facts proved:	Charges 1, 2, 3, 4
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Fisher's registered email address by secure email on 16 January 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the date and the fact that this meeting was to be heard virtually.

In the light of all the information available, the panel was satisfied that Miss Fisher has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse

1) On 3 December 2021:

    a) Did not administer prescribed medications to one or more patients;

    b) Disposed of a bag of prescribed medication intended for patients in a general waste bin.

2) On 5 December 2021:

    a) Did not administer prescribed medications to one or more patients, including the patients set out in Schedule 1;

    b) Disposed of a bag of prescribed medication intended for patients, including the medications set out in Schedule 2, in a general waste bin.

3) Recorded in the MAR charts of the patients set out in Schedule 1 that one or more of their prescribed medications had been administered, when they had not.

4) Your actions as set out in charge 3 above were dishonest, in that you knew you had not administered the medications.

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

Schedule 1:

i) Resident A
ii) Resident C
iii) Resident D
iv) Resident G
v) Resident H
vi) Resident J
vii) Resident K
viii) Resident L

Schedule 2:

i) Aymes liquid
ii) Risperidone tablets
iii) Colagen drink
iv) Atorvastatin (Lipitor)
v) Paracetamol
vi) Adcal
vii) Nitrofurantoin tablets
viii) Digoxin
ix) Omeprazole
x) Rivaroxaban tablets

Background

On 7 February 2022, the Nursing and Midwifery Council ("NMC") received a referral from HC-One. At the time of the alleged concerns raised in the referral Miss Fisher was working at Oakhill House Home ("the Home") as a nurse. The Home caters for residents with a variety of nursing and special care needs. Miss Fisher commenced her employment as a nurse at the Home on 22 January 2021.

On 6 December 2021, a nursing assistant working at the Home on the day shift discovered a bag full of residents' medication in the general waste bin. The nursing assistant reported this to the management team and photographs were taken of the medications that had been found. The medications included antipsychotics, anti-coagulants and dementia medications and several other medications that could not be identified. Some medications were loose, and some were still in blister packs and packaging. The nursing assistant also stated that she had found tablets in a bag attached to the medicine trolley on 3 December 2021 following the drug round that she had carried out with Miss Fisher.

A local investigation was initiated. This revealed that the medications for the previous day had all been signed for as having been administered on the relevant MAR charts. Miss Fisher was on the rotas as having worked as a nurse at the Home on 3, 4 and 5 December 2021 and she had signed medications as having been administered. The Deputy Home Manager subsequently identified several residents who were affected by Miss Fisher's actions, although no harm was recorded.

On 6 and 8 December 2021, the Home Manager held investigation meetings with Miss Fisher to discuss the concerns. During these meetings, Miss Fisher confirmed that she did not give all the residents their medications and admitted to disposing of some medications in the waste bin. She admitted deliberately withholding medications from residents and falsifying documentation by signing MAR charts to indicate medications had been given when they had not. She provided no explanation for her actions, which she said she regretted.

Miss Fisher was suspended from her duties and on 16 December 2021 she was dismissed for gross misconduct.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC. The panel noted that there were no representations from Miss Fisher in relation to this hearing.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Nursing Assistant employed by the Home at the time.
- Witness 2: Deputy Manager employed by the Home at the time.
- Witness 3: Senior Home Manager employed by the Home at the time.

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

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

Charge 1

"That you, a registered nurse

1) On 3 December 2021:

a) Did not administer prescribed medications to one or more patients;

b) Disposed of a bag of prescribed medication intended for patients in a general waste bin."

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 1, as well as the contemporaneous documents including the disciplinary notes dated 16 December 2021.

In relation to charge 1a, the panel considered the statement of Witness 1 in which they state that they saw Miss Fisher start her drug round, and then 15 minutes later saw her sat down again. Witness 1 stated that *'some of the residents in the Home could be difficult, and a round would typically take thirty minutes or longer in my experience...'* The panel accepted the evidence of Witnesses 1 and 2 that Miss Fisher had a duty to administer medications to the residents that day. The panel also took into account the Home's medication administration and disposal policy that detailed the actions required when medication was not administered to residents and noted that Miss Fisher's training record was up to date in relation to these policies. The panel determined that as Witness 1 had found medications in the green plastic bag tied to the trolley Miss Fisher was using, this indicated that it was more likely than not that they had not been administered to residents.

The panel also took into account Miss Fisher's admissions during the local investigation that she had not administered prescribed medication to one or more patients on 3 December 2021.

The panel therefore determined that this part of the charge is proved on the balance of probabilities.

In relation to charge 1b, the panel accepted Witness 1's account detailing that they saw a green plastic bag tied to Miss Fisher's medication trolley and inside the bag were '*a number of loose tablets*.'

The panel also had sight of the disciplinary record in which Miss Fisher made admissions to disposing of the medication. The panel noted that although this contemporaneous document was not signed, it was not contested either.

The panel therefore determined that on the balance of probabilities, it is more likely than not that Miss Fisher also disposed of the bag of prescribed medication which was intended for patients.

The panel finds charge 1 proved in its entirety.

Charge 2

"That you, a registered nurse

2) On 5 December 2021:

a) Did not administer prescribed medications to one or more patients, including the patients set out in Schedule 1;

b) Disposed of a bag of prescribed medication intended for patients, including the medications set out in Schedule 2, in a general waste bin."

This charge is found proved.

In reaching this decision, the panel took into account the written witness statements, and the contemporaneous documents including interview notes from the local investigation and photographic evidence.

In relation to charge 2a, the panel accepted Witness 2's evidence that they had seen the medication in the waste bin and cross-referenced the prescribed medicines on the residents' MAR charts with the medications found in the bin and also identified that Miss

Fisher would have been responsible for the administration of these medications to these residents.

The panel again took into account the Home's medication administration and disposal policy that detailed the actions required when medication was not administered to residents and noted that Miss Fisher's training record was up to date in relation to these policies.

The panel noted that there is no evidence of a prescription for Nitrofurantoin tablets in relation to Resident L. Therefore, the panel could not find the charge proved in relation to that particular medication and Resident L.

The panel finds charge 2a proved on the balance of probabilities.

In relation to charge 2b, the panel considered Witness 1's statement in which they stated that they opened the general waste bin and saw prescribed medication intended for patients inside. The panel also had sight of the photographic evidence of the red and green bags showing all of the medication inside.

The panel accepted the evidence of Witness 2 that they created a list of the tablets and cross-referenced them against residents who should have received those medications.

The panel had sight of the local investigation interview notes in which Miss Fisher was asked about these incidents and made admissions to the allegations.

The panel noted that there is no contemporaneous documentary evidence for Nitrofurantoin tablets to be administered to any patient and therefore this charge is not proved in relation to Nitrofurantoin only.

The panel therefore found this charge proved on the balance of probabilities in relation to the other drugs in Schedule 2.

Charge 3

"That you, a registered nurse

3) Recorded in the MAR charts of the patients set out in Schedule 1 that one or more of their prescribed medications had been administered, when they had not."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and contemporaneous local investigation reports.

The panel considered that Miss Fisher's signature on the MAR charts is consistent with the witness statements of Witnesses 1 and 2 that she was responsible for the administration of medication and had indeed signed that they had been administered.

As the panel has already determined, prescribed medication was not administered to the residents in Schedule 1 on 5 December 2021 when the MAR charts signed by Miss Fisher would indicate otherwise.

The panel also considered Miss Fisher's admission of this allegation in the local investigation interview.

The panel finds this charge proved on the balance of probabilities.

Charge 4

"That you, a registered nurse

4) Your actions as set out in charge 3 above were dishonest, in that you knew you had not administered the medications."

This charge is found proved.

In reaching this decision, the panel took into account all of the contemporaneous evidence, as well as the written witness statements.

The panel noted that Miss Fisher's medication training was up to date at the time, and that there was a clear policy at the Home which set out what she needed to do when administering medication. By not administering the medications to the residents and signing the MAR chart to indicate she had when she knew she had not, Miss Fisher would have known that her actions were misleading.

The panel determined that by the standards of ordinary decent people, her conduct by signing that medication had been administered when she knew it had not would be deemed as dishonest.

The panel finds this charge proved on the balance of probabilities.

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

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

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

Representations on misconduct and impairment

The NMC invited the panel to take the view that the facts found proved 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.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC made the following written representations in relation to misconduct:

> *'It is submitted that the misconduct is serious and falls significantly short of what would be expected of a registered nurse. The areas of concerns identified relate to basic nursing practice and put patients at risk of harm by throwing away medications that were due to be administered to them and falsifying patient records. The conduct and dishonesty involve a serious departure from expected standards and put patients at significant risk of harm.'*

The NMC invited the panel to find Miss Fisher's fitness to practise impaired on the grounds that:

> *'There is a significant risk of harm to the public were the registrant allowed to practise without restriction. A finding of impairment is therefore required for the protection of the public.*
>
> *…*
>
> *We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. The registrant's conduct engages the public interest because members of the public would be appalled to hear of a nurse not administering medication to patients,*

disposing of the medication and then dishonestly recording that she had administered the prescribed medication. Such conduct would severely damage and undermine public confidence in the nursing profession and the NMC, as the regulator, and undermines the reputation and trust the public have in the profession.

It is therefore submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

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

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 Make sure you deliver the fundamentals of care effectively

4 Act in the best interests of people at all times

8 Work Cooperatively
To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

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

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 …'

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 both a fellow registrant and the public would be shocked and outraged by a nurse failing to administer medication to vulnerable residents and throwing the medication in the bin.

The panel found that Miss Fisher's 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, Miss Fisher's fitness to practise is currently impaired.

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

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

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

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

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

Not administering prescribed medication to patients did put patients at risk of harm, which was further exacerbated by misrepresenting that they had been administered breached a fundamental tenet of the profession.

The dishonesty found in misrepresenting the medications were administered to the residents in Schedule 1 breached a fundamental tenet of the profession, put patients at risk of harm, and brought the reputation of the profession into disrepute.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious and difficult to remedy.

Miss Fisher has not engaged in these proceedings. She has not provided an account or explanation of what happened since the local investigation neither has she responded to any communications from the NMC other than to say she is no longer in the nursing profession. The panel therefore considered that there is nothing before it to suggest any insight by Miss Fisher into her actions.

The panel noted Miss Fisher's early admissions in the local investigations, which may have indicated some level of early acknowledgment of her failings but as she had not engaged, the panel could not determine the level of her current insight.

The panel was of the view that the misconduct in this case is difficult to remediate as it relates in part to dishonesty and attitudinal concerns. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Fisher has taken steps to strengthen her practice. The panel did not have any evidence of remediation or strengthening of practice before it.

Therefore, the panel is of the view that there is a real risk of repetition as Miss Fisher does not appear to understand why she acted the way she did. The panel therefore decided 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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Fisher's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Fisher's 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 Miss Fisher off the register. The effect of this order is that the NMC register will show that Miss Fisher has been struck-off the register.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 16 January 2024, the NMC had advised Miss Fisher that it would seek the imposition of a striking-off order if it found Miss Fisher's fitness to practise currently impaired.

The NMC's written submissions included:

‘The panel may consider that the aggravating factors are:

• Lack of insight into failings

• Conduct put patients at risk of suffering harm

The panel may consider that the mitigating factors are:

• Early admissions at local level

• [PRIVATE]

…

Miss Fisher has not engaged with the NMC to demonstrate remorse, insight or remediation. In all the circumstances, a striking-off order is the only appropriate sanction.’

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Dishonesty
- Abuse of a position of trust
- Lack of insight into failings or attempts to remediate
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Early local admissions

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 Miss Fisher's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Fisher's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Fisher's 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. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Fisher's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Fisher's actions is fundamentally incompatible with Miss Fisher remaining on the register.

The lack of evidence of insight and remediation and obvious attitudinal problems around the dishonesty and throwing away prescribed medication, linked to an increase risk of repeat behaviour due to a lack of understanding of why Miss Fisher acted the way she did.

In this particular case, the panel 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?*

Miss Fisher's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that its findings demonstrate that Miss Fisher's actions put patients at risk of harm and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, including the serious risk to patients by failing to administer prescribed medication and the effect of Miss Fisher's 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.

This will be confirmed to Miss Fisher in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that:

> *'An Interim order of 18 months is necessary to cover any possible appeal period. It is submitted that an interim suspension order is appropriate as this would be consistent with the sanction imposed by the panel and would address public protection and public interest concerns already identified in this document.'*

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.

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

That concludes this determination.