Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 7 – Wednesday, 15 May 2024

Virtual Hearing

Name of Registrant:	Elaina June Moynihan
NMC PIN	02I1206S
Part(s) of the register:	Registered Nurse – Adult (23 June 2006)
Relevant Location:	Aberdeenshire
Type of case:	Misconduct
Panel members:	Shaun Donellan (Chair, Lay member) Esther Craddock (Registrant member) Nicola Hartley (Lay member)
Legal Assessor:	Suzanne Palmer (7 -10 May 2024) Ian Ashford Thom
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Kamran Khan, Case Presenter
Mrs Moynihan:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 1f, 1g, 2a, 2b, 3a, 3b, 3c, 4a and 4b
Facts not proved:	Charges 1d and 1e
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

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

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

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 go into private session in connection with [PRIVATE].

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Moynihan was not in attendance and that the Notice of Hearing letter had been sent to Mrs Moynihan's registered email address by secure email on 4 April 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, and, amongst other things, information about Mrs Moynihan's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Moynihan has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Moynihan

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

Mr Khan referred the panel to the email correspondence from Mrs Moynihan's representative dated 6 May 2024 which states *"… the registrant will not be attending the hearing tomorrow and will not be represented. Apologies for the late notice."* Mr Khan referred the panel to the relevant NMC guidance.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Mrs Moynihan. In reaching this decision, the panel considered the submissions of Mr Khan, the email correspondence from Mrs Moynihan's representative dated 6 May 2024, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Moynihan or her representative;

- Mrs Moynihan's representative had informed the NMC that she will not be attending the hearing nor will she be represented;
- There was no reason to suppose that adjourning would secure Mrs Moynihan's attendance at some future date;
- A number of witnesses have been arranged to give live evidence today and over the course of the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Moynihan in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Moynihan, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Moynihan's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Moynihan. The panel will draw no adverse inference from Mrs Moynihan's absence in its findings of fact.

Details of charge

That you, a registered nurse,

1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:

a) Failed to inform the GP about Resident A's lower than normal oxygen saturation levels when it would have been clinically appropriate to do so.

b) Failed to record Resident A's observations on the observation sheet after 14:00 hours.

c) Failed to write in Resident A's care notes for the afternoon.

d) At 14:00 hours failed to administer Resident A's medication to him.

e) Initialled Resident A's MAR chart to record medication had been administered to Resident A at 14:00 hours.

f) Failed to record Resident A's MAR chart that he had refused medication at 14:00 hours.

g) Left medication unattended in Resident A's room.

2) On 3 April 2022 in the presence of Resident A and/or his family members:

a) Raised your voice.

b) Said "I am fucking sick of this family" or words to that effect.

3) On 3 April 2022 having been instructed by Colleague A you failed to:

a) Call the GP about Resident A's lower than normal oxygen saturation levels.

b) Record Resident A's observation on the observation sheet.

c) Make a record in Resident A's care notes.

4) On 3 April 2022, having found Resident B on the floor following a fall:

a) failed to check Resident B for any injuries.

b) Instructed others to move Resident B without first checking for injuries.

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

Background

Mrs Moynihan was employed by Badenscoth House Nursing Home (the Home) prior to joining the NMC register as an adult nurse on 23 June 2006. Mrs Moynihan started employment at the Home as a staff nurse on 17 January 2016, though she had worked in the Home in other roles for approximately 18 years.

It is alleged on 3 April 2022, that Mrs Moynihan failed to act on Resident A's lower than normal oxygen saturation levels.

Resident A's two daughters, Witness 1 and Witness 2, were at the time visiting Resident A with his granddaughter who was 9 years old. It is alleged that Mrs Moynihan was confrontational towards Resident A's daughters. She raised her voice and swore in the presence of Resident A and in front of Witness 5. In addition, it is alleged that Mrs Moynihan demonstrated poor medication practice by leaving medication in Resident A's room unattended. On the same day, Colleague A (the home manager) attended the Home and spoke with Mrs Moynihan about the incident.

An allegation in respect of Resident B was made on the same day and brought to the attention of Colleague A. It was reported that Mrs Moynihan had failed to respond appropriately to Resident B's needs after they suffered a fall. It is alleged that she directed carers to lift Resident B from the floor without first checking for injuries.

A local investigation was carried out and on 4 April 2022 when reviewing Resident A's documentation, found there were no entries of the incident, of him being unresponsive and having a lower than normal oxygen saturation level, in the care plan or observation chart. The only entry about the incident was in the handover note.

Following the local investigation Mrs Moynihan was dismissed from the Home on 27 April 2022 and a referral to the NMC was made on 11 May 2022.

Decision and reasons on application to admit the hearsay evidence of Witness 6

The panel heard an application made by Mr Khan under Rule 31 to allow the hearsay testimony of Witness 6 into evidence. He referred the panel to the principles outlined in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and applied them to the circumstances of this case. Despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Witness 6 nor any information regarding their attendance at the hearing. He stated that an email was sent on 29 January and 15 February 2024. He noted a telephone call was made to Witness 6 on 28 February 2024 and a message was left but no response had been forthcoming. He stated that on 4 March 2024, a letter was sent to Witness 6 and a further telephone call was made 26 March 2024. Further emails were also sent on 26 March, 8 and 26 April to Witness 6 but still there had been no response. Mr Khan invited the panel to grant this hearsay application in light of the efforts made by the NMC to secure Witness 6's attendance at the hearing.

Mr Khan accepted that there was no reason that he could offer for the non-attendance of this witness. He also accepted that Mrs Moynihan was unaware that a hearsay application was being made in respect of the evidence of Witness 6.

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

The panel applied the principles set out in *Thorneycroft* to the circumstances of this case.

Whether the statements were the sole and decisive evidence in support of the charges
The panel took into consideration that Witness 6's evidence was not sole and decisive evidence as it had witness statements from other witnesses which spoke to these incidents.

The nature and extent of the challenge to the contents of the statements
The panel took into consideration that Mrs Moynihan was unaware that a hearsay application in relation to Witness 6 was being made and as a consequence there has been no challenge to the application.

Whether there was any suggestion that the witness had reasons to fabricate their allegations
The panel was of the view that there was no reason for Witness 6 to fabricate her account. The panel took into consideration that Witness 6's unsigned NMC statement was consistent with her local statement made on 7 April 2022. It noted that Witness 6's account was candid in that she stated *"…Elaina came to me crying, worried what was going to happen once [Colleague A] came in, and that Resident A family said she was unfit to be a nurse and that the place was full of shit stirrers."*

The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career
The panel took into consideration that the NMC's sanction bid was a 6-month suspension order with a review which would have an impact on Mrs Moynihan's nursing registration.

Whether there was a good reason for the non-attendance of the witnesses
The panel was not aware of any good reason for Witness 6's non-attendance at the hearing.

Whether the Respondent had taken reasonable steps to secure the attendance of the witness

The panel noted that Witness 6's NMC statement was not signed. It took into consideration the reasonable attempts made by the NMC to secure Witness 6's attendance at the hearing.

Did the registrant have prior notice that the witness statement was to be read?

The panel bore in mind that Mrs Moynihan did not have any prior notice that a hearsay application would be made to allow Witness 6's witness statement into evidence.

The panel was of the view that, although Mrs Moynihan had chosen not to attend this hearing, she was not aware at the time of making that decision, of this application to allow Witness 6's hearsay testimony into evidence. The panel determined that it was a basic principle of fairness that Mrs Moynihan has notice of Mr Khan's application and given the opportunity to factor this into any defence Mrs Moynihan chose to present to the panel. Further, the panel took into consideration that it had no means to assess the reliability of Witness 6's hearsay evidence as it is an unsigned account which Witness 6 has not verified through her signature. In these circumstances the panel refused the application.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Moynihan.

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:

- Colleague A: Home manager of the Home at the material time. She considered Mrs Moynihan to be her friend.
- Witness 1: Resident A's daughter who attended the Home on the material date.
- Witness 2: Resident A's daughter and a registered nurse. She attended the Home on the material date.
- Witness 3: Deputy home manager and a registered nurse. He conducted the interviews for the local investigation. He had a professional relationship with Mrs Moynihan.
- Witness 4: Retired nurse and proprietor of the Home. She considered herself a 'mother' figure to Mrs Moynihan.
- Witness 5: A carer at the Home at the material time. She had a professional relationship with Mrs Moynihan.

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

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

Charge 1a

> "That you, a registered nurse,
> 1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
> a) Failed to inform the GP about Resident A's lower than normal oxygen saturation levels when it would have been clinically appropriate to do so."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A, Witness 1, Witness 3 and Mrs Moynihan's reflective statement dated May 2022.

The panel considered whether Mrs Moynihan had a duty to inform the GP about Resident A's lower than normal oxygen saturation levels. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel therefore concluded that Mrs Moynihan was under a duty to inform the GP about Resident A's lower than normal oxygen saturation levels.

The panel considered the evidence of Colleague A. She said in her oral evidence that Resident A's oxygen saturation levels were low, and that Mrs Moynihan had to do regular observations in response to these low readings.

The panel considered the evidence of Witness 1. In her oral evidence, she said that Resident A, her dad, was unresponsive.

The panel considered the evidence of Witness 3. In his oral evidence, he said that the low oxygen saturation levels triggered the need for observations.

The panel had regard to the Investigation Meeting Minutes between Witness 3 and Mrs Moynihan, dated 15 April 2022. Mrs Moynihan stated *"I went through to the room and checked Resident A obs, his BO was 130/60 and his O2 was 88%. I didn't do anything about it, as in he was sleeping, but in realisation, I should have done something."*

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She stated *"I was asked to go and look at the resident by the resident's family. I thought the resident had gone into possible freezing episode due to his Parkinson's as I was aware this happening previously…I took his blood pressure which was within normal range and checked his oxygen levels which were a little low at 88%. I now realise that I should have phone G-meds in regards to the oxygen level, I should have phoned for advice…but when I said I would phone G-meds the daughter said they would probably laugh in your face, and she said don't bother."*

The panel noted that there was some uncertainty about the observation readings for the oxygen saturation levels being at 84% or 88%. However, the panel concluded that either of these readings are significantly lower than what would be normally expected, and Mrs Moynihan would be required to act on either of these readings however she did not do so.

The panel considered the evidence before it. It noted that as Mrs Moynihan was the sole nurse on duty, she had a responsibility to inform the GP about Resident A's lower than normal oxygen saturation levels. The panel therefore concluded that on 3 April 2022 in relation to Resident A, and before speaking to Colleague A, Mrs Moynihan failed to inform the GP about Resident A's lower than normal oxygen saturation levels when it would have been clinically appropriate to do so. The panel therefore found charge 1a proved.

Charge 1b and 1c

"1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
b) Failed to record Resident A's observations on the observation sheet after 14:00 hours.
c) Failed to write in Resident A's care notes for the afternoon."

This charge is found PROVED.

In reaching this decision, the panel took into account Colleague A's evidence and Mrs Moynihan's reflective statement.

The panel considered whether Mrs Moynihan had a duty to record Resident A's observations on the observation sheet after 14:00 hours. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel therefore concluded that Mrs Moynihan had a duty to record Resident A's observations on the observation sheet after 14:00 hours.

The panel considered the evidence of Colleague A. In her NMC statement, she stated *"There was also nothing written in Resident A's notes about what had happened, only a small amount in the handover, which said 'good humour in the morning, good breakfast and lunch taken, unresponsive episode at 14:00, pulse 88, bp 128/72, 97%, bp 128/72p 93…".* The panel had sight of the handover sheet where Mrs Moynihan had made a record of Resident A's observations.

In Colleague A's oral evidence, she said that Resident A had a personal file, observation sheet and daily diary care notes. She stated that Mrs Moynihan did not make an entry on any of these documents. She stated that the handover sheet that Mrs Moynihan had

recorded her observations was not considered a continuous log of Resident A's care. The panel noted that it did not have access to these documents referred to in Colleague A's oral evidence other than the handover notes.

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She states *"I recall that I documented that the resident had an unresponsive episode, however can't recall if I noted the observations. I may have missed documenting everything due to the stressful situation."* She also states *"On the day of the incident, I was a 12 hour shift which was my sixth day in a row. I had been put on a long spell of shifts and was feeling stressed and tired. I was the only nurse in a duty and usually a senior carer to help with medication, but manager had to come in and help."* The panel was of the view that Mrs Moynihan has led the reader to believe that she was on her sixth consecutive shift however the panel heard evidence from Witness 4 which clarified that Mrs Moynihan had not worked the day before which was a Saturday and her previous shifts had been shorter in length.

The panel considered the evidence before it. The panel took into consideration that it heard evidence that the handover is a 'useful' aid to assist staff however patient records (including the observation sheet and care notes) are legal documents which need to be completed in a timely manner. The panel accepted the evidence of Colleague A.

In respect of charge 1b, the panel concluded that on 3 April 2022 in relation to Resident A, and before speaking to Colleague A, Mrs Moynihan failed to record Resident A's observations on the observation sheet after 14:00 hours.

In respect of charge 1c, the panel concluded that on 3 April 2022 in relation to Resident A, and before speaking to Colleague A Mrs Moynihan failed to write in Resident A's care notes for the afternoon.

The panel therefore found charges 1b and 1c proved.

Charge 1d

"1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
d) At 14:00 hours failed to administer Resident A's medication to him."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 3 and Mrs Moynihan's reflective statement.

The panel considered whether Mrs Moynihan had a duty to administer Resident A's medication to him. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel therefore concluded that Mrs Moynihan had a duty to administer Resident A's medication to him.

The panel had regard to the Investigation Meeting Minutes between Witness 3 and Mrs Moynihan, dated 15 April 2022. Mrs Moynihan stated *"I didn't do the 2pm meds and I had left them in his room. I dreaded going in the room, as Resident A told me to piss off…"*

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She states *"The resident had been fine all morning, taken his breakfast medication and 11am medication. I had gone to give resident medication at 2pm, several attempts by asking the resident to take medication, saying that's it helps his pain and for his Parkinson's but he declined all medication…I knew that the resident was down to be discussed with GP on Tuesday to change some of his medications to possibly patches, due to him refusing them orally."*

The panel considered the evidence before it. The panel took into consideration that no one else was present when Mrs Moynihan attempted to administer Resident A's medication.

The panel was of the view that Mrs Moynihan took Resident A's medication to him to administer it to him but he refused to take it. The panel bore in mind that Mrs Moynihan was under no duty to force Resident A to take his medication. The panel concluded that on 3 April 2022 in relation to Resident A, and before speaking to Colleague A Mrs Moynihan at 14:00 hours did not fail to administer Resident A's medication to him as he refused to take it. The panel therefore found charge 1d not proved.

Charge 1e

> "1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
> e) Initialled Resident A's MAR chart to record medication had been administered to Resident A at 14:00 hours."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A and Witness 3. The panel had regard to its finding at charge 1d.

The panel had regard to the MAR chart dated 14 March 2022 for Resident A. It noted in the corner of the record, a key which defined each letter abbreviation that was to be used on the MAR chart. It noted that a circle, 'O', indicated 'other'.

The panel had regard to the evidence of Colleague A. She said in her oral evidence, that Mrs Moynihan completed the MAR chart with her initials and circled it to indicate that the medication was not administered. She stated that Mrs Moynihan's initials may have indicated that she took the medication out of the bottle. She accepted that Mrs Moynihan may not have completed the MAR chart correctly per the key and should have put a 'R' for 'Refused' instead. The panel considered Witness 3's oral evidence which corroborated Colleague A's evidence in this respect.

The panel considered the evidence before it. The panel was satisfied that although Mrs Moynihan did not use the key at the top of the MAR chart, Colleague A and Witness 3 understood that her entry indicated Resident A had not taken his medication. The panel took into consideration that Mrs Moynihan had circled and initialled the MAR chart as she may have taken the medication out of the bottle. The panel was of the view that Mrs Moynihan circled her initials to indicate an 'other' action had occurred. The panel concluded that Mrs Moynihan did not initial Resident A's MAR chart to record that medication had been administered to Resident A at 14:00 hours. The panel therefore found charge 1e not proved.

Charge 1f

> "1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
> f) Failed to record Resident A's MAR chart that he had refused medication at 14:00 hours."

This charge is found PROVED.

In reaching this decision, the panel took into account the MAR chart dated 14 March 2022.

The panel considered whether Mrs Moynihan had a duty to record on Resident A's MAR chart that he had refused medication at 14:00 hours. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel therefore concluded that Mrs Moynihan had a duty to record Resident A's MAR chart that he had refused medication at 14:00 hours.

The panel had regard to the MAR chart dated 14 March 2022 for Resident A. It noted in the corner of the record, a key which defined each letter abbreviations which was to be used on the MAR chart. The panel bore in mind that Colleague A and Witness 3 stated that Mrs Moynihan had her own entry which she used to indicate that a resident had not taken their medication.

The panel considered the evidence before it. It bore in mind that Mrs Moynihan had completed the MAR chart incorrectly as per the key on the chart. The panel concluded that on 3 April 2022 in relation to Resident A, and before speaking to Colleague A, Mrs Moynihan failed to record Resident A's MAR chart that he had refused medication at 14:00 hours. The panel therefore found charge 1f proved.

Charge 1g

> "1) On 3 April 2022 in relation to Resident A, and before speaking to Colleague A:
> g) Left medication unattended in Resident A's room."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1, Colleague A, Witness 3, Witness 4 and Mrs Moynihan's reflective statement.

The panel considered the evidence of Witness 1. In her NMC statement she stated *"Just before [Witness 2] arrived at the Home, I noticed there were two open containers sitting beside the TV… These looked like Resident A's normal medication… The medication had been left there for the entirety of our visit.*" She repeated this in her oral evidence.

The panel took into account Colleague A's local witness statement dated 3 April 2022, where she spoke with Mrs Moynihan. Colleague A stated *"She was aware she had left medication sitting out in front of the Tv as he was sleeping."*

The panel noted that in Colleague A's submission to the Care Inspectorate notification, she wrote *"[Mrs Moynihan] allegedly left medication in his room in front of the public".*

The panel had regard to the local witness statement of Witness 6, exhibited by Witness 3. Witness 6 stated *"I came on shift at 2pm. When I first came in, Elaina was in with Resident A and he would not take his meds. She asked me to try, but with no success."*

The panel noted that during Witness 4's oral evidence, she said that nurses could ask other members of the team to assist with medication administration but that the nurse would ultimately be responsible for following up and any disposal of medication.

The panel had regard to the Investigation Meeting Minutes between Witness 3 and Mrs Moynihan, dated 15 April 2022. Mrs Moynihan was asked if she left medication out in Resident A's room in front of a minor, to which she replied *'Yes'.*

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She stated, *"…I asked a carer to try resident with medication, but she had no success either and the carer left the medication in the room. I noticed when I went to give resident medication at 4pm the 2pm medication was still sitting in room, I removed it from room and disposed of it in the medicine bucket."*

The panel considered the evidence before it. The panel took into consideration that Mrs Moynihan asked a carer to assist her with administering medication to Resident A and it was of the view that Mrs Moynihan should have remained with the carer to ensure that the medication was administered and if unsuccessful, Mrs Moynihan could then take the appropriate steps to dispose of the medication. The panel determined that Mrs Moynihan was responsible for administering medication and any disposal. The panel concluded that on 3 April 2022, in relation to Resident A, and before speaking to Colleague A, Mrs Moynihan left medication unattended in Resident A's room. The panel therefore found charge 1g proved.

Charge 2a and 2b

"2) On 3 April 2022 in the presence of Resident A and/or his family members:

a) Raised your voice.

b) Said "I am fucking sick of this family" or word to that effect."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A, Witness 5, Witness 2, Witness 3 and Mrs Moynihan's reflective statement.

The panel had regard to Colleague A's evidence. In her NMC witness statement she said *"During this call I could hear Nurse Moynihan shouting above [Witness 2] saying 'just have my resignation now I'm sick of this'."*

The panel considered Witness 5's evidence. In her NMC witness statement she stated *"At around 17:00, I gave Resident A supper. In the room at the time was me, Resident A, Child A, Resident A's great great granddaughter, [Witness 1] and [Witness 2]. [Witness 1] and [Witness 2] are Resident A's daughters were popping in and out. I am not sure when [Witness 2] arrived in…Nurse Moynihan then came into Resident A's room and was upset. In front of Resident A, their granddaughter (who was around nine years old) and I, Nurse Moynihan said 'I am fucking sick of this family' or words to that effect."*

During Witness 5's oral evidence she said that Mrs Moynihan raised her voice and swore. Witness 5 described feeling shocked by the incident. She clarified that Mrs Moynihan was not shouting but the tone of her voice was raised.

The panel considered Witness 2's evidence. During her oral evidence, she stated that her granddaughter had told her that Mrs Moynihan had said a 'bad word'. Witness 2 subsequently brought this to the Home's attention.

The panel had regard to the Investigation Meeting Minutes between Witness 3 and Mrs Moynihan, dated 15 April 2022. Mrs Moynihan was asked if she remembered swearing *'in*

front of the family and a 9yr old child?' to which she said, no. She said, *"…I just can't remember swearing".*

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She stated *"I unfortunately* did *raise my voice in the presence of the family and I admit I did swear about the situation as I was feeling very stressed… I understand that I was acting in an unprofessional manner by raising my voice at family members."*

The panel considered the evidence before it. The panel concluded that on 3 April 2022 in the presence of Resident A and/or his family members Mrs Moynihan raised her voice and said *"I am fucking sick of this family"* or words to that effect. The panel therefore found charges 2a and 2b proved.

Charge 3a

> "3) On 3 April 2022 having been instructed by Colleague A you failed to:
> a) Call the GP about Resident A's lower than normal oxygen saturation levels."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A, Witness 2 and Mrs Moynihan's reflective statement.

The panel considered whether Mrs Moynihan had a duty to call the GP about Resident A's lower than normal oxygen saturation levels after being instructed to do so by Colleague A. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel took into consideration that Colleague A advised Mrs Moynihan to call the GP. It concluded that Mrs Moynihan had a duty to call the GP about Resident A's lower than normal oxygen saturation levels after being instructed to do so by Colleague A.

The panel considered the evidence of Colleague A. In her NMC witness statement she said *"During this call… I asked to speak to Nurse Moynihan again and asked them to go and complete recording (blood pressure, temperature and oxygen saturations) on Resident A and phone the GP for some advice… I came into the Home at roughly 18:00… I asked Nurse Moynihan if they had informed the GP, which they said they had not, despite me asking them to in our earlier call around 17:15."* Colleague A was consistent in her oral evidence, she said she asked Mrs Moynihan to do more recordings and to phone the out of hours to get advice.

The panel took into account Colleague A's local witness statement dated 3 April 2022, where she spoke with Mrs Moynihan. Colleague A stated *"She then called me [Colleague A] at [Witness 2]'s request… she went to room and rechecked the recordings as [Colleague A] had asked her to do [Colleague A] had asked her to phone gmeds but family asked her not too."*

During Witness 2's oral evidence, she said that she was not the nurse in charge of Resident A's care and that Mrs Moynihan should have contacted the GP if she felt that was the correct action to take.

The panel considered Mrs Moynihan's reflective statement provided to the NMC in May 2022. She stated *"I now realise that I should have phoned G-meds in regards to the oxygen levels, I should have phoned for advice, also my manager told me to phone them but when I said I would phone G-meds the daughter said they would probably laugh in your face, and she said don't bother."*

The panel considered the evidence before it. The panel took into consideration that as Mrs Moynihan was the sole nurse on duty, she had a responsibility to inform the GP about Resident A's lower than normal oxygen saturation levels when instructed by Colleague A to do so. The panel concluded that on having been instructed by Colleague A, Mrs Moynihan failed to call the GP about Resident A's lower than normal oxygen saturation levels. The panel therefore found charge 3a proved.

Charge 3b and 3c

"3) On 3 April 2022 having been instructed by Colleague A you failed to:
b) Record Resident A's observation on the observation sheet.
c) Make a record in Resident A's care notes."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A. It also had regard to the evidence outlined at charges 1b and 1c.

The panel considered whether Mrs Moynihan had a duty to record Resident A's observation on the observation sheet and to make a record in Resident A's care notes after being instructed to do so by Colleague A. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. The panel took into consideration that Colleague A advised Mrs Moynihan to call the GP. It concluded that Mrs Moynihan had a duty to record Resident A's observation on the observation sheet and to make a record in Resident A's care notes after being instructed to do so by Colleague A.

The panel considered the evidence of Colleague A. In her NMC statement, she stated *"There was also nothing written in Resident A's notes about what had happened, only a small amount in the handover, which said 'good humour in the morning, good breakfast and lunch taken, unresponsive episode at 14:00, pulse 88, bp 128/72, 97%, bp 128/72p 93… I asked Nurse Moynihan before they left the Home to write in Resident A's notes what had happened that afternoon and his recording into the observation sheet… Nurse Moynihan said they would complete this before they left the Home, but they did not".* The panel took into consideration that Colleague A's NMC statement was consistent with her oral evidence. It noted that she said in her oral evidence that it is important to record on the patient notes if something significant happens to a resident during a shift so that the

information can be shared with the wider team who were not present at the Home at all times.

The panel considered the evidence before it. In respect of charges 3b and 3c, the panel took into consideration that as Mrs Moynihan was the sole nurse on duty, she had a duty to record Resident A's observation on the observation sheet and make a record in Resident A's care notes when instructed by Colleague A to do so. The panel concluded that on having been instructed by Colleague A, Mrs Moynihan failed to record Resident A's observation on the observation sheet and make a record in Resident A's care notes.

The panel therefore found charges 3b and 3c proved.

Charge 4a

> "4) On 3 April 2022, having found Resident B on the floor following a fall:
> a) failed to check Resident B for any injuries."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague A and Witness 5.

The panel considered whether Mrs Moynihan had a duty to check Resident B for any injuries following a fall where they were found on the floor. It noted that Mrs Moynihan has been a registered nurse since 2006 and it took into account that she was the sole nurse on duty in the Home at the material time. It had regard to the evidence of Colleague A who stated that Mrs Moynihan had been trained on moving and handling, and that residents suffering falls was a weekly occurrence at the Home. It concluded that Mrs Moynihan had a duty to check Resident B for any injuries following a fall where they were found on the floor.

The panel considered the evidence of Colleague A. in her NMC statement she said *"[Witness 5] informed me that there was another incident with another resident, Resident B, on 3 April 2022. I understand that Resident B had fallen onto the floor upstairs in their bedroom. They were found by staff member … who called Nurse Moynihan to come and check Resident B before they lifted them off the floor…If a resident has had a fall, a nurse should check all limbs before attempting to move them as the residents are very fragile and bones can be broken easily. There is no relevant policy about this… Nurse Moynihan would have been trained during their time at the Home in relation to dealing with falls of residents."* Colleague A said in her oral evidence that a resident is not moved until a nurse has checked for any injuries following a fall.

The panel considered the evidence of Witness 5. In her NMC witness statement, she stated *"Nurse Moynihan did not do any checks on Resident B before we lifted them off the floor, such as blood pressure or looking for any injuries. Instead Nurse Moynihan asked me to look if Resident B had any bruising or red marks from the fall after we had picked them up. This is not normal procedure. Normally, a nurse would look over the resident before standing them up and then sitting them back down."*

In Witness 5's oral evidence she said that Mrs Moynihan told the carers to check Resident B for any injuries following the fall. She said that she was surprised that Mrs Moynihan had not checked Resident B herself as she was the trained nurse and Witness 5 was upset that Mrs Moynihan had not checked Resident B.

The panel noted that this allegation was not addressed locally by the Home's investigation or in Mrs Moynihan's reflective statement.

The panel considered the evidence before it. The panel was of the view that it was accepted practice, in the Home, for a nurse to check over a resident who had suffered a fall and that by not carrying out this check Mrs Moynihan failed in her duty. The panel concluded on 3 April 2022, having found Resident B on the floor following a fall Mrs

Moynihan failed to check Resident B for any injuries. The panel therefore found charge 4a proved.

Charge 4b

> "4) On 3 April 2022, having found Resident B on the floor following a fall:
> b) Instructed others to move Resident B without first checking for injuries."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 5.

The panel considered the evidence of Witness 5. In her NMC witness statement, she stated *"Nurse Moynihan did not do any checks on Resident B before we lifted them off the floor, such as blood pressure or looking for any injuries."* Witness 5 was consistent in her oral evidence and said that she was upset and felt uncomfortable moving Resident B without them being checked by a nurse however she stated it wasn't for her to overrule or question Mrs Moynihan's instructions.

The panel considered the evidence before it and concluded that on 3 April 2022, having found Resident B on the floor following a fall, Mrs Moynihan instructed others to move Resident B without first checking for injuries. The panel therefore found charge 4b 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 Mrs Moynihan'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 ability to practise kindly, safely and professionally.

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, Mrs Moynihan's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Khan referred the panel 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.'* He also referred it to the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Mr Khan invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where Mrs Moynihan's actions amounted to misconduct. He submitted that Mrs Moynihan failed to respond appropriately to residents' needs, failed to communicate appropriately and professionally with colleagues, residents and visitors, and demonstrated some inconsistency in her record keeping which he submitted amounted to poor administration of medication.

Submissions on impairment

Mr Khan 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. Mr Khan referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and applied Dame Janet Smith's "test" to the circumstances of this case. He also referred to the case of *Cohen v General Medical Council* | [2008] EWHC 581 (Admin) and applied the principles established to the circumstances of this case.

Mr Khan submitted Mrs Moynihan's fitness to practise is impaired by reason of her misconduct. He submitted that Mrs Moynihan received criticism of her conduct and attitude from her peers, the residents and visitors which cannot be easily remedied. He submitted that there is no evidence from Mrs Moynihan to demonstrate that she has developed any further insight or evidence of any completed training. He noted the strong professional network Mrs Moynihan had and that she had a long affiliation with the care home. He invited the panel to make a finding of current impairment in relation to Mrs Moynihan's nursing practice.

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

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 considered that Mrs Moynihan's actions amounted to the following breaches of the Code:

> '***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.6 recognise when people are anxious or in distress and respond compassionately and politely

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

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

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges in turn as to whether Mrs Moynihan's actions amounted to misconduct.

In respect of charge 1a, the panel took into consideration that Resident A was a vulnerable resident and that he had a lower than normal oxygen saturation level and she should have rung the GP. The panel determined that Mrs Moynihan's actions in this charge are serious enough to amount to misconduct.

The panel next considered charges 1b and 1c. The panel bore in mind that Mrs Moynihan failed to record her observations on the relevant documents. The panel took into account that other members of staff would not be aware of the changes in Resident A's health status, nor would there be a complete record to track Resident A's progress or deterioration. The panel determined that Mrs Moynihan's actions in these charges are serious enough to amount to misconduct.

In relation to charge 1f, the panel was of the view that Mrs Moynihan's fellow staff members would need to know if Resident A had refused to take his medication so they would be able to take informed steps when providing him with supplementary medication. The panel determined that Mrs Moynihan's actions in this charge are serious enough to amount to misconduct.

The panel considered charge 1g and that Mrs Moynihan had left medication unattended in the room of a vulnerable resident. The panel bore in mind that Resident A had young family members visiting him who would have had access to this medication. The panel concluded that Mrs Moynihan's actions in this charge are serious enough to amount to misconduct.

Next, the panel considered charge 2a. The panel found that Mrs Moynihan raising her voice in the presence of Resident A and his family members was serious enough to amount to misconduct.

In respect of charge 2b, the panel found Mrs Moynihan's choice of words and profanity outlined in this charge to be wholly unprofessional and reprehensible. It determined that Mrs Moynihan's conduct in this charge is serious enough to amount to misconduct.

In relation to charge 3a, the panel bore in mind that Colleague A instructed Mrs Moynihan to call the GP about Resident A's lower than normal oxygen levels. As a consequence, the panel determined that Mrs Moynihan's conduct in this charge is serious enough to amount to misconduct.

The panel considered charges 3b and 3c together. The panel bore in mind that Mrs Moynihan failed to record her observations on the relevant documents on the instruction of Colleague A. The panel determined that Mrs Moynihan's actions in these charges are serious enough to amount to misconduct.

The panel was of the view that Mrs Moynihan's actions in charge 4a are serious enough to amount to misconduct as Resident B could have suffered a serious injury. The panel went on to consider charge 4b. It took into consideration that the residents of the Home were older adults and that Mrs Moynihan's actions in this charge set a poor example to the staff at the Home of how to deal with falls. The panel concluded that Mrs Moynihan's actions in charge 4b are serious enough to amount to misconduct.

The panel found that Mrs Moynihan'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, Mrs Moynihan's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* 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) *…'*

The panel finds that Resident A and Resident B were put at risk of harm as a result of Mrs Moynihan's misconduct. Mrs Moynihan's misconduct breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Moynihan's was limited. The panel took into account Mrs Moynihan's reflective statement dated May 2022. The panel took into consideration that Mrs Moynihan made no clear acceptance of what she did wrong, nor did she demonstrate an understanding of how her actions put the residents at risk of harm. The panel also considered that Mrs Moynihan has not demonstrated how her actions have impacted negatively on the reputation of the nursing profession. The panel noted that Mrs Moynihan said in her reflective statement that she apologised to Resident A's family when she realised that they had heard her comments and that she *'thought about writing an apology'* however, the panel had no evidence that she had done so. The panel took into account that it had no information about how Mrs Moynihan would handle a similar

situation differently in the future and what strategies she would employ to navigate a stressful situation.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Moynihan has taken steps to strengthen her practice. It noted that it did not have any evidence of training since these incidents, nor did it have any written testimonials from Mrs Moynihan's colleagues regarding her nursing practice.

The panel considered if there is a risk of repetition. It took into account that it had no information as to whether Mrs Moynihan was currently working in a nursing role or other healthcare role. It took into consideration that it had no evidence of training from Mrs Moynihan since these incidents nor did it have a recent reflective statement which addresses what she would do differently in a similar situation, how her actions have impacted negatively on the nursing profession or how her actions put residents at risk of harm. The panel concluded that there is a risk of repetition.

In light of the information before it, the panel considered whether Mrs Moynihan can practise kindly, safely and professionally. It determined that it had no current information that Mrs Moynihan has addressed the misconduct found in this case. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered whether a finding of impairment on public interest grounds is required. It took into consideration that an informed member of the public would be concerned to learn that a registered nurse was allowed to practise with no restrictions on

their registration in light of the charges found proved in this case. 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 Mrs Moynihan's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months with a review. The effect of this order is that the NMC register will show that Mrs Moynihan's registration has been suspended.

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

Mr Khan invited the panel to impose a six month suspension order with a review prior to the period of suspension ending in light of the panel's finding that Mrs Moynihan's fitness to practise is currently impaired. He took the panel through all the available sanctions and made submissions to the appropriateness of each given the circumstances of the case.

Decision and reasons on sanction

Having found Mrs Moynihan'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:

- Lack of meaningful insight from Mrs Moynihan.
- Mrs Moynihan's conduct put Resident A and Resident B at risk of harm.

The panel also took into account the following mitigating feature:

- Incidents took place over a single day.

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 Mrs Moynihan'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 Mrs Moynihan's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Moynihan's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel is of the view that there are no practical or workable conditions that could be formulated, given that Mrs Moynihan has not demonstrated to this panel that she is willing to comply with a

conditions of practice order. Further, it took into consideration her limited insight and that she has not provided any recent evidence of strengthened practice.

Furthermore, the panel concluded that the placing of conditions on Mrs Moynihan's registration would not adequately address the seriousness of this case.

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

- *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.*

Whilst the panel accepted that this was not a single instance of misconduct, it took into account that the misconduct took place during the course of a single shift.

The panel also took into consideration that the attitudinal concerns highlighted by the NMC took place over a single shift and that this snapshot of Mrs Moynihan's nursing practice did not portray a complete picture. On this basis, the panel concluded that Mrs Moynihan did not display any deep-seated personality or attitudinal problems.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate in the circumstances. Whilst the panel acknowledges that a suspension

may have a punitive effect, it would be unduly punitive in Mrs Moynihan's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Moynihan. However this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct. The panel was also of the view that this would provide Mrs Moynihan enough time to reflect on her misconduct and take appropriate steps to address it.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Moynihan's engagement with the NMC and attendance at any future hearing.
- A full reflective statement about the incidents which took place on 3 April 2022 which addresses:
    - How Mrs Moynihan's actions put the residents at risk of harm.
    - How her actions have impacted negatively on the reputation of the nursing profession.

    - How Mrs Moynihan would handle a similar situation differently in the future.
    - What strategies Mrs Moynihan would employ to navigate stressful situations.
- Evidence of any relevant training courses and professional development undertaken to address the underlying misconduct found in relation to the charges.
- Any testimonials about paid or unpaid work from line manager and colleagues.

This will be confirmed to Mrs Moynihan in writing.

Interim order

As the suspension 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 Mrs Moynihan 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 Khan. He submitted that an interim suspension order was necessary on the grounds of public protection and public interest for a period of 18 months to cover any potential appeal period.

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 due to cover any potential period of appeal.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Moynihan is sent the decision of this hearing in writing.

That concludes this determination.