Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Tuesday, 27 August 2024 – Friday, 6 September 2024
Monday, 23 December 2024
Monday, 10 February 2025 – Friday, 14 February 2025

Virtual Hearing

Name of Registrant:	**Bjork Sabino**
NMC PIN:	00C2160E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – July 2004 Registered Midwife – October 2007
Relevant Location:	Camden
Type of case:	Lack of competence / Misconduct
Panel members:	Deborah Jones (Chair, lay member) Judith Bayly (Registrant member) Kamaljit Sandhu (Lay member)
Legal Assessor:	John Donnelly (27 – 30 August 2024) Neil Fielding (2 – 6 September 2024, 23 December 2024 and 10 – 14 February 2025)
Hearings Coordinator:	Ruth Bass (27 August 2024 – 6 September 2024 and 23 December 2024) Samara Baboolal (29 August 2024) Clara Federizo (10 – 14 February 2025)

Nursing and Midwifery Council:	Represented by Wafa Shah (27 August 2024 – 6 September 2024 and 23 December 2024) Represented by Beverley Da Costa (10 – 14 February 2025)
Miss Sabino:	Present and represented by Thomas Buxton, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a, 1c, 1d, 2a and 3
Facts found proved:	Charges 1b, 1e, 1f, 2b, 2c, 4a in relation to 2b, 2c and 3, 4b in relation to 2a, 2b, 2c and 3, 4c in relation to 2a, 2b, 2c and 3
Facts not proved:	Charge 4a (in relation to 2a)
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse,

1. Between 25 December 2020 and February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:
    a) prioritising clinical tasks based on risk/patient safety;
    b) identifying and escalating deteriorating patients;
    c) medications practice;
    d) record keeping;
    e) working cooperatively with colleagues;
    f) communication with colleagues and patients.

2. You documented observations on patients records by using previously recorded observations from earlier shifts, on one or more occasions, including but not limited to:
    a) 3 January 2022
    b) 25 January 2022
    c) 17 February 2022

3. You did not amend the patient records after observations and/or assessments had taken place.

4. Your conduct at charges 2 and/or 3 was dishonest in that you:
    a) Knew that you were entering observations from a previous shift;
    b) Knew that you had not amended the observations;
    c) Intended to create the misleading impression that the observations recorded were the correct observations.

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

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

Ms Shah, on behalf of the Nursing and Midwifery Council (NMC), made an application for parts of the hearing to be heard in private which relate to your personal circumstances. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Buxton supported the application and requested that any personal matters previously mentioned be marked as private.

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

Having heard that there will be references to matters of a personal nature, the panel determined that such issues should be heard in private so as to protect your right to privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Shah under Rule 31, to allow an email dated 11 June 2022, from Ms 1 to Witness 2 and exhibited in Witness 2's witness statement, to be admitted as hearsay evidence.

Ms Shah submitted that the evidence was relevant. She submitted that the email related to charge 1, specifically in respect of your communication and alleged failure to work cooperatively with colleagues.

With regard to fairness, Ms Shah submitted that the email was not sole and decisive evidence; there was no evidence to suggest any allegation had been fabricated; efforts had been made by the NMC to secure the attendance of Ms 1, who had failed to

engage; no redactions to the email had been requested by your representatives; and you would have the opportunity to make submissions regarding the email.

Mr Buxton objected to the application on two grounds. Firstly, he acknowledged that the evidence was not sole and decisive. However, he submitted that the panel had evidence from four other witnesses commenting on the issues raised within the email, and as such the email would not add anything further.

Secondly, Mr Buxton submitted that the email set out a number of concerns about your alleged behaviour to include sudden outbursts, being manic and having disorganised thoughts. He submitted that the behaviour set out in the email was of a greater or more worrying order than what had been set out by the other witnesses, and should be subject to challenge. He submitted that it would be unfair to allow the email in evidence as hearsay, as it would place you at a greater disadvantage by not being able to explore Ms 1's evidence. He submitted that allowing the application would fall foul of achieving the threshold of fairness.

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 legal assessor referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565 *(Thorneycroft)* and the principles set out therein.

The panel first considered the relevance of Ms 1's email exhibited as part of Witness 2's witness statement. It had regard to the fact that Ms 1 was a member of staff on the ward who worked with you and had sent an email to her manager raising concerns about your behaviour. The panel noted that the information contained in the email was supported by several witnesses that would be attending to provide oral evidence and was satisfied as to both the provenance and relevance of the email.

In considering fairness, the panel took into account the fact that the email was not sole and decisive in respect of any of the charges, as there were several statements before it

setting out concerns regarding your alleged behaviour and practice whilst at work. The panel took into consideration the fact that four other witnesses, with supporting evidence, would be attending the hearing to give evidence and would be able to be cross-examined and questioned as to your alleged behaviour on the ward. The panel was also of the view that you are in attendance and would have the opportunity to challenge the content of the email.

The panel took into account that reasonable efforts had been made by the NMC to secure Ms 1's attendance, and that Ms 1 had failed to engage. It determined that although no reason had been provided for Ms 1's non-attendance, it would still be fair to admit the statement as hearsay due to the supporting evidence of the other witnesses who would be in attendance.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms 1, but it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose whilst you were employed as a band 5 registered nurse at University College London Hospital (UCLH). You started working at UCLH on 20 July 2020.

At the end of December 2020, concerns were raised about your ability to manage your patients, your professionalism on the ward, and other concerns spanning various aspects of your practice.

In January 2021, you were placed as a supernumerary and worked under supervision. Whilst under supervision, concerns continued to be raised about your ability to manage patients safely and to escalate concerns. Consequently, you were given a reduced number of patients in an effort to try and help you with managing and prioritising patients effectively. It is alleged that this did not lead to an improvement in your practice

and instead created a burden on the other nurses on the ward who had to take on additional patients.

Further concerns were raised about your communication and professionalism in front of patients and with work colleagues. It is alleged that you were seen talking to yourself on the ward and would have sudden outbursts of shouting on the ward, which led to patients querying your conduct with senior nurses.

The informal stage of performance management started in January 2021. An action plan was put in place which identified a number of areas of improvements. It was hoped that those objectives would be met by the 31 May 2021. However, your performance was inconsistent with you achieving all the objectives on one day but not on the next. As a result of you not meeting your objectives consistently, you were placed on stage one of the UCLH performance management process. On 15 July 2021 you subsequently received your first formal written warning, which gave you until 26 August 2021 to meet objectives, failing which the performance management would progress to the next stage. This time period was then extended until 6 December due to annual leave and also to provide you with additional support.

You were eventually placed on stage two of the performance management programme in January 2022 as it was considered that you continued to be inconsistent in meeting the objectives.

A final written warning was given to you on 19 January 2022. You were monitored for a further 12 weeks until 19 March 2022. However, concerns continue to be raised throughout 2022 regarding your competency.

You were under performance management for some two years, but were found to not have improved in your clinical or behavioural consistency nor in achieving all of the objectives set out.

A disciplinary hearing was held on the 24 February 2023, and subsequent to that, a referral was made to the NMC on 6 March 2023 following which allegations of

dishonesty were made in respect of some of the actions allegedly undertaken by you during your practice.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Buxton, who informed the panel that you made full admissions to charges 1a, 1c, 1d, 2a and 3. The panel therefore found charges 1a, 1c, 1d, 2a and 3 proved, by way of your admissions.

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

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

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

- Witness 2: Ward Sister on the Ward at the time of the alleged incidents.
- Witness 3: Senior Clinical Practice Facilitator at the time of the alleged incidents.
- Witness 4: Training Clinical Practice Facilitator at the time of the alleged incidents.

- Witness 5: Senior Staff nurse at the time of the alleged incidents.
- Witness 6: Deputy Ward Sister at the time of the alleged incidents.
- Witness 7: Clinical Practice Facilitator at the time of the alleged incidents.

The panel also heard evidence from you under affirmation.

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

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

Charge 1b

'That you, a registered nurse,

Between 25 December 2020 and February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:

b) identifying and escalating deteriorating patients'

This charge is found proved.

In considering this charge the panel had regard to the witness statement and oral evidence of Witness 5, the witness statement of Witness 2, the action plan dated 1 February 2022, and your oral evidence.

The panel first considered the witness statement of Witness 5, which states:

‘6: On 25 December 2020, Ms Sabino had a patient who was on ITU stepdown. When a patient has been in the Intensive Therapy Unit (ITU) but they are stable, they are moved to the Ward on ITU stepdown. Which means that they undergo additional observations to ensure they remain stable and safe to stay on the Ward.

7. I was sat at the nurses' station on one of the computers completing some paper work and Ms Sabino was sat on the computer opposite to me. One of the healthcare assistants came and told Ms Sabino that her patient had a NEWS score of 6. Ms Sabino asked the healthcare assistant to repeat the observations in half an hour. Half an hour later, the healthcare assistant told Ms Sabino that the patient's NEWS score was 7.

8. A NEWS score is given to patients as a way of interpreting their observations and to decide whether or not they are stable. I would usually expect a nurse to escalate a patient to the nurse in charge if the patient's score is 5 or above. If a patient has a NEWS score of 7, I would expect the nurse to escalate to the nurse in charge, as well as the patient's medical team and the PERRT team. The PERRT team are a team of very senior nurses that mainly work in ITU. The patient had covid-19 and we had been advised that due to the impact on respiration and oxygen levels, the NEWS score of covid patients may be higher than usual.

9. I waited around 5 or 10 minutes to see if Ms Sabino would do anything but she didn't move from the computer. I asked Ms Sabino if she had heard what the healthcare assistant had said. Ms Sabino said she had heard and so I asked her what she had done. I then went with Ms Sabino to see the patient and to try and determine why their NEWS score was high.

…

12. If Ms Sabino had checked the patient when she had been told that their NEWS score was 6, she may have seen that the NG tube was partially out and avoided this delay. When Ms Sabino was informed that her patient's NEWS score had increased to 7, I would have expected her to check the patient immediately and escalate to at least the nurse in charge. The nurse in charge could then have escalated to the doctors and PERRT team, if necessary. I am unsure whether the patient suffered any additional harm from Ms Sabino's delay but they had to stay in ITU longer than perhaps they otherwise would have. There was a risk that the patient could develop Aspiration Pneumonia as a result of the feed going into the patient's lungs.

13. I discussed my concerns with Ms Sabino towards the end of the shift and I think she understood why I was concerned that she didn't go and see the patient when the NEWS score increased. However, I am not sure she understood the significance of the NEWS score increasing to 7 when it had been 6 half an hour before. As the NEWS score was increasing, I would have expected Ms Sabino to check the patient even if it was a small increase.'

The panel considered Witness 5's oral evidence in this regard and was of the view that it was consistent with her written evidence, and further corroborated in an email to Witness 2 dated 30 December 2022, five days after the incident, which states:

'Further to our conversation on the 25th and your email below, kindly see my concerns I witness when I was on duty regarding Bjork.
I am just concern about the safety of the patient assigned to her.

- *one of her patient who was an ITU stepdown had a NEWS Score of 7 and she hadn't escalated this to either the NIC or doctors or the PERRT team. I over heard the HCA informing her of the NEWS score and that's when this alerted me. I personal had to PERRT the patient and get the doctors to come review this patient.*

- *on visiting the patient I noticed that his NG tube was out some centimetres but the feed was till running.*
- *Also I noticed that this patient was on insulin sliding scale but had no iv fluids running and when I asked why there was no fluids she replied that she was using her own discretion since his BM was high.*
- *On checking the patients MAR chart I noted that the insulin prescription was incomplete - it missed the titration guidelines. So I asked her what she has been using as a guide to titrate and she replied she was using her phone as advised by a certain nurse…'*

I hope this helps as we see how we can help her manage the patients safely. I think she needs to be allocated not complex patients until we are all certain of the patients safety…'

The panel next considered the witness statement of Witness 2, who Witness 5 had reported the incident to, which states:

'19. I understand the patient was on the stepdown intensive care unit. This meant they were safe enough to be on the Ward with additional observation. The patient had a National Early Warning Score (NEWS) of 7. The NEWS score is used to identify if a patient is becoming really unwell. A score above 4 is considered concerning. We would expect the nurse to ask a healthcare assistant to carry out observations every half hour, to call the patient emergency response team (PERRT), and to inform the nurse in charge and medical team so they can review the patient before PERRT arrived. Ms Sabino failed to escalate this patient to the nurse in charge, medical team, or PERRT.'

Although Witness 2 did not witness the incident, it was clear to the panel that her expectation was that you should have escalated the patient as a result of their NEWS score.

The panel next considered the action plan dated 1 February 2022 and noted that an objective to *'Identify unwell patients and/or those at risk of deterioration'* was set out in the action plan as a result of this incident. It was satisfied from the evidence of both Witness 5 and Witness 2, and the objective set out in the contemporaneous action plan, that you had failed to identify a deteriorating patient.

The panel also had regard to your oral evidence, where you described your nursing practice as sub optimal on occasions and accepted that there were times when you did not escalate deteriorating patients. It was satisfied from the evidence before it that you had failed to identify and escalate deteriorating patients and accordingly found charge 1b proved.

Charge 1e

> 'That you, a registered nurse,
>
> Between 25 December 2020 and February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:
>
> e) working cooperatively with colleagues'

This charge is found proved.

In considering this charge, the panel had regard to the witness statement and oral evidence of Witness 4, the witness statement and oral evidence of Witness 7, and your oral evidence.

The panel first had regard to the witness statement of Witness 4, which states:

> 11. *'During the shift on 26 April 2022, Ms Sabino had a patient who was bed bound and needed to be washed. A healthcare assistant was there and ready to help. The healthcare assistant went to get hot water and towels to*

clean the patient with. Ms Sabino decided to start cleaning the patient on her own. She stripped down the patient and then waited for the healthcare assistant to return. When the healthcare assistant arrived, Ms Sabino would not coordinate with them. Ms Sabino would start moving and turning the patient without talking this through with the healthcare assistant or the patient. The healthcare assistant was speaking to Ms Sabino but she would not respond, this meant that the healthcare assistant started to become frustrated.

12. *I would have expected Ms Sabino to wait until the healthcare assistant had returned with the apparatus to clean the patient before undressing them. This would avoid leaving the patient in a vulnerable state when waiting for the healthcare assistant to return. I would also expect Ms Sabino to have had a conversation with the healthcare assistant and the patient as they were cleaning them to avoid the patient feeling uncomfortable. From a safety perspective, cleaning a bed bound patient is a two person job to avoid injury to both the staff and the patient. By moving the patient without properly coordinating with the healthcare assistant, Ms Sabino was putting herself, the healthcare assistant and the patient at risk of injury. I discussed the concerns with Ms Sabino at the end of the day but I cannot recall her response.'*

The panel found Witness 4 to be a careful and considerate witness who was reluctant to find anything wrong with your practice. It therefore found Witness 4's evidence in this regard compelling, noting her reluctance to criticise you.

The panel also had regard to the witness statement of Witness 7 which states:

'11. On the same shift on 3 February 2022, there was a patient in bed 60 who had a intravenous (IV) fluids running but the IV was not connected properly so it had leaked on the floor. I gave Ms Sabino the equipment to clean and sort out the patient but she said she needed to get something and disappeared. The patient needed to be cleaned and to have a new IV connected as quickly as possible, as there was a risk they would become

dehydrated without the IV fluids. As Ms Sabino had walked away, I had to clean this patient and connect a new IV.

12. *I asked Ms Sabino to explain her process of prioritising patients, but she couldn't explain it to me. The medical team started asking me questions about this patient rather than Ms Sabino. I explained that I was not in charge of the patient's care but they told me that Ms Sabino was not engaging with them. I explained to Ms Sabino what my role was and, in that moment I thought she understood, but later incidents suggested she did not understand. Ms Sabino told me that she felt I was there to watch her fail. I explained compassionately that I did not want her to fail and that I was there to support her.'*

The panel noted Witness 7's evidence that the medical team were engaging with Witness 7 instead of you due to your alleged failure to engage with the medical team.

The panel found Witness 7 to be a credible witness, whose oral evidence it found to be compelling and consistent with her witness statement. The panel also took into account the contemporaneous feedback form completed by Witness 7 on the same day, which states:

'Patient in bed 60 called me over and stated that his IV was running but not connected and had leaked all over the floor to which I brought the necessary equipment to ger (sic) *and asked her to clean and sort out the patient while I go and help the patient in bed 62. She put the equipment doen* (sic) *and did not do anything. I saw the equipment and sorted the patient out.'*

The panel was of the view that the note recorded in the contemporaneous feedback form was further supportive and compelling evidence that the incident had taken place as alleged.

The panel also had regard to your oral evidence where you accepted that you did not work cooperatively on this occasion.

The panel also heard compelling evidence from Witness 2, Witness 6 and Witness 3 of other incidents where you had failed to work cooperatively with your colleagues. It was satisfied on the balance of probabilities that you had failed in working cooperatively with colleagues and accordingly found charge 1e proved on the balance of probabilities.

Charge 1f

> ‘That you, a registered nurse,
>
> Between 25 December 2020 and February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:
>
> f) communication with colleagues and patients’

This charge is found proved.

In considering this charge the panel had regard to the witness statement and oral evidence of Witness 7, the feedback form completed by Witness 7 on 2 February 2022, and the witness statement and oral evidence of Witness 6.

The panel had regard to the witness statement of Witness 7 which states:

> *‘18. At the start of the same shift on 2 February 2022, Ms Sabino had received a handover that the patient in bed 47 needed their insulin at 7:30am. The insulin needed to be dual signed so two clinicians needed to sign off when the insulin was administered. Ms Sabino administered the insulin at 10:45am and did so independently. Ms Sabino then came and asked me to dual sign the dose. I checked with Ms Sabino that she had administered the correct dose and the time that she had administered it and dual signed the dose. I explained to Ms Sabino that dual signing meant she needed to check with another member of staff before administering. Ms Sabino told me that she wouldn't do that again.*

19. *At 12:54pm, Ms Sabino administered a second dose without an independent countersign. The prescription stated that there must be 4 hours between each dose. I went through everything again and asked Ms Sabino to explain the safety issue to me. Ms Sabino could not recognise that she had given two large doses of insulin close together. I asked Ms Sabino what insulin is and what it does but she couldn't answer. I explained this to her and asked how much insulin the patient had in their bloodstream but Ms Sabino could not answer.*

    …

    23. Ms Sabino became very fixated about fixing this patient to avoid it reflecting badly on her. She became visibly distressed, so I told her to take 5 minutes and get some water and then come back to the ward. Ms Sabino didn't return for 47 minutes. When I asked her where she had been, Ms Sabino said that she had eaten some food. I was aghast that she thought this was acceptable. I explained that she had compromised patient safety as there was only myself and one other nurse left on the Ward due to lunch breaks.'

The panel had regard to your feedback form completed by Witness 7 on 2 February 2022, and noted that the incident set out by Witness 7 was set out in the contemporaneous feedback form, and stated:

'Came onto shift to see BS handling two different patients with their insulins. Patient in bed 49 on a sliding scale and a patient in 48 with long acting and short acting insulin. Had the patient in bed 48 up on epic, insulin on her WOW but was fiddling with the patients insulin in 49. I then took over and asked her to not do this in future and to focus on one patient at a time, I then took over and administered the insulin for 48 as they had eaten and expressed that BS had come to give their insulin but failed to do so as got side tracked.

…

Concerns regarding her ability to work under pressure as BS became shocked at her error and was unable to engage effectively with her patients. Prioritisation become non-existent and she became fixated on that patient. She then asked for a

5 minute break at 15.03 to which I agreed and said please only 5 minutes as I am on the ward on my own. BS then left and did not come back for 47 minutes as she went to have her lunch.

While she was away I went to turn her patient and change them as it was noted that she had not closed the PEG feed and it leaked all over the patient as well as not connecting the insulin for the patient – therefore they were only receiving glucose and potassium rather than the full VRII.

Upon her coming back, she did not tell me of her arrival back and did not communicate or engage with myself, she continued to speak to herself in both English and Italian and when asking her if she is okay, she replied yes and continued to act in a strange manner. This behaviour was noted by patients and staff alike and patients felt unsafe to ask her for help and therefore began to ask other members of staff.'

The panel considered the evidence of Witness 7 to be credible. It found her witness statement and oral evidence to be consistent and further supported by the contemporaneous feedback note made on the same day of the incident.

The panel was satisfied that this was evidence of a failure to communicate with colleagues in that you had been corrected for your actions and told how you should do it, but shortly after undertook the same incorrect action and took an extended break without communicating to your colleague that you would be doing so.

The panel also heard evidence from Witness 6. In her witness statement Witness 6 stated:

'27. There were several incidents where Ms Sabino would become upset and would start acting in an erratic way on the Ward. [PRIVATE].

28. On nearly every shift, patients would raise concerns to me about Ms Sabino and would ask if she was 'ok'. The patients seemed scared that their nurse wasn't there

mentally. If a patient asked Ms Sabino if she was ok or if there was anything they could do, she would snap at the patients and say something along the lines of, "do I look like I need your help, I'm fine". I explained to Ms Sabino that her patients were concerned about her. She said that she didn't mean for it to be that way. I told her that if she started feeling overwhelmed or upset then she should let me know and I could cover her for 10 minutes whilst she took a break. Ms Sabino did this once or twice but she didn't like leaving the Ward in her uniform and there wasn't enough time for her to change for a short break like this. I explained to [Witness 2] *that patients were raising concerns about Ms Sabino in the emails produced in this bundle.'*

The panel found Witness 6's oral evidence to be consistent in this regard, and noted that it was further supported by the contemporaneous records entitled *'Staff concerns Dated 07/02/2022'* and *'Concern dated 23/05/2022'* which respectively state:

'…I am sorry sister but like today since this after either she has been crying or talking to herself again.

Because she was upset [PRIVATE] when she was sitting in the end bay when she talks to herself and when asked by either myself or [Ms 8] *asked her if we could help her she says no thank you.*

Its not only that the staff are asking what I the matter but patients are telling me that they are scared of her and they don't want to be looked after by her…'

And

'I have tried to leave her alone as much as possible but when patients started to complain in that bay i needed to step in.

Bed 52 had voiced concerns and stated that she was worried that her nurse is not herself.

Bed 53 said the same. Each time i tried to have a conversation about how her day was or how she was doing today B was saying she didn't have any concern and that she was okay…'

The panel also heard evidence from Witness 6, Witness 7, Witness 4 and Witness 3 that you would talk to yourself on the ward in English and Italian or mumble, and that this had caused both patients and relatives to be concerned and raise their concerns with other members of staff. It also took into account the hearsay evidence of Ms 1, contained in a contemporaneous email dated 11 June 2022 which recorded similar behaviours. The panel was satisfied that, in totality, this was compelling evidence.

In your oral evidence you accepted that at times your communication was sub-optimal. You also accepted that you sometimes talked to yourself as a way of processing information and doing calculations, and that you were often loud. You stated that you were provided with feedback about this and recognised that this behaviour could be seen as unprofessional.

The panel was satisfied from the evidence before it that you had failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in the area of communication with colleagues and patients, and accordingly found charge 1f proved.

Charge 2b

'You documented observations on patients records by using previously recorded observations from earlier shifts, on one or more occasions, including but not limited to:

b) 25 January 2022'

This charge is found proved.

In considering this charge, the panel had regard to Witness 7's witness statement and oral evidence, the feedback from dated 22 February 2022 and your oral evidence.

The panel first had regard to the Witness 7's witness statement which states:

'10. On 25 January 2022, I raised a number of concerns in a feedback form…

11. During this shift, Ms Sabino completed her patient notes at 8:29am on System One and did not look at these or update them again during her shift. Ms Sabino would fill everything in at the start of her shift and then file it. This meant that other clinicians can view the notes when they are incorrect and form a plan for the patient based on this incorrect information. Ms Sabino would look at the previous day's plan and input the information into the current day's notes even though the medical team had not seen the patient. The patient's notes should not be filed until the medical team have finished their round and prepared a new plan.'

The panel noted that the statement only noted that you did not update the patients notes again for the remainder of the shift. However, during her oral evidence Witness 7 went into further detail about the incident, stating that you copied and pasted the information from a previous shift into the patients notes, and that it was this information that you did no go back to update. Witness 7 stated that she knew you had copied the information from the previous shift because she had checked and noted that it had been copied *"word for word"*, and did not reflect the actual situation of the patient.

The panel found Witness 7's oral evidence in this regard to be compelling, noting the actions she had taken in going to check the patient's record from the previous shift. The panel also found Witness 7's oral evidence to be consistent with her written statement. The panel also had regard to the contemporaneous feedback note dated 2 February 2022 which states:

'Poor verbal and written communication. Writing and signing notes @

08.34am – previously highlighted that this is not to continue and to pend notes and add accordingly throughout the day. Flowsheets are not true reflections of patients…'

The panel was of the view that the feedback recorded in the note was somewhat vague and did not specifically refer to information being copied and pasted. However, it was satisfied from Witness 7's oral evidence that she had clarified in detail why she believed the information had been copied and pasted by you from the previous shift, and that the note made in the feedback form was in reference to you copying and pasting previous notes which should never be done.

In oral evidence you stated that, although you could not recall the incident, Witness 7 had no reason to fabricate evidence. Further, in re-examination you stated that you must have copied it.

The panel was therefore satisfied on the balance of probabilities, from the evidence before it, that on 25 January 2022 you did document observations on patients records by using previously recorded observations from an earlier shift. It therefore found charge 2b proved.

Charge 2c

'You documented observations on patients records by using previously recorded observations from earlier shifts, on one or more occasions, including but not limited to:

c) 17 February 2022'

This charge is found proved.

In considering this charge the panel had regard to the witness statement and oral evidence of Witness 7, the Feedback form dated 17 February 2022, and your oral evidence.

The panel had regard to Witness 7's witness statement which states:

> *'42. On the same shift, I noticed that Ms Sabino had filed her patient's notes at 12:48pm, before she had completed half of her shift. I had raised this behaviour in a previous feedback form on 25 January 2022 but Ms Sabino had done it again. As Ms Sabino was filing the notes at the start of her shift, this meant that the medical team were using potentially incorrect notes to produce a plan for the patient.'*

The panel had regard to the fact that Witness 7's statement stated that you had repeated the incorrect clinical practice that she had told you about in relation to charge 2a (on 3 January 2022) and charge 2b (on 25 January 2022). The panel noted that the witness statement did not specifically refer to copying and pasting of patient notes but directed you to file your notes before the end of a shift.

The panel also took into account the contemporaneous Feedback form completed by Witness 7 following her observation of you on 17 February 2022, which states:

> *'Written communication persists as challenging as it is not reflective of the patients current states such as waterlow etc.'*

Again, the panel noted that the contemporaneous note made by Witness 7 did not specifically state that you had copied information from a previous shift. However, in oral evidence Witness 7 stated that she had been with you from 8am and that you had not been to see any of your patients but had still recorded in a tick box that the skin integrity and mobilisation for a patient was OK. Witness 7 gave evidence that you could not have assessed the patient's skin integrity or mobilisation as you had not assessed the patient. In her oral evidence, Witness 7 told the panel *"I had been with her from 8am, wherever Bjork was I was. I was with her the entire shift."* Witness 7 gave evidence that the nurse in charge had mentioned during the handover there was a potential for this patient's skin breaking which had not been checked at this point (the point of handover). The panel took into account the fact that Witness 7 was observing you on this shift and was required to feedback about your performance at the end of the shift. It considered

Witness 7's evidence in this regard to be detailed and compelling and noted that Witness 7 would have been specifically looking out for an assessment of the patient's skin, having been informed that there was potential for skin deterioration.

You told the panel that it was standard practice for you to introduce yourself to patients and assess them at the start of every shift, however you did not recall this date or the patient in question. You told the panel that you would not invent patient scores, could not think of a reason why you would have done this, but did not believe Witness 7 would fabricate evidence.

Having found Witness 7 to be a credible witness, who had made a contemporaneous note of feedback, that there was information recorded in a patient's notes made by you which did not match the patient's actual state, the panel accepted Witness 7's oral evidence that you had copied information from a previous shift, without having conducted an assessment of the patient. It therefore found charge 2c proved.

Charge 4a in relation to Charge 2a

'Your conduct at charges 2 and/or 3 was dishonest in that you:

a) Knew that you were entering observations from a previous shift;'

This charge is found NOT proved.

Having found charge 2a proved, the panel went on to consider your state of mind at the time of you entering observations from a previous shift on to the patient's records.

In considering this the panel had regard to your written reflection which states:

'…In this particular case I did not take the vital signs for two essential reasons. One, the patient was comfortable, pain-free, eating reasonably well as per patient standard, mobilising with not exhaust effort and unusual mobility equipment ie: walking stick, crutches, Zimmer frames. Most of all the patient narrative of his/her

feeling at the time of the assessment matched the vital signs picture in the previous 1.5 hours.

I did not think, at the time, that it was fear to take another set of vital signs as the patient was stable. I thought about the patient having the cuff inflated many times a day even when it is not necessary, and at time some people get a bit fed up with having to repeat them, it surely can be uncomfortable for some patients and they do not like to be bothered constantly. It can be a waste of nurse's resources too as time could be allocated to more urgent task and priorities like for instance administering medication to patient who are in pain

The ward manager appeared very serious about the potential cause of FRAUD the patient's information, that I really got somehow worried about her concern. I mean Fraud and Falsify someone notes is very serious accusation. It is equal to stealing or falsify someone information for ones own benefit, and that was surely not the case, because I was not benefitted by recording the health care notes in any shape of form. I have, however, removed the entrance of the notes there and then in front of the ward manager and that is how intimidated of the consequence of that action, I felt at the time. No, way under any sky I would have considered I could be accused of something as serious as that, I have always been known for my directness, sometime very serious manner, and honesty as my best qualities. In my opinion at the time I complied with the instructions that the senior nurse shown to me on my first 2 weeks of induction on T9Noorth.'

The panel noted that you accepted you had copied and pasted the notes, but you stated that you had not done it dishonestly and wanted to create a full picture without disturbing the patient. You stated in oral evidence that you had *"borrowed the observations for completeness".* The panel found your evidence in this regard to be confusing. It noted that when questioned by Ms Shah and the panel as to why you had cut and pasted the previous observations, at a point where observations were not required you stated that it was useful to cut and paste as that is how you worked on the notes. You were unable to give the panel any clear explanation as to why you thought it would have been helpful to other practitioners and stated that you believed that you had

been shown to work this way by a senior nurse during your induction. In oral evidence you told the panel that this way of working had now become a habit.

The panel also heard evidence from a number of the witnesses that you worked well on some days, and on other days would not do as well. It heard evidence that you were [PRIVATE] at this time due to the supernumerary programme that was in place and the fact that you were being performance managed. The panel also noted that no suggestion of dishonesty was made by the witnesses. The panel was of the view that [PRIVATE] as a result of being performance managed, and that you adopted a practice that you did not believe to be incorrect as you believed you had been told to do it this way.

The panel had regard to the evidence of Witness 2 that she told you on 3 January 2022 that this was not acceptable. It was of the view that this was the first time you had been directly challenged about this practise. The panel accepted that at this point you were unaware that this was incorrect practice until you were informed by Witness 2.

The panel determined that you had held a misguided belief at the time of the incident in charge 2a. It determined that your actions in documenting observations on patients records by using previously recorded observations from an earlier shift on 3 January 2022 would not be regarded as dishonest by the standards or ordinary decent people as you held a misguided belief until you were told by Witness 2 what you were doing was wrong. It therefore found charge 4a in relation to charge 2a not proved.

Charge 4a in relation to Charges 2b and 2c

‘Your conduct at charges 2 and/or 3 was dishonest in that you:

a) Knew that you were entering observations from a previous shift;’

This charge is found proved.

The panel noted that the incidents in charges 2b and 2c had taken place following Witness 2 bringing to your attention that you should not be copying and pasting patients’

previous observations on 3 January 2022 and should be undertaking your own observations and recording them.

In oral evidence Witness 7 stated that the observations put down by you on the patients records on 25 January 2022 did not reflect the actual status of the patient. Witness 7 gave evidence to the panel that she had been with you for the whole of your shift, and you did not carry out the observations for that patient. In relation to 17 February 2022 Witness 7 also gave evidence that you had documented that a patient did not have skin integrity issues, when she now did. Witness 7 told the panel that you would have picked up these issues had you undertaken the observations. The panel accepted the evidence of Witness 7, having found Witness 7's evidence in respect of charge 2b and 2c to be credible, and on the basis that she was the clinical practice facilitator whose role was to observe you on that shift.

During your oral evidence you told the panel that you did not recall the incident or the patient and were not able to provide any insight into your state of mind at the time of the incident. However, the panel had regard to the fact that you had, by this date, been informed by Witness 2 that you should not be recording observations that you had not taken yourself, and which you had accepted in evidence. Furthermore, in your reflection of dishonesty document dated 15 July 2024 you stated that you had taken Witness 2's mention of fraud very seriously. The panel also took into account that the observations in relation to charge 2b required boxes to be ticked and were therefore entries which required you taking an active role to mark that you had undertaken the observations when you had not. The panel was therefore satisfied that you were aware that recording these observations that you had not undertaken was wrong, and that you had done so with an intention to create the impression that you had undertaken the observations.

The panel took into account the fact that you were still being performance managed on 25 January and 17 February 2022, were eager to no longer be performance managed, and had been told three weeks prior that you must not copy previous observations from previous shifts. Further you recorded details of observations, despite knowing that you had not undertaken any such observations. It was therefore satisfied that you would

have known that your actions in documenting observations on patients records by using previously recorded observations from earlier shifts, were dishonest.

The panel was satisfied on the balance of probabilities that your actions in documenting observations from previous shifts would be seen as dishonest by the standards of ordinary decent people, with a view to misrepresent that you were capable of doing more work without supervision. Accordingly, it found charge 4a proved in relation to charges 2b and 2c.

Charges 4a and 4b in relation to Charge 3

4. ‘Your conduct at charges 2 and/or 3 was dishonest in that you:
    a) Knew that you were entering observations from a previous shift;
    b) Knew that you had not amended the observations;’

This charge is found proved.

The panel noted during your oral evidence you had appeared to contradict your earlier admission to charge 3 by claiming that you had deleted your entries on the smart text on 3 January 2022. In taking account of Witness 2’s written and oral evidence, and the letter dated 1 February 2022, the panel preferred the evidence of Witness 2 because it was contemporaneous and stated:

> *‘With regards to your written communication, this also remains poor. I gave you an example of when you worked on the bank holiday (3 January 2022), you started your shift at 7:25am and at 8:25am, you had already completed 10am patients' notes on EPIC. I explained that I was working on that shift and it was the previous nights' observations that were entered on EPIC. I subsequently spoke to you and asked you to update them as they were not correct. When I returned to work the next day, these observations were still unchanged, and you had not updated them.’*

Although it considered your oral evidence that you had deleted your entries, the panel accepted the evidence of Witness 2 that the notes had not been amended.

Following clarification from the parties, the panel accepted that you did not return to your notes on any occasion and that despite being instructed to amend the records you failed to do so. It was on this basis which your admission to charge 3 was made.

In considering your state of mind at the time, the panel took in account that you had been told by Witness 2 that the entries were not correct and that you needed to update them on the day in question. Further it was discussed in your one-to-one meeting with Witness 2. The panel was satisfied that you had a chaotic approach to case management. However, it found that you were aware that what you were doing was not in line with Trust policy. You had been told to update the patient records and did not do this. The panel was satisfied that your actions would be regarded as dishonest by the standards or ordinary decent people as you had consistently been told by managers to stop filling in information early, knew you would need to record observations, had been told to amend them and did not do it. It therefore found this charge proved.

Charge 4b in relation to Charge 2a

4. ‘Your conduct at charges 2 and/or 3 was dishonest in that you:
    b) Knew that you had not amended the observations;’

This charge is found proved.

The panel took into consideration the evidence of Witness 2, that she had told you to amend the observations, and when she had gone back the next day to check they had not been updated/amended.

You gave evidence to the panel that you knew you had not amended the observations and had copied and pasted them.

In the outcome letter to you dated 1 February 2022, Witness 2 stated the following:

‘With regards to your written communication, this also remains poor. I gave you an example of when you worked on the bank holiday (3 January 2022), you started your shift at 7:25am and at 8:25am, you had already completed 10am patients' notes on EPIC. I explained that I was working on that shift and it was the previous nights' observations that were entered on EPIC. I subsequently spoke to you and asked you to update them as they were not correct. When I returned to work the next day, these observations were still unchanged, and you had not updated them.’

And

I expressed concern that are copying and pasting previous shift observations when you were not even on duty. In summary, I said that you were updating patient’s notes before reviewing the patients appropriately which can ultimately have a serious impact on patient’s care and safety. I asked you whether you recall this shift and you said that your approach is different to my method of working. You said that you do this all the time and explained that when you start your shift, you would check all your patients, equipment, IV fluids, catheters etc and then proceed to do your notes. You further described your method of updating notes which involves you specifying that you have made the checks, copying the previous observations into the current shift with the intention of updating the vital signs at 10am when you do them.

I reminded you that this is not the correct procedure to follow. I explained that the assessments have to be completed after reviewing your patients and this it to be documented appropriately and not to be taken from previous notes…In response you acknowledged my concerns and said that you should not enter those notes on EPIC without having made the assessments…’

The panel also had regard to Witness 2’s statement which supported the outcome letter to you dated February 2022 and states:

‘35. Observations are carried out every 4 hours from 10am. Ms Sabino had copied the observations from 6am into the 10am notes. Usually the healthcare assistant would carry out the observations and then the nurse would sign these off once she had checked the patient. Ms Sabino was signing this off before the 10am observations, at 8:25am. I approached Ms Sabino on the Ward at the time and asked why she had done this. Ms Sabino explained that she would update the notes throughout the day if anything changed. I asked Ms Sabino to change these and to fill them out properly. I checked the notes again the next day and they remained unchanged.’

The panel was satisfied from the evidence before it that it was at this point, when Witness 2 had spoken to you, that you now accepted that your process of working was wrong and understood why. It accepted that it was your misguided custom and habit to use previously recorded observations from earlier shifts, and that you accepted that you did not amend them and should have done so.

In considering your state of mind at the time the panel had regard to Witness 6’s evidence that you became frustrated when you were asked to do so something. It also had regard to your evidence that you had your own way of doing things and preferred it to what you had been shown. The panel found that you were entrenched in your own way of working and were not prepared to move from it. It found your state of mind at the time to have been chaotic, and unreceptive to being told the right way of doing things. It was satisfied that the expectations of the Trust had been made clear to you, but you simply just did not do it, continuing to work in your way and disregarding the advice given.

In your oral evidence you stated:

‘That is fraud and you are a falsifying the patients notes. So…I kind of felt that dread like thing oh, why am I doing here and I didn't actually consider carefully. Like…the rational. But you know she's the ward manager and I have got to listen to what she's saying because obviously she has got a much more experience than me. She she's in a ward managing position. She is.

You know why? Beyond my level of understanding about the law, about a lot of things and only now I can see what she was saying. Truly, truly. And I'm going to say fully understand what she was saying at the time I thought or more. This is fraud.'

The panel was therefore satisfied that you knew you should have amended the observations and did not do so.

The panel considered whether your failure to amend the recorded observation would be considered as dishonest by the objective standard of ordinary decent people. It was made abundantly clear through feedback sessions, meetings and on-site support what you should have done. The panel determined that this would be considered as dishonest behaviour by the standard of ordinary and decent people. Accordingly, it found this charge proved.

Charge 4b in relation to Charges 2b

4. Your conduct at charges 2 and/or 3 was dishonest in that you:
   b) Knew that you had not amended the observations;

This charge is found proved.

In considering this charge, the panel considered the evidence in relation to your state of mind at the time. It took into account that at the time of the incident you had made an entry when you knew you had not observed the patient and had not undertaken the assessments. Further, you were aware that you had copied the scores from the previous day and knew that you had not amended the observations. Further you had been made aware by Witness 2 that you were not to do this and had accepted that this was not the correct process. The panel was therefore satisfied that you knew that the entries you had made were not based on an observation you had taken for the purpose of those entries.

The panel was satisfied that your actions would be seen by the standards of ordinary and decent people as dishonest. It therefore found this charge proved.

Charge 4b in relation to Charge 2c

4. ‘Your conduct at charges 2 and/or 3 was dishonest in that you:
   c) Intended to create the misleading impression that the observations recorded were the correct observations.’

This charge is found proved.

Having found that you had copied information from a previous shift without having conducted an assessment, the panel was satisfied that you would have known at the time that the record made did not derive from a corresponding assessment and therefore would have been misleading.

The panel was satisfied that your actions in this regard would be seen as dishonest by the standards of ordinary and decent people. It therefore found this charge proved.

Charge 4c in relation to Charges 2a, 2b, 2c and 3

4. ‘Your conduct at charges 2 and/or 3 was dishonest in that you:
   c) Intended to create the misleading impression that the observations recorded were the correct observations.’

This charge is found proved.

The panel was satisfied that, in respect of charges 2a, 2b, 2c and 3 you were aware that you had not changed the observations you had recorded and that another set of observations should have been carried out. These were acutely ill patients whose conditions were likely to change, and you had not updated any of those changes. Further, you had copied and pasted the last set of observations and, despite being informed by Witness 2 and Witness 7 what you needed to do, you instead left the shift.

The panel was satisfied that you knew what you were supposed to do and deliberately chose not to do it in order to create the misleading impression that the observations recorded were the correct observations. You did not simply forget, and you did not have an alternative explanation for this.

The panel was satisfied that your actions would be considered dishonest by the standards of ordinary and decent people. It therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence, in relation to charge 1, and/or misconduct, in relation to charges 2, 3 and 4, and if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

The panel heard oral evidence from you under affirmation in relation to this stage.

Submissions on lack of competence, misconduct and impairment

Ms Da Costa's submissions on behalf of the NMC focused first on whether your actions at charges 2 to 4 amount to misconduct, and whether your actions in charge 1 amount to a lack of competence, and then whether as a result, you are currently impaired.

Misconduct

Ms Da Costa 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.*'

Ms Da Costa invited the panel to take the view that the facts found proved in charges 2 to 4 amount to misconduct as these fell short of what would have been proper in the circumstances and breached the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). She identified the specific, relevant standards where your actions amounted to misconduct. These were:

- Section 4: Acting in the best interests of people at all times.
- Section 10: Keeping clear and accurate records relevant to practice.
- Section 20: Upholding the reputation of the profession at all times.

Ms Da Costa submitted that you repeatedly failed to act in the best interests of your patients, failed to maintain clear and accurate records, and engaged in dishonest conduct, all of which placed patients at significant risk of harm.

Further, Ms Da Costa emphasised the dishonesty element of the charges and submitted that this compounded your failings and called into question your trustworthiness and professionalism. She submitted that this presents an attitudinal issue.

Ms Da Costa submitted that the relevant legal test to be applied is set out in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She submitted that you had put patients at

unwarranted risk of harm, brought the nursing profession into disrepute, breached fundamental tenets of the profession and acted dishonestly, therefore, your fitness to practise was impaired in the past.

Ms Da Costa further submitted that you remained liable to do so in the future. She highlighted that dishonesty is not always easy to remediate, and at this stage, there was insufficient evidence before the panel to satisfy that you are no longer impaired.

Lack of competence

Ms Da Costa noted that 'lack of competence' is not defined in statute, but submitted that the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) established that a fair sample of work must be considered when determining whether performance was to an unacceptably low standard as to amount to a lack of competence.

Ms Da Costa outlined for the panel that you were placed on supernumerary status in January 2021 and remained under supervision for at least two years, yet you were never signed off as competent to be able to work independently. She submitted that this period provided a fair sample of your work, which demonstrated that your performance was unacceptably low. She submitted that your practice was described as "inconsistent" and that there was repeated risk of harm to patients due to your failings.

Ms Da Costa submitted that the facts found proved show that your competence at the time was below the standard expected of a registered nurse with your experience, and as a result, you also remain currently impaired due to your lack of competence.

To conclude, Ms Da Costa submitted you are currently impaired on both public protection and public interest grounds, due to serious departures from the expected standards, repeated failings and dishonesty that is not easily remediable.

Mr Buxton structured his submissions in reverse order, first addressing the issue of lack of competence and then moving to the misconduct allegations.

Lack of Competence (Charge 1)

Mr Buxton accepted that you were placed on a performance improvement plan for a considerable period and submitted that you understood the purpose of it and sought to improve your performance. He outlined that the panel may consider the context that you had difficult working relationships with your line manager and colleagues, with the exception of Witness 3, who spoke highly of you.

Mr Buxton did not dispute the facts, some of which you admitted from the outset. He submitted that you had taken learning and remediation steps, including courses on nasogastric tube placement, patient safety, record-keeping and communication. However, due to your lack of recent clinical work since 2023, there was no current evidence to assess your present level of competence.

Mr Buxton requested the panel to recognise that you had reflected deeply on your past actions and taken a responsible attitude towards your professional development.

Misconduct (Charges 2 to 4: Record-Keeping and Dishonesty)

Mr Buxton did not dispute that your record-keeping failures and dishonesty amounted to misconduct. He acknowledged that the test in *Grant* was properly satisfied in relation to your past actions, but the key issue was whether you remain impaired moving forward.

Mr Buxton submitted that record-keeping failures are remediable and that you have undertaken relevant training to address these deficiencies.

Regarding dishonesty, Mr Buxton acknowledged that it is often considered hard to remediate but submitted that it does not mean a person can never be trusted again. He emphasised that there was no prior history of dishonesty or misconduct before the incidents in question and no evidence of repetition since then.

Mr Buxton submitted that you had demonstrated insight into your failings and acknowledged your past mistakes. He highlighted your frankness during your oral

evidence in the hearing, where you admitted that NMC witnesses had no reason to lie about their concerns.

Mr Buxton also submitted that you had shown an ability to self-reflect, even describing yourself as arrogant in the past but now recognising the need for change. He suggested that this level of self-awareness reduced the risk of repetition and demonstrated that you had learned from the experience.

Mr Buxton submitted that that the risk of future misconduct was low, given your remedial efforts and attitude change.

In terms of the public interest, Mr Buxton acknowledged that dishonesty damages public confidence in the profession and is a serious concern for regulators. However, he submitted that if the panel found sufficient remediation and insight, it could conclude that public confidence would not be undermined if impairment was not found on public interest grounds.

In conclusion, Mr Buxton left the decision to the panel but invited it to consider the low risk of repetition, the remediation efforts you made and the passage of time before making a finding of current impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v General Medical Council* [2009], *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008].

Decision and reasons on lack of competence

The panel referred to the NMC guidance (FTP-2b) on lack of competence, which defines this as:

"Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk."

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

*'**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'

The panel took into account the context of the circumstances at the time, as well as your professional history. It recognised that a single clinical incident does not, in itself, indicate a general lack of competence. However, the matters found proved and admitted in charges 1a, 1b, 1c, 1d, 1e, and 1f relate to multiple, serious and wide-ranging failures in fundamental aspects of nursing care, all of which are covered in detail in the panel's earlier decisions on facts. For the purposes of this stage, the panel identified some examples which illustrate unacceptable deficiencies in your practice and breaches of the Code, that amount to a lack of competence:

Charge 1a

In February 2022, you left a patient at risk of falls, naked and covered in faeces on an elevated bed, unattended with no bedsides up, while you went to retrieve supplies to clean the patient. This left the patient in an undignified position and at significant risk of harm.

This demonstrated an unacceptably low standard of professional performance in basic clinical care. Your actions breached Code 1.1, as you failed to treat the patient with kindness, respect, and compassion, thereby compromising their dignity and leaving them vulnerable.

Charge 1b

On 25 December 2020, you failed to escalate a concerning NEWS score. You also admitted in oral evidence that there were multiple occasions when you did not escalate deteriorating patients. Escalating concerns is a fundamental aspect of nursing care for all patients, and failing to do so can have severe consequences. Your actions breached Code 1.2 and 1.4, as you failed to provide timely and effective care, amounting to a lack of competence.

Charge 1c

On 2 February 2022, you made multiple errors in medication administration, particularly in regards to the dispensing of insulin. You failed to obtain a dual signature from another clinician before administering insulin, administering it independently before seeking a countersignature. Witness 7 corrected you, yet you repeated the same error by giving a second dose without an independent check. Furthermore, you administered the second dose prematurely, failing to adhere to the required four-hour interval between doses. Your lack of understanding regarding the importance of having an intravenous infusion running alongside an insulin sliding scale further demonstrated a serious deficiency in your practice. Your repeated errors breached Code 2.1 as you failed to listen to your colleagues concerns and act upon their professional guidance. This demonstrated an unacceptably low standard of professional performance and a clear lack of competence.

Charge 1d

The panel noted that on several occasions you signed off records prematurely, failed to update patient records throughout shifts and recorded observations without assessing patients. Despite being corrected by colleagues, you continued these serious documentation failures, which compromised patient safety. Accurate record-keeping is a fundamental nursing responsibility, and persistent failures in this area demonstrate an

unacceptably low standard of professional performance and amount to a clear lack of competence.

Charge 1e

As an example, the panel considered the incident where your colleague gave you a five-minute break to de-escalate a situation as you appeared visibly distressed. However, you took 47 minutes to return, leaving two of your colleagues to manage the ward alone. When questioned, you appeared to show no concern for how this affected patient care or staff workload. Your failure to work cooperatively breached Code 2.1 and demonstrated an unacceptably low standard of professional performance. A lack of awareness of the need for teamwork in a clinical setting amounted to a lack of competence.

Charge 1f

Following on from the incident above, the panel noted that upon your return from the break, you did not communicate with colleagues and instead spoke to yourself in Italian, making those around you feel confused and concerned. Patients and staff alike reported that this behaviour made patients feel unsafe, causing them to seek assistance from other nurses rather than approach you for help. Your inability to maintain professional communication and reassure patients demonstrated inadequate clinical conduct and a lack of competence.

The panel determined that your conduct in Charge 1, which were admitted and found proved, relate to fundamental aspects of nursing care including: patient dignity, medication administration, escalation of concerns, record-keeping, teamwork and communication. These were not isolated incidents or minor errors of judgment; they were repeated conduct and wide-ranging failures that persisted despite significant support and correction.

The panel also considered that you were under supervision and a performance management plan for two and a half years. Despite an apparently well planned, executed and documented management plan involving a high level of support from experienced colleagues, you were unable to sustain any improvement in your practice.

Your performance fell significantly below the expected standard of a registered nurse, as assessed over a fair sample of your work.

Taking all these factors into account, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on misconduct

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

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

*'**1 Treat people as individuals and uphold their dignity***

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

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

8 Work cooperatively

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

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, 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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly…

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, in this case, the panel found that the seriousness, scope and repeated nature of your conduct in charges 2 to 4 posed a direct and indirect risk to patient safety and undermined public confidence in the nursing profession.

In reaching these findings about breaches of the Code, the panel reminded itself of the multiple serious incidents covered in its findings of facts and detailed in the individual charges above.

The panel noted that these charges were in relation to documentation errors, not amending patient records and dishonesty. The panel also noted that you accepted that charges found proved amounted to misconduct.

Dishonesty

Dishonesty is widely regarded as serious misconduct, though some instances are more severe than others. In this case, the panel determined that your actions of copying patient observations posed a significant risk of harm as it compromised the accuracy of clinical records. This misrepresentation of patient information could mislead colleagues and medical practitioners about a patient's actual condition, obstruct timely identification of deterioration leading to delayed or inappropriate treatment and result in clinical decisions being made on false information, potentially leading to severe consequences. The panel determined that your dishonesty put patients at significant risk of actual harm by not portraying a true clinical picture at the time of documentation.

Furthermore, the panel considered that your dishonesty was not an isolated incident but rather part of a repeated pattern of behaviour, further exacerbating the risk to patients.

Link to other record-keeping failures

The panel noted that your dishonesty was closely tied to other serious documentation failures, including your failure to accurately record observations, copying patient observations instead of conducting assessments and failing to perform observations at the allocated times.

These errors falsified the clinical picture of vulnerable patients, particularly in a high-risk ward where many patients were recovering from intensive care. Given the fragile condition of these patients, even minor documentation errors could have life-threatening consequences.

The charges found proved show that you cut and pasted previous observations, taken by other members of staff on a previous shift, into your patients' records. You were repeatedly advised not to record observations in this way but persisted with this unacceptable practice in the knowledge that it potentially put patients at risk and was not consistent with Trust practice and policies.

The panel found that your actions fell seriously short of the conduct and standards expected of a registered nurse. Given the nature, extent and impact of your misconduct, particularly the dishonesty, the panel concluded that your conduct amounted to serious professional misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel determined that all four limbs of the test, as set out above, were engaged.

The panel found that your misconduct and lack of competence resulted in patients being put at risk, and in some instances, led to actual harm. An example of this is your repeated unsuccessful attempts to canulate a patient. The panel determined that your past actions had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was also satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Having found that you were impaired in the past, the panel referred itself to the case of *Cohen* and discerned whether your misconduct and lack of competence are remediable. Given that your errors were primarily clinical, the panel acknowledged that they are potentially capable of remediation. However, it also considered your history of performance improvement efforts. Despite being placed on a supported performance management plan for over two years, you continued to make repeated errors. This was

also despite your caseload being reduced to two patients per shift and your being supported at all times by a senior nurse or a Clinical Practice Facilitator. There is insufficient evidence before the panel to suggest that you have in fact fully addressed each of the relevant concerns.

The panel also noted that while clinical shortcomings may be remediable, dishonesty and attitudinal concerns are more difficult to address.

Regarding insight, the panel considered that you made admissions and produced an extensive reflective piece. You also gave oral evidence at this stage. While it acknowledged your self-reflection, including your recognition of arrogance and immaturity at the time, it found your insight to be extremely limited. Although you reflected on what you could do differently in the future, this reflection was mainly focused on you, the impact this had on you and your practise and your future aspirations. The panel also found there was insufficient demonstration of remorse or understanding of the extent of your wide-ranging failings and the broader consequences of these, such as the impact that they had on the patients, your colleagues and the profession. The panel found your reflection difficult to follow at times, and it appeared that you sought to minimise responsibility for your actions:

> *"so as to ensure that patient's safety is preserved amongst all the uneventful circumstances is to be able to attend to the needs of the patients immediately, and this what I would normally do, but in this particular patient I was pressurised into ensuring that the sliding scale was administering the insulin that the patient was required, and in order to do so, at the time my priority was to take the patient back to safety he needed to have the sliding scale working effectively. In other words, what I should have ideally done is to make a quick call to the site manager of the matron ask their help, and then return back to reconnecting the sliding scale." [sic]*

Also, in your reflection you state:

> *"Lastly, I write an incident of the occurrence and the rationale for this is that there is no evidence really that took any considerations of the difficulties that we had on the ward because some of the equipment was not working effectively at the time, and the reason I know this is that though I was on the management performance for significant period of time, the ward conditions did actually not changed much, hence, signifying that either no effort was allocated to identify causes other than nurses effort and experience that could have impacted on the suboptimal outcomes of patient condition and deterioration. And, because I felt I was not truly getting through to the members of the staff at the time, I actually wrote it about into my revalidation and considered how human factors such as staffing, equipment, lighting and so on could impact the safety of the patients on the ward." [sic]*

The panel carefully considered whether you had taken sufficient steps to improve your practice. It reviewed the additional training and courses you undertook, including the certificates submitted as evidence. However, the panel found that the training was limited in scope and relevance to the matters in issue, and did not adequately address the breadth of concerns raised. It also noted that some of the courses you completed dated back to 2019–2023, with limited evidence of recent or ongoing training to address your deficiencies. Further, it found that your oral evidence at this stage did not provide sufficient assurance that you fully understood the severity of your failings.

You told the panel in your oral evidence that you did not wish to return to practise in a ward setting as you felt that you would be unsafe to administer medication. You talked about working in health promotion teaching, research, or in an out-patient setting. The panel reminded itself that being on the register implies that a nurse or midwife is safe and competent to work in any nursing or midwifery environment.

While the panel believes your conduct could potentially be remediated, it identified a risk of repetition due to your extremely limited insight and insufficient evidence of

strengthened practice. As a result, the panel concluded that a finding of impairment is necessary on the ground of public protection.

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

The panel determined that a finding of impairment on public interest grounds was required. A reasonable member of the public would be concerned that you have not yet fully addressed the issues identified. The public expects nurses to be both competent and honest and failure to uphold these standards would undermine confidence in the profession.

Having regard to all of the above considerations, the panel was satisfied that your 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 12 months. The effect of this order is that the NMC register will show that your 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

Ms Da Costa submitted that the panel is required to consider all available sanctions, starting from the least serious and going in ascending order. She submitted that the NMC has undertaken the same exercise and invited the panel to consider that the

appropriate sanction in this case is a suspension order for a period of at least 12 months, with a review before the order expires.

Ms Da Costa noted that the panel's earlier decision concluded that there is insufficient evidence to suggest that you have fully addressed each of the relevant concerns, after considering your oral evidence, the reflection you provided, and the training undertaken during the period between the concerns being raised and the date of this hearing.

Ms Da Costa noted that the panel found that although you reflected on what you could do differently in the future, your reflection mainly focused on yourself, the impact on your practice and your future aspirations, rather than demonstrating sufficient remorse or understanding of the extent of your wide-ranging failings and the broader consequences of these.

Ms Da Costa reiterated that much of the concerns can be remediated, particularly the clinical concerns, and that a suspension order would allow you a further period of reflection and remediation before being reviewed.

Regarding the panel's finding of misconduct, Ms Da Costa acknowledged that dishonesty is very serious and can have the consequence of a registrant struck off the register. However, Ms Da Costa submitted that it is the NMC's position that the dishonesty in this case is not entirely incompatible with you remaining on the register. Instead, a suspension order would sufficiently mark your conduct as unacceptable, protect the public from any risk of harm or risk of repetition, and be appropriate in relation to the public interest.

Mr Buxton submitted that, considering the totality of this case, your nursing experience and previous professional record, it is difficult to understand how you found yourself before the regulator in this way. He described you as an intelligent and decent person and acknowledged that while dishonesty is always of concern, it comes in various forms and degrees of culpability. In this case, he submitted that the dishonesty sits at the lower end of the scale, emphasising that there was no deliberate attempt to hide information, no planning and no attempt to implicate others.

Mr Buxton submitted that your actions, particularly in relation to recording on the EPIC system, were a misguided habit and custom, rather than an intentional effort to deceive. While these recordings did not portray a true clinical picture, they did not deceive anyone or cause actual harm, even if they were dangerous in nature. He suggested that the panel may consider the chaotic working environment, anxiety and frustration at the time contributed to your failure to change her practice despite reminders.

Mr Buxton emphasised that this case does not indicate a deep-seated attitudinal problem, but rather a period of inefficiency, inconsistency and difficulty in accepting feedback. He submitted that you have learned from this experience and there is little or no prospect of future dishonesty. He further told the panel that despite the apparent limited insight, you have started to rebuild your confidence and develop a greater understanding of what went wrong. He acknowledged the criticisms of your reflection but submitted that you have demonstrated a willingness to change.

Mr Buxton submitted that a strike-off order would be inappropriate, agreeing with the NMC's position that your failings are not fundamentally incompatible with remaining on the register. However, he proposed to the panel that a conditions of practice order would allow you to demonstrate safe and professional practice under structured supervision, remediating your failings while maintaining public confidence.

If the panel was not persuaded by this, Mr Buxton accepted that a suspension order would be the next available sanction, providing you time for further reflection and development before review. He submitted that you deserve another chance and that a suspension order, as opposed to a strike-off, would ensure the door remains open for you to return to nursing after demonstrating the necessary improvements. He stressed that you are capable of being a competent and honest nurse, you have engaged with these proceedings and should be given the opportunity to return to the career you have worked hard for.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Misconduct over a period of time
- Conduct which put patients at risk of suffering harm
- Lack of insight into failings

In considering insight, the panel referred itself to the NMC guidance on 'Has the concern been addressed?' (FTP-15b):

A nurse, midwife or nursing associate who shows insight will usually be able to:

- *Step back from the situation and look at it objectively*: The panel determined that you have not yet, at this stage, been able to demonstrate this. It noted that in your reflection, you have not made sufficient reference to the impact of your conduct on patients, colleagues and the wider nursing profession.

- *Recognise what went wrong*: The panel considered that you still have not fully understood the implications of your failings at the time.

- *Accept their role and responsibilities and how they are relevant to what happened*: The panel recognised that you mostly accepted your role and responsibilities but are yet to demonstrate your understanding of how they are relevant to what happened. It noted that you accepted you were acting immaturely and arrogantly at time, but you also explained that you [PRIVATE].

- *Appreciate what could and should have been done differently*: The panel accepted that, in your written and oral evidence, you have talked about your attitudes at the time, how they should have been different and how you are working to improve them.

- *Understand how to act differently in the future to avoid similar problems happening*: You showed the panel that you have some understanding of what went wrong, and the panel accept that your attitudes at the time were a barrier to your learning and improving your practice. The panel would have benefitted from a more in-depth reflection from you regarding how you would mitigate that going forward.

Whilst the panel recognised that you demonstrated some insight at this hearing, it concluded that the sufficiency of your insight remained a concern, as this as yet remains extremely limited. Therefore, taking all the considerations above into account, the panel determined 'lack of insight' to be an aggravating feature.

The panel also took into account the following mitigating features:

- Evidence of some relevant training and courses in regards to the charges found proved and admitted
- Early admissions to some of the charges and meaningful engagement throughout

In reaching its decision on sanction, the panel then had regard to the NMC guidance on 'Considering sanctions for serious cases' (SAN-2). Given the specific circumstances of this case, the panel considered the following in relation to dishonesty:

> *"Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to*

Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious."

In light of this, the panel considered the NMC's guidance on the seriousness of dishonesty. It noted, as in its earlier findings, that there was no direct personal gain in your actions. However, the panel determined that there was a potential for direct risk of harm to people receiving care.

The panel further considered the following from the guidance:

"Nurses, midwives and nursing associates who have behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again."

In this regard, the panel considered that you assured the panel, in your oral and written evidence, that you would not exhibit the behaviours which led to your misconduct again.

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

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

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

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

The panel 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 panel had evidence before it of a wide-ranging lack of competence. Further, whilst it considered that there is some evidence of a potential and willingness to respond positively to retraining, the panel noted that these failings arose during a lengthy period where you were under a performance management plan, directly supervised and a much-reduced patient case load. The panel had insufficient evidence before it, at this stage, to determine how you would sustain working effectively and safely with conditions of practice going forward.

The panel looked carefully at the guidance. While the panel accepted that there are clinical failings which can be addressed through conditions of practice, the panel's concerns regarding your limited insight yet to be developed and attitude towards the performance management plan at the time, the panel was not convinced, at this hearing, that the placing of conditions on your registration would 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:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *In cases where the…issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered that your lack of competence covered wide-ranging and fundamental areas of nursing care. It expressed concern that your record-keeping failures, which ultimately led to its finding of dishonesty, stemmed from your "entrenched" and "chaotic" way of working at the time, which placed patients at risk of harm.

While the panel acknowledged your oral evidence indicating a commitment to approaching your work differently in the future, it remained concerned about potential attitudinal issues. However, it did not find these issues to be deep-seated. There was some evidence of attitudinal concerns, but also indications from you that you recognise these shortcomings and have made some efforts to address them.

However, the panel concluded that while there was no evidence of deep-seated harmful attitudes, it was not satisfied that you had demonstrated sufficient insight or strengthened practice to fully mitigate the identified risks of harm and repetition of conduct. As a result, the panel determined that a sanction was necessary, and a suspension order would restrict your practice for a period of time and adequately protect the public, whilst providing you with the opportunity to reflect and demonstrate the necessary improvements.

The panel considered the context of your working environment at the time. It noted your explanation that you were moved to an unfamiliar ward with a high level of acuity, which you struggled to adapt to. It also took into account your previous years of nursing and

midwifery practice, during which no regulatory concerns had been raised regarding your competence.

The panel acknowledged your active engagement in these proceedings and recognised that you should be given the opportunity to safely return to the profession, provided you can demonstrate meaningful progress.

Additionally, the panel emphasised that there is a public interest in supporting good nurses back into safe practice. The period of suspension will provide you with the time needed to further develop your insight, remorse and remediation.

The panel was satisfied that in this case, the misconduct and lack of competence were not fundamentally incompatible with remaining on the register.

It did go on to carefully consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your 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 you. 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 12 months, with a review, was appropriate in this case to mark the seriousness of the misconduct.

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:

- A clear and focused up-to-date reflective piece, which addresses the matters that the panel has raised, including:
  - Insight into the effect of your failings on patients, colleagues and the nursing profession
  - Remorse
  - An explanation of how you intend to strengthen your practise going forward
  - How you would behave differently in a similar situation
  - Your openness to learning or coaching with examples from your current employment
- References and testimonials from current or previous employers and/or colleagues
- Evidence of recent training relevant to the charges found proved
- Continued engagement with the hearings process, at future reviews

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 your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Da Costa. She invited the panel to consider an interim suspension order for 18 months. This duration accounts for the possibility that an appeal may be lodged during the interim period. In light of the panel's findings, she submitted that an interim order is necessary under the grounds of public protection and otherwise in the public interest.

Mr Buxton told the panel that you have been under an interim suspension order in any event. He submitted that your position was neutral in relation to the application.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive suspension order.

The panel determined that an interim suspension order was necessary to protect the public and uphold public confidence in the nursing profession and to do otherwise would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

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

That concludes this determination.