Conduct and Competence Committee  
Substantive Hearing  
27 October 2014  
Held at  
20 Old Bailey  
EC4M 7LN

Name of Registrant Nurse: Jacqueline Arnold  
NMC PIN: 72J0072E  
Part(s) of the register: Registered Nurse – Sub part 2  
Adult Nursing – November 1974  
Registered Nurse – Sub part 1  
Adult Nursing – May 1999  

Area of Registered Address: England  
Type of Case: Misconduct  

Panel Members:  
Kenneth Caley (Lay Chair)  
Sarah Goodwin (Registrant member)  
Pradeep Khuti (Lay member)  

Legal Assessor: Andrew Prynne  
Panel Secretary: Laura O’Sullivan  

Ms Arnold: Present and represented by Mr Gledhill, Counsel  

Nursing and Midwifery Council: Represented by Ms Parry instructed by the NMC  

Consensual Panel Determination: Accepted – 5 year caution order
Details of charge:

That you, a registered nurse whilst employed by East and North Hertfordshire NHS Trust as a Band 5 staff nurse at Queen Elizabeth II Hospital:

1) During the night shift of 12 – 13 February 2012 failed to take appropriate action in response to vital signs observations taken from Patient A in that you did not:
   a) Ensure that a doctor reviewed Patient A within 30 minutes.
   b) Repeat and/or ensure that Patient A’s vital signs observations were repeated after 60 minutes.

2) During the night shift of 14 – 15 February 2012 failed to take appropriate action in response to vital signs observations taken from Patient B in that you did not:
   a) Ensure that a doctor reviewed Patient B within 30 minutes.
   b) Repeat and/or ensure that Patient B’s vital signs observations were repeated after 60 minutes.

3) During the night of 14-15 February 2012 did not source a replacement mattress for Patient B.

That you, a registered nurse:

4) Between approximately 18 June 2013 and 26 July 2013, did not disclose to Spire Healthcare that an allegation about your fitness to practise had been referred (‘the referral’) to the NMC.

5) Your actions at Charge 4 above were dishonest in that you chose not disclose the referral to Spire Healthcare when you knew you were required to do so.

And, in light of the above, your fitness to practise is impaired by reason of your misconduct.
Consensual Panel Determination:

The panel considered the provisional agreement reached by the parties, which reads as follows:

“The Nursing and Midwifery Council and Mrs Jacqueline Arnold, PIN 72J0072E, (the parties) agree as follows:

1. Mrs Arnold admits the following charges:

That you, a registered nurse whilst employed by East and North Hertfordshire NHS Trust as a Band 5 staff nurse at Queen Elizabeth II Hospital:

6) During the night shift of 12 – 13 February 2012 failed to take appropriate action in response to vital signs observations taken from Patient A in that you did not:
   a) Ensure that a doctor reviewed Patient A within 30 minutes.
   b) Repeat and/or ensure that Patient A’s vital signs observations were repeated after 60 minutes.

7) During the night shift of 14 – 15 February 2012 failed to take appropriate action in response to vital signs observations taken from Patient B in that you did not:
   a) Ensure that a doctor reviewed Patient B within 30 minutes.
   b) Repeat and/or ensure that Patient B’s vital signs observations were repeated after 60 minutes.

8) During the night of 14 – 15 February 2012 did not source a replacement mattress for Patient B.

That you, a registered nurse:

9) Between approximately 18 June 2013 and 26 July 2013, did not disclose to Spire Healthcare that an allegation about your fitness to practise had been referred (the referral’) to the NMC.

10) Your actions at Charge 4 above were dishonest in that you chose not disclose the referral to Spire Healthcare when you knew you were required to do so.
And, in light of the above, your fitness to practise is impaired by reason of your misconduct.

Facts

The facts are as follows:

2. Mrs Arnold was employed by the East and North Hertfordshire NHS Trust (‘the Trust) and worked as a Band 5 Staff Nurse on the Medical Assessment Unit (‘MAU’) at the Queen Elizabeth II Hospital.

3. The MAU is a 28-bedded unit that takes any medical patient admitted by emergency or GP clinic referral that does not require admission to the critical care unit. The dependency of the patient group on the MAU can be varied, with some requiring rehabilitation and others for example, requiring high dependency care. The MAU’s objective is to assess patients, put a treatment plan in place and then transfer them to an appropriate unit to deliver care or discharge them. It is a fluctuating environment in terms of workload and intensity.

4. Mrs Arnold worked the night shift of 14 – 15 February 2012 on the MAU, from 19:45 to 08:00 and was the nurse responsible for Patient B’s care on the MAU. The registrant was on shift with one other registered nurse, two healthcare assistants and one first year student nurse, who was supervised by the registrant. There were approximately 24 - 25 patients to care for on that shift. This was not an abnormal staffing level for the MAU. There was one registered nurse less on this shift, however, there was an additional healthcare assistant working that night.

5. The registrant, one care assistant and the student nurse were working on the male side of the ward, which has a maximum of 14 patients.

6. Patient B had been admitted on 12 February 2012 with two small grade II pressure ulcers on his left buttock. He was suffering from chronic obstructive pulmonary disorder (COPD), which meant that his respiratory function was compromised. He was receiving oxygen to bring his oxygen saturation levels to an acceptable level. He was also nutritionally compromised, weighing 51kg on admission and had reduced mobility. Both factors increased the risk of worsening his pressure ulcers and meant that he was at increased risk of developing further pressure ulcers.
7. The registrant failed to escalate the deterioration of Patient B in accordance with the Trust’s Observations Policy (‘the Policy’) and Early Warning Score (‘EWS’) system. The Policy sets out what observations are required, and that observations must be compared to the Trust’s EWS system. Observations are given a colour coding of white if they are within normal range, yellow if they are a cause for concern, and red if they cause serious concern. The policy also sets out what action that must be taken in the event that a patient does trigger the EWS. The appropriate response was clearly described by way of a flow chart on the front of every patient’s observation chart.

8. In an interview at the Trust on 3 April 2012 the registrant admitted that she had the relevant training on EWS procedures and had known what to do in the event of an EWS trigger.

9. According to Patient B’s records, each of Patient B’s documented vital signs observations at 21:45, 00:10, 02:30, 03:30 and 06:30 triggered the EWS. Each of those 5 observations created a duty on the registrant to procure a doctor to review Patient B within 30 minutes and ensure that the observations were repeated within 60 minutes. The registrant failed to discharge these duties.

10. The registrant delegated Patient B’s observations to the student nurse on that shift. Each time the student nurse recorded the observations for Patient B she informed the registrant of the results and showed the registrant where she had recorded the results on Patient B’s observation chart. However, the student nurse noted that whilst the registrant had completed the all the medication administration during the shift, she also appeared to spend a considerable amount of time within the nurses’ station and the registrant told her she was working on paperwork. Notwithstanding the delegation of observations, the registrant was ultimately responsible and accountable for Patient B’s care and for taking action in response to any EWS triggers.

11. Further to this, the risk assessment conducted upon Patient B’s admission had led him to be issued with a Nimbus 3 air mattress. This was a special airflow mattress to mitigate the risk that he might develop more pressure ulcers or suffering worsening of the existing ones.

12. At around 02:00 on the 15 February 2012 the alarm on Patient B’s mattress started sounding and Patient B was found by a member of staff slumped on his bed complaining of being uncomfortable. The member of staff informed the registrant of this and the registrant attended
to the patient and stopped the alarm for approximately 20 minutes. After this 20 minute period the mattress alarm started sounding again and continued for the rest of the shift.

13. Another registered nurse who took over on the morning shift of 15 February 2012 noticed that Patient B was effectively lying on the bed frame. This nurse was able to source a normal contour replacement mattress within 10-15 minutes of being aware that Patient B was on a deflated mattress. This was done through hospital porters who were available 24 hours a day.

14. A Sister on the MAU conducted a full skin assessment of Patient B on 15 February 2012 to check for any deterioration in his skin as a result of lying on a deflated mattress. She did not find any evidence of deterioration at that stage but as pressure ulcers take up to 72 hours to manifest, the lack of visible deterioration on 15 February 2012 was inconclusive as to harm whether harm had been caused.

15. Patient B’s health deteriorated during the shift. When the nursing staff on the next shift took over in the morning of 15 February they escalated Patient B’s condition and Patient B was given a nebuliser to help open up his airways and improve his breathing. After being reviewing by the Critical Care Outreach Team (CCOT), Patient B was transferred to the Respiratory High Dependency Unit. He died on 18 February 2012. There is no clear evidence of a direct causal link between the death of the patient and the omission of care.

16. Following the registrant’s shift on 14 – 15 February 2012, the Ward Manager who was also the Senior Sister of the MAU and was also the registrant’s line manager, commenced an investigation into concerns regarding Patient B’s care. It was during this investigation that a further incident involving another patient, Patient A, was identified from the previous day, the night shift 12 – 13 February 2012.

17. The registrant worked the night shift of 12 – 13 February 2012 on the MAU, from 19:45 to 08:00. During this shift she was in charge of Patient A’s care. Patient A was admitted on 10 February 2012 with reduced mobility secondary to knee pain. There was also a query on diagnoses of pneumonia, heart failure and a collapsed lung.

18. The registrant failed to escalate the deterioration of Patient A in line with the Policy and EWS system. On that shift, Patient A’s documented vital signs observations at 24:00 and 02:00 triggered two yellow alerts on the Trust’s EWS. The observations on both of these occasions
created a duty on the registrant to ensure a doctor reviewed Patient A within 30 minutes and to
repeat, or ensure that observations were repeated, 60 minutes after each alert.

19. The registrant had delegated the observation at 24:00 to an unqualified clinical support worker. The registrant was entitled to delegate the task but the registrant was responsible for ensuring that she was aware of Patient A's observations as soon as they were done.

20. Patient A died from a cardiac arrest at approximately 09:00 on 13 February 2012. The registrant's failure to escalate her deteriorating condition in line with the EWS was discovered during an audit of cardiac arrests. There is no clear evidence of a direct causal link between the death of the patient and the omission of care. Patient A had a number of co-morbidities and her prognosis was poor in any event.

21. The outcome of the investigation conducted was a recommendation that the allegations be considered at a disciplinary hearing. Mrs Arnold resigned from the Trust in June 2012, before the internal disciplinary process concluded.

22. Since June 2012, the registrant has been employed by Spire Healthcare on a surgical ward at the Spire Harpenden Hospital. This was initially a full time role but the registrant resigned from her substantive post and transferred to the hospital’s nurse bank.

23. The registrant was notified that her fitness to practise had been called into question by a letter from the NMC dated 18 June 2013. This letter was sent in respect of a referral received by the NMC from the Trust concerning the registrant’s care of Patients A and B.

24. The registrant did not inform her line manager at Spire Healthcare about any fitness to practise concerns. Her manager discovered that the NMC was investigating the registrant’s fitness to practise on 26 July 2013 when the NMC contacted her to obtain information about the registrant.

25. Her line manager asked her why she had not told her about the fitness to practise concerns, and the registrant explained that she had been embarrassed and provided her account. Spire Healthcare took no further action.

Misconduct
26. Mrs Arnold accepts that the admitted facts amount to serious misconduct because her actions in relation to the above charges fell seriously below the standard expected of a registered nurse, as set out in *Roylance v General Medical Council [2000] 1 AC 311*. The registrant acknowledges her failures in the care provided to vulnerable patients. The registrant accepts she failed to provide adequate nursing care to Patients A and B and further that she acted dishonestly when she did not disclose to her employer that her fitness to practise had been called into question. The registrant acknowledges that these failures were fundamental departures in her practice.

27. Mrs Arnold accepts that she acted in a manner contrary to the following provisions of the NMC Code of Professional Conduct ‘Standards of conduct, performance and ethics for nurses and midwives (May 2008)’ (“the Code”), in particular:

*Preamble:*
- Make the care of people your first concern, treating them as individuals and respecting their dignity.
- Provide a high standard of practice and care at all times.
- Be open and honest, act with integrity and uphold the reputation of your profession.

1 You must treat people as individuals and respect their dignity.

3 You must treat people kindly and considerately.

21 You must keep your colleagues informed when you are sharing the care of others.

26 You must consult and take advice from colleagues when appropriate.

28 You must make a referral to another practitioner when it is in the best interests of someone in your care.

32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.

35 You must deliver care based on the best available evidence or best practice.

51 You must inform any employers you work for if your fitness to practise is called into question.
61 You must uphold the reputation of your profession at all times.

28. The parties agree that in failing to take appropriate action following the vital signs observations taken for Patients A and B, the registrant’s practise fell well below the standards expected from her as a registered nurse. The registrant acknowledges she was trained in EWS procedures and accepts she failed to discharge her duties as she did not contact a doctor and observations were not repeated after 60 minutes.

29. During the Trust’s investigatory process, the registrant admitted that she had been aware that Patient B’s mattress was partly deflated during the night and that he was lying on a completely deflated mattress by around 06:00. The registrant recognised that the patient had inadequate pressure relief and could have come to harm as a result. The registrant said that she was too busy to think about it, but would have changed it if she had the time.

30. The parties agree that as soon as the registrant became aware that Patient B’s mattress was not properly inflated it should have been a priority for her to source another mattress. If there were no Nimbus 3 mattresses available the registrant ought to have transferred Patient B to a normal contour mattress and implemented a turning regime until another Nimbus mattress could be sourced. The risk of Patient B lying on a deflated mattress would be elevated because he was nutritionally compromised and because of his immobility.

31. Further the parties agree that honesty, integrity and trustworthiness are to be considered the bedrock of a nurse’s practice. The parties agree that the registrant had a duty to inform her employer that her fitness to practise had been called into question and that her failure to do so was not only dishonest but a breach of a fundamental tenet of the profession.

32. Mrs Arnold accepts that her actions fell significantly below the standards expected of a registered nurse and that the misconduct admitted is serious.

Impairment

33. Mrs Arnold admits that her fitness to practise was and is impaired by reason of her misconduct, adopting the formulation set out by Mrs Justice Cox in CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin) and the four questions posed specifically by Dame Janet Smith in her Fifth Report to The Shipman Inquiry. Mrs Arnold acknowledges that a consideration of current fitness to practise looks backwards as well as forwards and accepts that she:
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 professions into disrepute; and/or

c) Has in the past and/or is liable in the future to breach one of the fundamental tenets of the profession; and

d) Has in the past and/or is liable in the future to act dishonestly.

34. The registrant accepts that failing to escalate Patient A’s condition placed her at unwarranted risk of harm. She accepts that she should have taken action in response to several observations over the course of the shift and should have made a referral to a doctor. She accepts that her conduct also put Patient B at unwarranted risk of serious harm and that she also should have taken steps to escalate several observations over the course of the shift and again should have sought assistance from a doctor.

35. Mrs Arnold accepts that failure to provide the correct mattress may have caused Patient B further harm and distress and could have led to a worsening of his pressure ulcers. Mrs Arnold accepts that in not prioritising the replacement of the mattress, Patient B’s dignity was not maintained. She accepts that she failed to act in the best interests of the patients, failed to adhere to best practice and placed patients at risk of harm.

36. Whilst accepting that her dishonest conduct has breached a fundamental tenet of the profession, Mrs Arnold also acknowledges that her misconduct has brought the profession into disrepute.

37. Mrs Arnold completed a reflective piece in June 2014\(^1\) and has demonstrated insight into these charges. She recognises the risks her actions posed to patients:

\(^1\) Appendix 1
“In relation to patient A, I have now admitted I was at fault in not calling the Doctor in response to 2 yellow triggers at 1200 and 0200.”

“Most importantly I should have adhered to the EWS system and ensured I called the Doctor to review the patient within 30 minutes and then repeated the observations within 30 minutes.”

“In relation to patient B I should have adopted an emergency staffing level policy and so would have been able to better prioritise his care. The emergency procedures would be carried out first and other duties done if time and staff allowed it.”

“In an emergency situation I could have utilised the Student nurse to turn the patient and to help change the faulty mattress. With reference to the charge about the mattress I have admitted this charge and have reflected on this incident and realise I was at fault in not trying harder to source a new mattress because it would have improved the patients quality of care. I realise on reflection that the patient would have been much more comfortable with a proper functioning mattress: it would have helped his pressure sore issue and helped relaxation…”

“On reflection I did not fully understand the policy. I can assure the panel that I will always keep up to date with new policies in my current and future positions.”

“As a qualified Nurse we are so closely involved with important matters of care and confidentiality with patients and it is essential for us to be open and honest at all times so we can deliver a high standard of care. If patients or relatives thought we were lying about any aspect of care then all trust and confidence would be lost. We are responsible for the care of very vulnerable patients with issues of life and death on a daily basis and if this was carried out in a dishonest way the whole process would breakdown. The trust and confidence of the patients in our work is paramount and I know with reflection and insight that honesty is a major part if this process.”

38. The registrant has also demonstrated remorse for her actions:

“I have great remorse for what happened”

“There is no excuse for dishonesty in any situation and especially in Nursing where we are responsible for patient’s lives. I am very sorry for this occurring and have reflected over a year of why it happened and over this period developed a state of mind where I have
regained trust in my colleagues and am determined to maintain good nursing care and good character for the rest of my career.”

39. The registrant has also indicated what she has learnt from this matter and she is able to explain how she has remediated her misconduct by explaining how she would act in a similar situation in the future:

“In my Nursing practise at Spire Hospital, where I have worked since June 2012, I have always followed the EWS policy which is in place. I ensure I follow the policy to the letter. It is slightly different to the NHS system, but I studied the system when I first started my position as a Staff Nurse and made sure I adopted it at all times, especially when I was busy and under pressure.”

“I have recently completed a course which included the EWS system, which took place at Spire Hospital, Harpenden. I would like to state that I am so very grateful for the tremendous support an encouragement which has been given by the Matron Veronica Magee in all aspects of my Nursing care, where she states she has no concerns and praises me for a lot of verbal and written compliments from patients for my good care.”

“I have and will always adhere to this system with strict discipline; it is ingrained into my nursing practise. I realise now that it is of the utmost importance for me and all Nurses to follow the EWS policy in order to do the best to prevent deterioration in a patients condition at an early stage.”

“I have studied at the Code on the NMC website and have spent a lot of time on the sections related to honesty and integrity. I do have insight into why it was so wrong to be dishonest in not informing my employer of the NMC investigation.”

“I can assure the panel that I am totally focused on continuing my Nursing career in good practise and that the lessons I have learnt through this very stressful and painful process will never be forgotten.”

40. The parties accept that these instances of misconduct have occurred in the context of an otherwise unblemished career spanning 40 years. Since these charges the registrant has been practicing without any restriction and without further incident. Ms Magee has also

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2 Appendix 2
provided positive testimony in respect the registrant’s current practice\textsuperscript{3}. This is further to other positive references the registrant has received\textsuperscript{4}.

41. As a result of the level of insight and remorse shown and remediation carried out through further training\textsuperscript{5}, the parties agree that there is no risk that the misconduct will be repeated.

42. However, the registrant also acknowledges that public confidence in the profession would be undermined if no finding of impairment were made, given the seriousness of her misconduct.

43. It is therefore agreed that a finding of impairment is necessary to uphold the public interest by maintaining public confidence in the profession and in the regulatory body, and by declaring and upholding proper standards of conduct and behaviour.

**Sanction**

44. The appropriate sanction in this case is a **5 year caution order**.

45. The aggravating factors are as follows:

a) There were repeated failings to act on observations in respect vulnerable patients.

b) Patient B’s dignity was not maintained for a prolonged period in respect of the defective mattress.

c) Spire Healthcare were only made aware of the fitness to practise referral through contact with the NMC.

46. The mitigating factors are as follows:

a) The registrant has made full admissions and has expressed remorse.

b) The registrant has engaged throughout the regulatory process.

c) The registrant has undertaken further training.

d) The charges occurred in a 40-year otherwise unblemished career.

e) The registrant has been practising without restriction and without any further incident.

\textsuperscript{3} Appendix 3  
\textsuperscript{4} Appendix 4  
\textsuperscript{5} Appendix 5
47. The parties have considered the ‘Indicative sanctions guidance to panels’ ("ISG"), and in particular paragraphs 63 – 65 regarding caution orders. In reference to paragraphs from the ISG, the parties note the following:

65 When fitness to practise is impaired by reason of misconduct and a panel is minded to impose a caution order, it should consider whether such an order provides adequate public protection, bearing in mind that it does not restrict the nurse or midwife’s practice rights. It might be appropriate where the nurse or midwife’s history is such that the panel is confident that there is no risk to the public or to patients which requires the nurse or midwife’s practice rights to be restricted.

48. Starting with the least restrictive sanction first, to take no further action would not be proportionate and would not adequately address the public interest. Mrs Arnold’s misconduct was in respect of patient care. Further, Mrs Arnold acted dishonestly because she was embarrassed by her previous misconduct. To take no action would not maintain public confidence in the profession and in the regulatory body, nor declare and uphold proper standards of conduct and behaviour.

49. It is agreed that a caution order is the appropriate and proportionate sanction in this case. It is accepted that the behaviour should be marked as unacceptable. The parties agree that a caution order will provide adequate public protection to mark the behaviour as such. In the context of her otherwise unblemished career both before and since these incidents, the level of insight the registrant has shown, together with the fact that the registrant has remediated her failings, there is no risk of repetition. It is therefore considered that no form of restriction on the registrant’s practice is required.

50. The appropriate length of the caution order is the maximum of 5 years. This is to mark the fact that although no restriction is required on the registrant’s practice in the circumstances, her misconduct is serious and is at the top end of the spectrum for this sanction. The parties agree that the public interest would not be proportionately marked by a lesser period. A 5 year caution order would also serve as a reminder to the registrant of the standards of conduct and behaviour expected of her as a registered nurse.

51. The circumstances of the case do not necessitate a conditions of practice order. For the reasons stated above, no restriction is required on this registrant’s practice. As Mrs Arnold has remediated the risk that she posed towards patients, there are no further identifiable areas of the registrant’s practice that require further assessment or retraining.
52. In the case of *Parkinson v Nursing and Midwifery Council [2010] EWHC 1898* Mr Justice Mitting said that a nurse who is found to have acted dishonestly is always at risk of having their name erased from the register. However, panels must always have in mind that each case is different and should be decided on its own unique facts and merits. In the circumstances the seriousness of the case does not require a removal from the register either temporarily or permanently. The dishonesty was an isolated matter, for which the registrant has shown a high level of insight and expressed remorse. It is also considered the dishonesty was at the lower end of the spectrum of seriousness. Mrs Arnold has also taken steps to remediate the dishonesty by reflecting on her misconduct and her obligations under the Code. The parties agree removal from the register, temporary or otherwise would be disproportionate.

53. For the reasons stated above, it is therefore submitted that a 5 year caution order is necessary, proportionate and the least restrictive sanction that would meet the public interest. A 5 year caution order would mark the registrant’s conduct as being a serious departure from the standards expected of registered nurses, and maintain confidence in and uphold the reputation of the profession.

The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges set out at paragraph 1 above, and the agreed statement of facts set out from paragraph 2 above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.”
The panel noted that Mrs Arnold has made admissions with regard to all of the charges against her. The panel has accepted these admissions and accordingly it has found all of the facts proved by way of those admissions.

The panel accepted the advice of the legal assessor as to the meaning of current impairment of fitness to practise and, in addition, upon the role of a panel when a CPD has been indicated.

The panel acknowledged that Mrs Arnold has made admissions to all of the allegations against her and she has accepted that her fitness to practise is currently impaired by reason of her misconduct. She has taken full professional accountability for her actions and she has not attempted to deflect the blame or minimise her behaviour.

Mrs Arnold has provided the panel with evidence of reflection and has shown a high degree of remorse for her actions. Taking these factors into account, the panel considered that Mrs Arnold has demonstrated insight into her actions and into her capabilities as a nurse. She has undergone an extensive review of the relevant policies and procedures and she has further undertaken training courses in ‘Manual Handling’ and ‘BLXS EWS Shock’ to remedy her clinical failings.

In addition, with regard to her dishonest behaviour, the panel considered that Mrs Arnold’s dishonesty was isolated and was an omission on her part to disclose to her current employer that an allegation about her fitness to practise had been referred to the NMC. Mrs Arnold has, without equivocation, admitted that she should have disclosed that information and she has expressed remorse and regret for her actions. Therefore, the panel determined that Mrs Arnold’s dishonesty falls at the lower end of the spectrum of seriousness and demonstrated an isolated error in judgement on Mrs Arnold’s part.

The panel took account of the bundle of favourable references before it which indicate that Mrs Arnold had previously enjoyed an unblemished nursing career spanning some 40 years. The references also indicate that she is currently working at Spire Healthcare without issue and that she is a hard-working and professional nurse. On that basis the panel determined that the risk of repetition in this case is low.

However, Mrs Arnold’s clinical failings had the potential to place two vulnerable patients at risk of harm. In addition, she has admitted to acting dishonestly in a matter relating to her employment as a nurse. On that basis the panel concluded that the public’s trust and confidence in the nursing profession and in the NMC as its regulator would be undermined if a finding of no impairment were to be made. The panel therefore finds that Mrs Arnold’s fitness to practise is currently impaired by reason of her misconduct.
The panel then went on to consider what, if any sanction, should be imposed in this case.

In considering this matter, the panel took account of the Indicative Sanctions Guidance (ISG) together with the CPD agreement before it and had regard to the need to protect the public as well as the wider public interest. The panel applied the principle of proportionality, weighing the interests of the public with Mrs Arnold’s interests; it has taken into account the aggravating and mitigating factors in the case.

The panel has exercised its own independent judgement on this issue and has accepted the advice of the legal assessor.

The panel first considered taking no action. Although the panel accepted that Mrs Arnold has fully remedied her clinical failings and poses no risk to patients, she has been found to have been dishonest in a matter relating to her employment as a nurse. Such misconduct requires a sanction to mark the departure from the professional standards set out in the NMC code and to maintain the reputation of the nursing profession. Accordingly, the panel has concluded that the facts found proved in this case are too serious for it to be appropriate to take no action.

The panel next considered a caution order and gave consideration to paragraphs 63-65 of the ISG as well as the provisional CPD agreement before it. The panel noted that before these incidents came to light, Mrs Arnold had enjoyed lengthy and otherwise unblemished nursing record. It accepted that neither her clinical practice nor her integrity had been previously called into question and that since the incidents occurred, she has been working as a registered nurse without issue.

Mrs Arnold has shown a high level of insight and remorse into her actions and that she has fully cooperated with the NMC’s investigation into her conduct. She has never denied the charges against her and the panel considered that Mrs Arnold has genuinely reflected on the incidents and understood the gravity and seriousness of her misconduct and dishonesty.

Mr Gledhill on behalf of Mrs Arnold has produced a number of favourable references from Mrs Arnold’s colleagues’ and current employer which all indicate that she is a competent, reliable and trustworthy nurse. The panel noted that Mrs Arnold’s current employers are now fully aware of these proceedings and remain supportive of her. This coupled with Mrs Arnold’s high level of insight and reflection as well as the significant evidence of remedial action, has persuaded the panel to accept the provisional CPD agreement and impose a caution order. The caution order will be for the maximum period of 5 years.
Accordingly, the panel accepted the CPD agreement and has decided to impose a sanction of a caution order for 5 years in this case.