Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Hearing

7 – 10 August 2017
&
21 September 2017

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant: Musa Dungeni

NMC PIN: 02A2181O

Part(s) of the register: Registered Nurse (sub part 1)
Adult (23 January 2002)

Area of Registered Address: England

Type of Case: Misconduct

Panel Members: John Crawley (Chair, Lay member)
Diane Corderoy (Registrant member)
Colin Sturgeon (Lay member)

Legal Assessor: Tim Bradbury

Panel Secretary: Aoife Kennedy

Registrant: Present and represented by Neair Maqboul, instructed by Royal College of Nursing (RCN)

Nursing and Midwifery Council: Represented by Rose Harvey, counsel, instructed by NMC Regulatory Legal Team.

Facts proved: 1, 2, 3 (by way of admission) and 7

Facts not proved: 4, 5, 6 and 8

Fitness to practise: Impaired

Sanction: Conditions of Practice Order (9 months)

Interim Order: Interim Conditions of Practice Order (18 months)
Details of charges

That you, a registered nurse, whilst employed at Moston Grange Care Home:

1) On 15 January 2016, failed to administer Epanutin 30mg to Resident A.

2) On 15 January 2016, failed to safely store Epanutin medication intended for Resident A.

3) On 15 January 2016, signed Resident A’s medication administration record to indicate that you had administered Epanutin 30mg when you had not.

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

5) On a date between 15 and 18 January 2016, made an entry on Resident A’s PEG feed chart to indicate that you were unable to administer Resident A’s Epanutin on 15 January 2016.

6) Your actions, as set out in charge 5 above, were dishonest in that you attempted to mislead others as to your failings as set out in charges 1 and 2.

7) On a date, or dates, from 15 to 18 January 2016, breached Resident A’s confidentiality by removing Resident A’s care records out of a clinical setting and/or using them for purposes other than to meet Resident A’s needs.

8) Your actions in charge 7 put your interests above Resident A’s interests in that your intention was to limit the impact upon you of your failings as set out in charges 1 and 2.
AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

At the start of this hearing you admitted the following charges; 1, 2, 3 and 5. These were therefore announced as proved. However, following your evidence to the panel, you, through your counsel, sought leave to vacate your admission to charge 5. The panel acceded to your application, it being satisfied that you had made your admission on an erroneous basis.

**Background**

The allegations in this case arose whilst you were employed at Moston Grange Care Home (the Home). The alleged incidents are said to have occurred between 15 to 18 January 2016, and concern Resident A, a resident at the Home. You worked at the Home on the night shift, between 20:00 and 08:00. You were responsible for some 32 residents with varying and often very high dependency needs, across two units. You were assisted by four support workers.

Resident A had epilepsy and required anti-epileptic medication, namely Epanutin. It is alleged that on 15 January 2016 the nurse on the in-coming day shift alerted Mr 1 that a cup of pink medication had been found beside Resident A’s table in his room. It appeared that the Epanutin was due to have been given at 06:00 to Resident A but was not administered. It is alleged that you had failed to administer Epanutin 30mg to Resident A, you failed to safely store the drug intended for Resident A by leaving it by his bedside, and you had signed Resident A’s medication administration record (MAR) chart to indicate Epanutin had been administered when it had not. It is the NMC’s case that in signing the MAR chart to indicate Epanutin had been administered when it had not, your actions were dishonest.

Furthermore, it is alleged that on a date between 15 and 18 January 2016 you made an entry on Resident A’s PEG feed chart to indicate that you were unable to administer
Resident A’s Epanutin on 15 January 2016. It is alleged that in doing so your actions were dishonest in that you attempted to mislead others in relation to why you failed to administer Epanutin to Resident A.

Furthermore, Mr 1 reported that on the weekend after the incident on 15 January 2016, he received a call from a staff member stating that Resident A’s care file was missing from the Home’s unit. A search was conducted by the staff and they could not find the file. Mr 1 reported that when he attended work he saw Resident A’s care file placed under the office doorway with a note from you. It is alleged that you breached Resident A’s confidentiality by removing his notes from the clinical setting and/or used the notes for purposes other than to meet Resident A’s needs. It is alleged that, in doing so, you put your own interests above Resident A’s interests in that your intention was to limit the impact upon you of your failings in relation to failing to administer Epanutin to Resident A.

Decision and reasons on panel’s request for documentation

The panel expressed concerns about the lack of clear documentation in relation to charge 6. It considered that the documents directly involved with this charge, namely the PEG Feed and Water Flush Charts for Resident A, were incomplete and for the most part illegible. These documents related to the period of 14 January 2016 between 08:00 and 17:00, and for 15 January 2016 from 08:00 through to 08:00 of 16 January 2016. However, the period from 17:00 on 14 January 2016 until 08:00 on 15 January 2016 is missing, this is a highly relevant period. Legible copies paginated in their original sequence are required by the panel to properly evaluate this evidence.

The panel was of the view that these documents are essential to ensure fairness of the proceedings and bearing in mind the gravity of the charge that the NMC has brought. The charge alleges, in effect, that your entry on Resident A’s PEG feeding document was made in an attempt to mislead anyone investigating the missed administration of Epanutin at 06:00 on 15 January 2016. In your evidence in chief, you explained that the
entries concerned were made by you but were made in respect of an entirely separate later incident, arising on the night shift of 15/16 January 2016. Further, the panel was of the view that, whilst not essential, legible copies of Resident A’s Multidisciplinary Daily Record would also assist its understanding of both the chronology and the context of the original medication incident.

The panel was of the view that it is reasonable to expect the NMC to make every attempt to produce such documentation, bearing in mind the seriousness of the charge which involves dishonesty. The panel had attempted to clarify Ms 2’s evidence, contained in paragraph 21 of her NMC witness statement, concerning charge 6. However, Ms 2 indicated that she could not clarify matters in the absence of legible documentation.

Following its expression of concern regarding the legibility and completeness of NMC documentation, the panel was provided with enlarged and legible copies of some of the documentation, and on that basis decided to proceed.

**Decision on the findings on facts and reasons**

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Ms Caslin, on behalf of the NMC, and those made by Ms Maqboul, on your behalf.

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

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 the facts will be proved if the panel is satisfied that it was more likely than not that the incidents occurred as alleged.
The panel heard oral evidence from two witnesses called on behalf of the NMC. In addition, the panel heard oral evidence from you.

Witnesses called on behalf of the NMC were:

- Mr 1 – Clinical Nurse Manager at the Home, at the time of the allegations; and
- Ms 2 – Registered Manager of the Home at time of the allegations;

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from, including you.

Mr 1
The panel found that Mr 1 did his best to assist the panel. It noted that Mr 1 had provided the NMC with a statement some 13 months after the incidents occurred and without the benefit of viewing any contemporary records. The panel noted that at times Mr 1’s evidence appeared to be inconsistent. For example, in his evidence in chief Mr 1 stated that you had given him no explanation for taking the care file, but in cross examination he was taken to paragraph 19 of his witness statement where he had described you doing so. Further, in his oral evidence when asked what had gone missing, Mr 1 modified the account given in his witness statement, where he had described the care file as missing; he explained it was sheets from the multidisciplinary daily record that were pushed under his door. Whilst the panel found him to be a credible witness, it could only place limited reliance on his testimony in certain regards.

Ms 2
The panel found that Ms 2 was cautious, and she did not speculate during her evidence and did her best to assist the panel. Whilst, the panel found her to be a credible witness, it noted that she was not a direct witness to the incidents and due to a number of errors in her NMC witness statement, in particular at paragraph 21, it concluded it could only place limited reliance on her testimony in key respects.

Your evidence
The panel found that at times your responses to the panel’s questions were defensive and you were not always apparently willing to fully explain the rationale behind your actions. Nevertheless, the panel had no reason that your factual version of events and what you had done, was other than truthful, and it was of the view that you were candid in your responses. The panel therefore found you overall to be a credible witness.

The panel then went on to consider the remaining charges. The panel considered each charge and made the following findings:

Charge 4

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

This charge was found NOT PROVED.

In reaching this decision, the panel took into account your evidence.

The panel took into account your admission to charge 3, that you had signed Resident A’s MAR chart to indicate you administered Epanutin when you had not. It also took into account your evidence in which you stated that you were distracted during your shift as there was another high dependency resident who required your assistance and you were the only nurse on shift. Furthermore, you stated that you would normally flush a resident’s PEG feeding tube pre and post administration of medication and, as you had flushed Resident A’s tube, you thought you had administered the medication, and therefore wrote in the MAR chart that you had administered Epanutin.

The panel had regard to the fact that you explained you had left the medication by Resident A’s table as at the time you first went to administer it Resident A was receiving personal care. You explained to the panel that you were extremely busy between 06:00 and 08:00 that morning, and you intended to return to give the medication. The panel
was of the view that you had a clear intention to administer the medication. Further, it was of the view that if you had sought to cover up a failure to administer medication by subsequently signing the MAR sheet to say you had, knowing you had not, it is likely that you would have disposed of the evidence, the medication.

The panel had regard to the two stage test in relation to dishonesty:

- whether you acted dishonestly by the standards of ordinary and honest people (the objective test);
- if so, whether it is more likely than not that you realised that what you were doing was by those standards dishonest (the subjective test).

In all the circumstances, the panel concluded that the objective test had not been made out, as the panel accepted your evidence that you believe you had administered the medication when you had not. Accordingly, the panel found that your actions at charge 3 were not dishonest.

**Charges 5 and 6**

5) *On a date between 15 and 18 January 2016, made an entry on Resident A’s PEG feed chart to indicate that you were unable to administer Resident A’s Epanutin on 15 January 2016.*

6) *Your actions, as set out in charge 5 above, were dishonest in that you attempted to mislead others as to your failings as set out in charges 1 and 2.*

These charges were found NOT PROVED.

In reaching this decision, the panel took into account your evidence, Mr 1’s evidence and Ms 2’s evidence.
In relation to charge 5, the panel noted that the NMC had not produced evidence of a PEG chart with such an entry made in relation to an incident on 15 January 2016. It noted that there was an entry documenting that Epanutin could not be administered to Resident A on 16 January 2016, however there was a clear clinical justification for not doing so documented on this chart. The panel accepted your explanation that the entry, which you confirmed you had made, related to a wholly separate incident on the night shift of 15/16 January 2016.

For these reasons, the panel found this charge not proved.

As the panel had found charge 5 not proved, it follows that charge 6 is not capable of being proved.

Charge 7

7) **On a date, or dates, from 15 to 18 January 2016, breached Resident A’s confidentiality by removing Resident A’s care records out of a clinical setting and/or using them for purposes other than to meet Resident A’s needs.**

This charge was found PROVED in the alternative, namely that on a date, or dates, from 15 to 18 January 2016, you breached Resident A’s confidentiality by using Resident A’s care records for purposes other than to meet Resident A’s needs.

In reaching this decision, the panel took into account your evidence, Mr 1’s evidence and Ms 2’s evidence.

Mr 1 stated that shortly after the incident on 15 January 2016, he received a telephone call from a staff member stating that Resident A’s care file was missing from the Home’s unit. A search was conducted by staff and the file could not be found. When attending work on Monday 18 January 2016, he found Resident A’s care file placed under his office doorway with a note from you which stated “FAO [Mr 1] I have taken off these
notes off the unit as to allow investigation/your acting in a confidential manner as it is open to all to read. Thanks Musa Dungeni." Mr 1 confirmed that when he inspected the file there were no missing papers.

You stated that you did take some papers, comprising pages of the multidisciplinary daily record where you had written a lengthy account of the medication error incident and its implications, out of Resident A’s care file. Further, you stated that you had photocopied the papers using the Home’s nearby photocopier and then put the photocopies in your locker located within the Home. You deny that you had removed either the original document or the copies from the Home. You stated that you undertook this action because you did not trust other staff members and wanted to keep your own copy of your record of the incident.

The panel considered the appropriate meaning to be attached to the term “clinical setting” used in the charge, and formed the view that it should comprise the whole Home, not just the unit where the incident occurred. The panel accepted your explanation that you had left the photocopied documents secure in your locker located in the Home, and therefore had not taken them or the original papers out of the clinical setting.

The panel then considered the mischief alleged in the alternative charge. It noted that by taking some of Resident A’s notes because you wanted to have your own record of the incident, you used the documents for your own purpose, which was not meeting Resident A’s needs.

For these reasons, the panel has found that whilst you had not taken Resident A’s care records out of the clinical setting, you had breached Resident A’s confidentiality by using them for a purpose other than to meet Resident A’s needs. Accordingly, the panel found this charge proved in respect of the alternative.

**Charge 8**
8) Your actions in charge 7 put your interests above Resident A’s interests in that your intention was to limit the impact upon you of your failings as set out in charges 1 and 2.

This charge was found NOT PROVED.

In reaching this decision, the panel took into account your evidence, Mr 1’s evidence and Ms 2’s evidence.

The panel was of the view that by using Resident A’s care records for purposes other than to meet Resident A’s needs, you put your own interests above Resident A’s interests. The panel accepted your evidence that you had made copies of pages from Resident A’s care records, so that you would have a detailed record of the incident that occurred on 15 January 2016, which you documented in Resident A’s multidisciplinary record. The panel was of the view that whilst this might suggest defensive behaviour on your part, the NMC’s evidence does not establish that your intention was to limit the impact upon you of your failings as set out in charges 1 and 2, which you had admitted to your managers at an early stage. Accordingly, the panel found this charge not proved.

Submissions on misconduct and impairment

Having announced its finding on the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant’s suitability to remain on the register without restriction.

Ms Caslin invited the panel to take the view that your actions amounted to breaches of “The Code: Professional standards of practice and behaviour for nurses and midwives
(2015)” (the Code). She then directed the panel to specific paragraphs and identified where, in the NMC’s view, your actions amounted to breaches of the Code such as to amount to misconduct.

Ms Caslin referred the panel to the case of Roylance v GMC (No. 2) [2000] 1 AC 311 which defines misconduct as a “word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.” She also referred the panel to the following cases: Cheatle v GMC [2009] EWHC 645 Admin, R (on the application of Remedy UK Limited) v GMC [2010] EWHC 1245 Admin, Nandi v GMC [2004] All ER (D) 25, GMC v Meadow [2007] 1 All ER 1 and Calhaem v GMC [2007] EWHC 2606 (Admin).

Ms Caslin submitted that by failing to administer Epanutin to Resident A, leaving it bedside his bedside table, and then signing his MAR chart to indicate that you had administered the medication, your actions amounted to misconduct. Ms Caslin submitted that you exposed other residents to the risk of harm, and you had conceded in your own evidence that there was a resident wandering around in the vicinity of Resident A’s room.

Ms Caslin submitted that, whilst the medication incident could be categorised as an oversight, you had made a deliberate decision to photocopy Resident A’s care notes and breached his confidentiality. Ms Caslin submitted that by putting your own interests above Resident A’s your actions amounted to misconduct.

Ms Caslin then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Caslin referred the panel to the cases of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) and R (on the application of Cohen) v General Medical Council [2008] EWHC 581 Admin.
Ms Caslin submitted that whilst there is no evidence of actual patient harm being caused, there was a risk of harm to the health and well-being of Resident A and other residents who may have ingested medications not prescribed for them. Ms Caslin reminded the panel that in your written reflections, you accepted that Resident A could have experienced convulsions and fits as a consequence of not receiving the medication prescribed for him. Further, Ms Caslin submitted that by taking Resident A’s care notes and photocopying them for your own purpose, you had flagrantly breached Resident A’s rights to privacy and confidentiality. Ms Caslin submitted that these are failures in basic nursing practice.

Ms Caslin submitted that in relation to your failings at charges 1-3, you have provided some evidence of insight, training and remediation. However, in relation to your failings at charge 7, Ms Caslin submitted that you have failed to reflect on how your actions affected Resident A, his family, and the reputation of the nursing profession as a whole. Ms Caslin submitted that whilst the risk of repetition in relation to charges 1-3 may be low, in light of the absence of full insight and remediation for charge 7, there is a high risk of repetition. Ms Caslin therefore invited the panel to find that your fitness to practise is currently impaired on the ground of the need to protect the public and also as being in the wider public interest.

Ms Maqboul, on your behalf, submitted that you accept your failings at charges 1, 2, 3 and 7 amount to misconduct.

Ms Maqboul invited the panel to assess your oral evidence and the documentary evidence you have provided to it. She reminded the panel of its earlier decision that it had found your evidence to be generally credible.

Ms Maqboul submitted that the panel has found not proved the most serious charges brought against you, namely those of dishonesty. She submitted that you have been
open and honest throughout these proceedings and made early admissions of your failings in relation to charges 1-3.

Ms Maqboul submitted that you were apologetic during your evidence, demonstrated insight into your failings, and explained to the panel how you would act differently in the future. She submitted that since the incident you have reflected on your actions and accept that harm could have been caused to Resident A. She invited the panel to consider the training you have undertaken including training in relation to medicines management, record keeping and data protection.

Ms Maqboul submitted that in light of the insight and remediation you have demonstrated, there is a low risk of repetition, and therefore invited the panel to find that your fitness to practise is not currently impaired.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant, these included: Roylance, Meadow, Cheatle, Grant and Cohen.

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

**Decision on misconduct**

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the Code.
The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel identified the following breaches of the Code arising from its findings of facts in this case:

**Paragraphs:**

4 Act in the best interests of people at all times

5 Respect people’s right to privacy and confidentiality
   - As a nurse or midwife, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.
   - To achieve this, you must:
     5.1 respect a person’s right to privacy in all aspects of their care
     5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

8 Work cooperatively
   - To achieve this, you must:
     8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice
   - This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
   - To achieve this, you must:
     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
10.5 take all steps to make sure that all records are kept securely, and
10.6 collect, treat and store all data and research findings appropriately.

18.4 take all steps to keep medicines stored securely

20 Uphold the reputation of your profession at all times

The panel also considered that your failings amounted to breaches of the NMC’s “Standards for medicines management”, specifically:

**Section 3, standard 6**
“Registrants must ensure all medicinal products are stored in accordance with the patient information leaflet, summary of product characteristics document found in dispensed UK-licensed medication, and in accordance with any instruction on the label.”

**Section 4, Standards 8, paragraph 2.10**
“You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine.”

The panel appreciated that breaches of the Code and the NMC’s standards for medicines management, do not necessarily amount to professional misconduct.

In relation to charges 1-3, the panel had regard to the following paragraph in the NMC standards for medicines management:

**Section 9, standard 24, paragraph 5**
“When considering allegations of misconduct arising from errors in the administration of medicines, the NMC takes great care to distinguish between those cases where the error was the result of reckless or incompetent practice and/or was concealed, and
those that resulted from other causes, such as serious pressure of work, and where there was immediate, honest disclosure in the patient’s interest. The NMC recognises the prerogative of managers to take local disciplinary action where it is considered to be necessary but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described above.”

The panel noted that by failing to administer Epanutin to Resident A, you had placed him at risk of harm. Further, by failing to ensure safe storage of the drug and leaving it on Resident A’s bedside table, you had placed other residents at risk of harm. The panel heard evidence that a resident was in fact wandering around in the vicinity of Resident A’s room, and therefore could have taken the drug. Additionally, you had then signed Resident A’s MAR chart to indicate that Epanutin had been administered to Resident A when it had not. This caused some confusion to day staff and therefore your actions could have had an adverse impact on the subsequent care provided to Resident A.

However, the panel accepted that you were the only registered nurse present during the night shift, and that you had responsibility for some 32 residents many with high dependency needs. It accepted your evidence in which you stated that the Home was particularly busy between the periods of 06:00 and 08:00, when it was agreed that Resident A would have this particular medication administered; it noted that whilst an unnecessary risk was created, there was no evidence of actual patient harm having been caused to either Resident A or any other resident at the Home. The panel further took into account that when you were made aware of the incident by Mr 1, you were open and honest about your failings. It also noted that this was an isolated incident in your nursing career, and that whilst it was an oversight, it did not amount to reckless or incompetent practice; the panel has concluded that it was not sufficiently grave to warrant a finding of misconduct.

Even had the panel concluded that your actions in charges 1-3 amounted to misconduct, it would have been satisfied that by reason of your written reflective
statement, positive testimonials and training certificates, your errors are unlikely to be repeated.

In relation to its findings in regard to charge 7, the panel took into account that you had taken pages from Resident A’s care notes, photocopied them, and kept them for your own use. The panel found that you had breached Resident A’s privacy and confidentiality and placed your own interests above his. Further, the staff responsible for Resident A’s care could not find Resident A’s most recent daily record notes as they were placed under Mr 1’s office door, which was locked. The panel considered that this had the potential to impact adversely on the care provided to Resident A.

The panel was in no doubt that it was inappropriate and wrong for you to have used Resident A’s care records to make such a lengthy detailed account of the incident on 15 January 2016. Whilst you were entitled to make a separate record for your own purpose, and to retain it, subject to protecting Resident A’s right to privacy, you were not entitled to use Resident A’s clinical records for this purpose.

The panel concluded that in breaching Resident A’s confidentiality by using his care records in this way, for purposes other than to meet his needs, and handling that record in the wholly inappropriate way you did, your conduct fell far below the standards expected of a registered nurse, and would be considered deplorable by fellow practitioners. The panel determined that your actions in respect of its findings of charge 7 amounted to placing Resident A at unwarranted risk of harm by breaching his right to have his personal clinical details handled confidentially. These actions amounted to serious misconduct.

**Decision on impairment**

The panel next went on to decide if as a result of this 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. 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 judgement of Mrs Justice Cox in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) where she endorsed the following test formulated by Dame Janet Smith:

Do our findings of fact in respect of the [nurse's] misconduct...show that her fitness to practise is impaired in the sense 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 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 has found that the first three limbs are engaged in this case. In reaching this conclusion, the panel took into account all of the evidence including your oral evidence and the documentary evidence you have provided. It noted that whilst you expressed some remorse and regret for your actions relating to charge 7, you had failed to demonstrate any clear understanding of how your actions were ill-judged and inappropriate, and put Resident A at risk of harm. You have not assured this panel that you understand why what you did was wrong and how this had the potential to impact
negatively on Resident A, and your colleagues. When questioned during the course of this hearing about how you would handle the situation differently in the future, you were unable to provide sufficiently cogent and clear answers. The panel was not therefore satisfied that you have demonstrated sufficient insight in relation to your actions, which amounted a serious breach of patient confidentiality.

The panel concluded that your behaviour amounted to a breach of a fundamental tenet of the nursing profession, in that you put your own interests above the interests of a service user, and as such your actions were liable to bring the profession into disrepute.

The panel has taken into account the fact that you have taken positive steps towards remediating your failings, in that you have undertaken courses relating to record keeping and information governance. It also had regard to the numerous positive testimonials you have provided including from several registered nurses, and that you have been described by colleagues as “someone with a genuine concern and care for service users” who “always goes the extra mile to see that her duties are wholly completed.” The panel also noted that the majority of the referees stated that they are aware of the charges against you. However, the panel was not satisfied that you yet fully appreciate the potential impact of your breach of a resident’s confidentiality.

For these reasons, the panel is of the view that there remains a risk of repetition of similar misconduct if comparable circumstances arise in the future. The panel has therefore decided that a finding of impairment is necessary on the ground of the need to protect the public.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 was of the view that by photocopying a resident’s care records and using them for your own purpose,
your actions had the potential to undermine the trust the public places in the nursing profession. The panel therefore determined that, in this case, a finding of impairment in the wider public interest is also required, to uphold the reputation of the nursing profession and to declare and uphold the proper standards of conduct.

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

**Decision on interim order**

Ms Caslin, on behalf of the NMC, submitted that the NMC does not wish to seek an interim order in this case. Ms Maqboul, on your behalf, concurred with the NMC’s position.

Having regard to its earlier findings and considering the nature of the risk, the panel was of the view that an interim order is not necessary in this case. The panel is not satisfied that the test of necessity has been met in relation to public protection. Neither of the remaining statutory grounds are met, namely otherwise in the public interest or in the registrant’s own interest.
Determination on sanction

Having determined that your fitness to practise is impaired, the panel has considered what sanction, if any, it should impose. In reaching its decision, the panel has considered all the evidence provided, including your recent reflective piece and training certificates for courses completed in confidentiality and record keeping since the hearing adjourned in August 2017. It considered Ms Harvey’s oral submissions on behalf of the NMC, and Ms Maqboul’s oral submissions on your behalf.

The panel accepted the advice of the legal assessor.

The panel has considered this case very carefully and has decided to make a conditions of practice order.

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 Sanctions Guidance (“SG”) published by the NMC. It had regard to the need to protect the public as well as the wider public interest. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Before making its decision on the appropriate sanction, the panel established the aggravating and mitigating features in your case.

The panel considered the aggravating features to be:

- Your actions could have resulted in patient harm.
- There remains a residual risk of repetition of such conduct if comparably difficult circumstances arose, due to your still-developing insight.
- You breached the trust of a resident, your employers, and your colleagues.
The panel considered the mitigating features to be:

- This was an isolated event.
- You have provided a number of positive testimonials, including from registered nurses, and have completed training courses to remediate your failings.
- You have worked as a nurse since 2002 and have not been subject to previous regulatory concerns regarding your practice.
- You have demonstrated some insight, have apologised for your misconduct, and expressed remorse.
- You have engaged with NMC proceedings.
- You made early admissions to a number of charges.

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 your still-developing insight, nor would it protect the public. 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 was mindful that any conditions imposed must be relevant, proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions, as set out in paragraph 64 of the SG, which would address the failings
highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel considered that you have demonstrated developing insight and the capacity and motivation to remediate your practice in the context of your clinical errors. However, it did not consider your insight was fully developed in respect of those matters in this case where the panel has found your fitness to practise to be impaired.

The panel took into account the passage in your reflective piece where you stated:

“The panel was of the "view that, by photocopying resident care records" I had undermined the trust the public places in the nursing profession…”

It concluded that this passage is indicative of the need for you to further develop your insight such that you can demonstrate that you understand the reasons why the panel came to this conclusion. The panel had regard to the need, in respect of good record keeping, for you to be aware of the rules governing confidentiality in respect of the supply and use of data for secondary purposes.

The panel had regard to the fact that, other than these incidents, you have had a long, unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse with conditions providing a clear route back to safe practice.

Balancing all of these factors and after having taken into account both the aggravating and mitigating features of this case, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order. It is satisfied that this will assist your development and expedite your return to unrestricted nursing practice.

The panel was of the view that to impose a suspension order would be disproportionate in this case and would not be an appropriate sanction in the circumstances. The panel
took into account your developing insight and testimonials which demonstrate that you have good qualities as a nurse. It would not be in the public interest to prevent you from practising as a nurse.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

1. At any time that you are employed or otherwise providing nursing services, you must place yourself and remain under the indirect supervision of a workplace line manager, mentor or supervisor nominated by your employer. Such supervision to consist of monthly meetings with your line manager to review your progress with the objectives outlined in your PDP.

2. You must work with your line manager, mentor or supervisor (or their nominated deputy) to create a PDP designed to address the following:

   - Your awareness of the rules governing confidentiality in respect of the supply and use of data for secondary purposes;
   - How you have demonstrated that understanding together with your understanding of the general principles of information governance in your nursing practice;
   - Practical examples of how you have applied the principles of good record keeping in your practice to enhance patient or resident care.

3. You must send a report from your line manager, mentor or supervisor (or their nominated deputy) setting out the standard of your performance and your
progress towards achieving the aims set out in your PDP to the NMC at least 14 days before the NMC review hearing to review this order.

4. You must tell the NMC within 14 days of any nursing appointment (whether paid or unpaid) you accept within the UK or elsewhere, and provide the NMC with contact details of your employer.

5. You must tell the NMC about any professional investigation started against you and/or any professional disciplinary proceedings taken against you within 14 days of you receiving notice of them.

6. a) You must within 14 days of accepting any post of employment requiring registration with the NMC, or any course of study connected with nursing, provide the NMC with the name/contact details of the individual or organisation offering the post, employment or course of study.

   b) You must within 14 days of entering into any arrangements required by these conditions of practice provide the NMC with the name and contact details of the individual/organisation with whom you have entered into the arrangement.

7. You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC’s fitness to practise procedures and disclose the conditions listed at (1) to (5) above, to them

   - Any organisation or person employing, contracting with or using you to undertake nursing work

   - Any agency you are registered with or apply to be registered with (at the time of application) to provide nursing services
• Any prospective employer (at the time of application) where you are applying for any nursing appointment

• Any educational establishment at which you are undertaking a course of study connected with nursing, or any such establishment to which you apply to take a course (at the time of application).

The period of this order is for 9 months.

Before the end of the period of the order, a panel will hold a review hearing to assess your compliance with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

The reviewing panel will be assisted by your attendance at the hearing, evidence of your continued professional development, and any further testimonials or other evidence you wish to provide.
Decision on interim order and reasons:

The panel has considered the submission made by Ms Harvey, on behalf of the NMC, that an interim conditions of practice order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim order was necessary for the protection of the public and was otherwise in the public interest. In reaching the decision to impose an interim order, the panel had regard to the reasons set out in its decision for the substantive order. The panel decided to impose an interim conditions of practice order for the same reasons and on the same terms as it imposed the substantive order. To do otherwise would be incompatible with its earlier findings.

The period of this interim suspension order is for 18 months to allow for the possibility of an appeal to be made and determined. If no appeal is made then the interim order will be replaced by the substantive order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.

This decision will be confirmed to you in writing.