Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 19 - Friday 22 April 2022 & Monday 25 April - Tuesday 26 April 2022

Virtual Hearing

Name of registrant:	**Sally Rita Furlong**
NMC PIN:	73A2896E
Part(s) of the register:	Registered Nurse - Mental Health Nursing RN2: Adult, level 2 (August 1976) RN3: Mental Health, level 1 (November 1979)
Area of registered address:	Kent
Type of case:	Lack of competence
Panel members:	Patricia Richardson (Chair, lay member) Donna Green (Registrant member) Nicola Strother Smith (Lay member)
Legal Assessor:	Fiona Moore
Hearings Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Amy Woolfson, Case Presenter
Mrs Furlong:	Not present and unrepresented
No case to answer:	None
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 8, 11, 12, 13a, 13b, 13c, 13d, 13f(i), 13f(ii), 13f(iii), 14, 15b(i), 15(ii), 15b(iii), 15b(iv), 16, 17a, 17b, 18a, 18b, 19, 20a, 20b, 20c, 21, 23a, 23b, 25a, 25b, 25c, 25d, 26
Facts not proved:	Charges 7, 9a, 9b, 10a, 10b, 13e, 15a, 22, 24a, 24b
Fitness to practise:	**Impaired**

Sanction: **Suspension order (12 months)**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Furlong was not in attendance and that the Notice of Hearing letter had been sent to Mrs Furlong's registered email address on 9 March 2022.

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

Ms Woolfson, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mrs Furlong

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

Ms Woolfson invited the panel to continue in the absence of Mrs Furlong on the basis that she had voluntarily absented herself. Ms Woolfson referred the panel to a Case Management Form (CMF) received by the NMC in December 2021, which was completed by Mrs Furlong. Ms Woolfson submitted that in the CMF, Mrs Furlong indicated that she did not intend to attend a hearing if one is scheduled for this case.

Ms Woolfson further submitted that in the completed CMF, Mrs Furlong also indicated that she would have a representative present and this is not the case so the panel may want to take this into account in its consideration. She stated that Mrs Furlong was represented by the Royal College of Nursing (RCN) 18 months ago, however, the RCN was no longer a representative for Mrs Furlong and Mrs Furlong did not have a representative for this case.

Ms Woolfson submitted that there is clear public interest in the expeditious disposal of this case. She submitted that there are three witnesses due to give live evidence and further delay may have an adverse effect on the ability of the witnesses to accurately recall events. She further submitted that the three witnesses are healthcare professionals and not proceeding today may have an impact on them and their employer's professional resources and services.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Furlong. In reaching this decision, the panel has considered the submissions of Ms Woolfson, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v*

Jones and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Furlong;
- Mrs Furlong has informed the NMC in a completed CMF that she does not propose to attend the hearing;
- There has been very limited engagement with the NMC from Mrs Furlong in relation to these proceedings;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses are due to give evidence, and may be caused inconvenience if there was a delay to this hearing;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Furlong in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, Ms Woolfson suggested that she will, as far as she is able to, question the witnesses on the basis of the case that Mrs Furlong has put forward in the CMF. The panel noted the limited disadvantage is the consequence of Mrs Furlong's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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

At the outset of the hearing, Ms Woolfson, on behalf of the NMC, made a request that this case be held partly in private on the basis that proper exploration of Mrs Furlong's case involves reference to health matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there may be reference to health matters, the panel determined to hold parts of the hearing in private as and when such issues are raised.

Details of charge (as amended)

That you, between 16 January 2017 and 22 July 2018 failed to demonstrate the standards of knowledge, skill and judgement to practise without supervision as a band 6 nurse in that you:

1) Failed to adequately supervise and support a student nurse under your mentorship **[PROVED]**

2) Failed to send GP letters without delay **[PROVED]**

3) Sent a letter/fax to Patient A's GP surgery when the letter/fax should have referred to Patient H who was registered at a different GP surgery **[PROVED]**

4) Failed to adequately document Patient I's care plan **[PROVED]**

5) Failed to complete the core assessment for Patient B **[PROVED]**

6) Failed to document adequate details of Patient C's depot injection **[PROVED]**

7) Provided a patient with incorrect advice regarding their scans **[NOT PROVED]**

8) Failed to promptly request a letter be sent to a patient following an assessment thereby incurred a 2 month delay **[PROVED]**

9) Having noted a patient to have low blood pressure;
   a) Failed to notify the patient's GP **[NOT PROVED]**
   b) Failed to arrange an ECG **[NOT PROVED]**

10) In relation to Patient D;
   a) Failed to seek a diagnosis **[NOT PROVED]**
   b) Incorrectly notified the patient that he was 'under assessment' **[NOT PROVED]**

11) Failed to ensure a patient received their depot injection on the same day each month **[PROVED]**

12) Requested a colleague administer a depot injection to Patient C on the wrong day **[PROVED]**

13) In relation to Patient R:
   a) Failed to document 'needs and risks' **[PROVED]**
   b) Failed to adequately document the 'mental state examination' **[PROVED]**
   c) Failed to obtain the patient's signature on the care plan **[PROVED]**
   d) Having failed to obtain the signature in charge 13 c) above, failed to document any reasons why the patient had not signed **[PROVED]**

e) Failed to book an appointment with the outpatient clinic **[NOT PROVED]**

f) Failed to adequately complete areas of the RIO notes, including:

i) Advance care/recovery plans **[PROVED]**

ii) Crisis and contingency plan **[PROVED]**

iii) Risk assessment **[PROVED]**

14) Failed to re-arrange a follow up appointment for Patient E **[PROVED]**

15) In relation to Patient F:

a) Failed to document the 'mental state examination' **[NOT PROVED]**

b) Failed to adequately complete areas of the RIO notes, including:

i) Behaviour **[PROVED]**

ii) Speech **[PROVED]**

iii) Presenting situation **[PROVED]**

iv) Current medication **[PROVED]**

16) Failed to arrange a home medic visit for Patient G **[PROVED]**

17) In relation to Patient Q:

a) Failed to document any discussion with the medic regarding the CT scan results **[PROVED]**

b) Failed to arrange a meeting with the patient to deliver their diagnosis **[PROVED]**

18) In relation to Patient N:

a) Failed to arrange an ECG **[PROVED]**

b) Failed to arrange a home visit wellbeing check **[PROVED]**

19) Failed to arrange an appointment for a wellbeing check on Patient S **[PROVED]**

20) In relation to Patient T:
    a) Failed to conduct and/or document the core assessment **[PROVED]**
    b) Failed to adequately document the risk assessment **[PROVED]**
    c) Failed to adequately document the care plan **[PROVED]**

21) Failed to adequately document Patient L's 'mental state examination' without prompting and assistance **[PROVED]**

22) Failed to adequately document Patient M's care plan without assistance **[NOT PROVED]**

23) In relation to Patient HH:
    a) Failed to discuss medication with the doctor **[PROVED]**
    b) Failed to discharge the patient **[PROVED]**

24) In relation to Patient F:
    a) Failed to document details of the patient's memory **[NOT PROVED]**
    b) Failed to document details of the patient's anxiety **[NOT PROVED]**

25) In relation to Patient Z, failed to adequately document details including:
    a) Family and personal history **[PROVED]**
    b) Social history **[PROVED]**
    c) Formulation **[PROVED]**
    d) Pre-morbid history **[PROVED]**

26) Failed to complete the 'non-compliance' section of Patient S's notes **[PROVED]**

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

Decision and reasons on application to amend charge 3

The panel heard an application made by Ms Woolfson, on behalf of the NMC, to amend the wording of charge 3.

The proposed amendment was to change the wording in charge 3 from '*letter*' to '*letter/fax*'. It was submitted by Ms Woolfson that the proposed amendment would more accurately reflect the evidence, as it is apparent from the exhibited evidence in this matter that the complaint from Patient A's General Practitioner's (GP) surgery makes reference to a fax. In addition, she submitted that although the fax may well have been in a letter format, this amendment would be useful to provide clarity.

Ms Woolfson submitted that such amendment would be a technical amendment and would not cause any unfairness as it does not alter the overall substance of the charge.

Original charge 3:

3) Sent a letter to Patient A's GP surgery when the letter should have referred to Patient H who was registered at a different GP surgery

Proposed charge 3:

3) Sent a ~~letter~~ **letter/fax** to Patient A's GP surgery when the ~~letter~~ **letter/fax** should have referred to Patient H who was registered at a different GP surgery

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such an amendment was minor in nature and did not affect the substance of the charge. The panel was satisfied that there would be no prejudice to Mrs Furlong and no injustice would be caused to either party by the proposed amendment

being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on no case to answer

At the closing of the NMC's case, the panel heard and accepted the legal assessor's advice on issues it should take into consideration regarding Rule 24(7), which states:

> *'24(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and—*
> *i) either upon the application of the registrant, or*
> *(ii) of its own volition, the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'*

The panel of its own volition considered whether there was a case to answer in respect of each charge. Ms Woolfson did not make any submissions on this matter.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented for each charge, such that it could reach a finding on the facts and whether Mrs Furlong had a case to answer.

The panel also reminded itself that if a charge alleges a failure the NMC must prove a duty on the registrant to carry out the actions alleged as a failure. It applied the test in *R v Galbraith [1981] 1 WLR 1039* to each charge and each part of each charge separately.

In respect of each charge, the panel considered whether there was any evidence to support the charge, or whether there was some evidence of such a tenuous character that taken at its highest it could not say that the NMC had satisfied it to the requisite standard that there was a case to answer.

The panel was of the view that there had been sufficient evidence to support each of the charges at this stage and, based on the evidence before it, there was a case to answer in respect of all charges. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on additional evidence from Colleague B

During the course of Colleague B's evidence, when questioned, Colleague B referred to a Pro Forma document, which relates to the recording of depot injections at the Trust at the time of the allegations. However, this document was not put before the panel. Colleague B stated that if necessary he could make enquiries to obtain a Pro Forma document, which would have been in use at the time of the allegations.

Ms Woolfson did not make an application to admit the additional evidence under Rule 31, however, she stated that the NMC could make enquiries to obtain the document if required by the panel. She informed the panel that this document had not been served on Mrs Furlong, and as Mrs Furlong is not in attendance, she is not able to comment on evidence that has not been served upon her. Ms Woolfson invited the panel to take into account fairness to Mrs Furlong and submitted that the panel may consider it is not particularly necessary to admit this additional evidence.

The panel heard and accepted the legal assessor's advice and had regard to Rule 31. Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel, in making its decision, bore in mind the principles of relevance and fairness. The panel considered whether it would be relevant to admit the additional evidence that could be produced by Colleague B. The panel was of the view that a Pro Forma document, which relates to the recording of depot injections at the Trust, would be

relevant in the circumstances of this case. The panel was of the view that this could aid the understanding of best practice at the Trust at the time of the allegations.

The panel next considered whether it would be fair to admit the additional evidence from Colleague B without causing prejudice. The panel considered that Mrs Furlong had not had sight of the additional evidence and at this stage in the proceedings would not have the opportunity to comment on the evidence. In these circumstances, the panel concluded that it was not fair to admit this additional information and would not be appropriate at this stage.

Background

The NMC received a referral from Kent and Medway NHS and Social Care Partnership Trust (the Trust) on 4 December 2018, in relation to concerns raised while Mrs Furlong was working as a Band 6 Community Psychiatric Mental Health Nurse (CPN) at the Trust. Mrs Furlong qualified as a Registered Mental Health Nurse in 1979 and started working for the Trust in December of that year. In March 2000, Mrs Furlong began work in the Trust's Community Team. At the relevant time, Mrs Furlong was working as a CPN initially in Tunbridge Wells at Highlands House (Highlands), from July 2001 until November 2017, and then in Dartford at Greenacres, from December 2017 until she resigned.

In her role, Mrs Furlong worked with older people with functional mental health illnesses and progressive conditions. The patients were typically, but not limited to, over 65 years of age with illnesses such as; Dementia, Schizophrenia, Anxiety and Depression.

In March 2017, Mrs Furlong's Line Manager at Highlands retired and Colleague A, a Registered Mental Health Nurse, became Mrs Furlong's Line Manager and Team Leader.

A student nurse was on placement at Highlands with Mrs Furlong as her mentor and another colleague as an associate mentor. On 20 May 2017, the student nurse provided feedback on a 'Report of Issues for Practice' (PIR1) form. The student raised concerns

about the Trust's Community Team as a whole and the two mentors that she had been allocated. The matter was investigated by Colleague B, who was the Trust's Service Manager at the time.

As a result of the concerns raised, Mrs Furlong was placed on an informal performance management plan in May 2017, regarding her performance. The informal performance management plan focused on Mrs Furlong's record keeping, patient care, attitude and respect to staff and others. Whilst on the informal performance management plan, Mrs Furlong's caseload was reduced from 52 patients to 39. There were also various support measures offered, including the use of templates; the use of a Dictaphone; and further administrative help. However, Mrs Furlong declined the offer of a Dictaphone. Mrs Furlong was also placed on monthly supervision, to receive support from Colleague A.

The referral alleges that despite the informal performance management plan, there were ongoing concerns about Mrs Furlong's ability to perform to an appropriate standard, placing patient safety at risk. It is alleged that the issues included:

- The quality of Mrs Furlong's record keeping and documentation;
- The quality of Mrs Furlong's risk assessments;
- The quality of Mrs Furlong's mental state examinations;
- Delays in updating progress notes and draft letters;
- Not seeking diagnosis for patients in a timely manner;
- The quality of Mrs Furlong's work fluctuating, with sporadic improvements for short periods of time, which would then decline again; and
- Inconsistencies in the improvement of Mrs Furlong's work.

The informal performance management plan was due to be completed at the end of July 2017. However, due to continued concerns it was extended until January 2018.

During a supervision meeting with Colleague A in October 2017, Mrs Furlong informed Colleague A that [PRIVATE]. Colleague A arranged for Mrs Furlong to undertake [PRIVATE], however, the results showed [PRIVATE].

In an email dated 29 October 2017, Mrs Furlong emailed Colleague B, who was Colleague A's manager at the time, alleging that Colleague A was bullying her. Colleague B met with Mrs Furlong on 17 November 2017 and sent a letter to Mrs Furlong dated 20 November 2017, summarising the discussion about the allegations. Colleague B advised Mrs Furlong that she would need to put the detailed allegations against Colleague A in writing if she wanted to pursue them. However, Mrs Furlong declined to do so.

Colleague B also offered to move Mrs Furlong to another team in the Trust, at Greenacres in Dartford, which she accepted. Mrs Furlong started work at Greenacres on 20 December 2017, after a period of sick absence in November 2017. The Operational Team Leader at the time, Colleague C, became Mrs Furlong's Line Manager at Greenacres and formally managed Mrs Furlong from January 2018 until her resignation.

Mrs Furlong was subsequently placed on a formal performance management plan in January 2018, due to continued alleged performance issues around poor record keeping and clinical competence. She remained on the formal performance management plan until her resignation.

Following induction at Greenacres, Mrs Furlong was given weekly supervision with Colleague C and additional administrative support. During the period from January 2018 to July 2018 numerous further concerns were allegedly identified, mostly relating to documentation issues. It is alleged that although there was some improvement in Mrs Furlong's practice, this was not sustained and Mrs Furlong's performance was not satisfactory.

A performance management meeting was held on 4 July 2018. At this time, Mrs Furlong refused to attend any further weekly supervision meetings but subsequently agreed to attend fortnightly.

The matter of Mrs Furlong's performance was scheduled to be heard at a performance management hearing in September 2018. However, Mrs Furlong resigned on 22 July 2018, in advance of this hearing.

On 5 September 2018, a performance management hearing was held, which determined that Mrs Furlong continued not to meet the minimum standards on a regular basis and could not perform to the level of a Band 6 nurse without supervision. The hearing concluded that Mrs Furlong would be dismissed if she had not already resigned.

Decision and reasons on facts

The panel noted from the CMF that Mrs Furlong denied all the charges.

In reaching its decisions on the disputed facts, the panel considered the evidence adduced in this case together with the submissions made by Ms Woolfson on behalf of the NMC.

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

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

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

- Colleague A: Team Leader at the Trust at the time, who was Mrs Furlong's Line Manager at Highlands in Tunbridge Wells;

- Colleague B: Service Manager at the Trust at the time;
- Colleague C: Operational Team Leader at the Trust at the time, who was Mrs Furlong's Line Manager at Greenacres in Dartford.

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

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

Charge 1

1) Failed to adequately supervise and support a student nurse under your mentorship.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and Colleague B. The panel considered documentary evidence exhibited, which included feedback from a student nurse in a PIR1 form and a placement evaluation. In addition, the panel also considered a reflective account from Mrs Furlong dated 10 April 2017.

The panel noted the PIR1 form, in which the student nurse details incidents from January 2017 to March 2017, while she was on placement at Highlands. The panel further noted that the concerning feedback given by the student nurse about her experience of the

incidents also involved Mrs Furlong, albeit with more emphasis on the culture of the team rather than on supervision.

The panel considered the student nurse's response in the placement evaluation form, in relation to a question about mentor support, in which she indicated that she was not satisfied with the support received from her mentor. The completed placement evaluation form states:

> *'34. I was satisfied with the support I received from my Mentor/Practice Educator*
> *Answers given:*
> *Yes: 0*
> *No: 1'*

The panel also considered Colleague A and Colleague B's evidence, which generally corroborated one another's account that support for the student nurse was the responsibility of all staff, but particularly the student's mentors. The panel further considered Colleague B's evidence where he investigated the student's feedback and found Mrs Furlong's supervision to be lacking, in that the student had not been able to complete a sufficient number of centrally set competencies.

The panel accepted the evidence of Colleague A and Colleague B as credible overall and was of the view that it was Mrs Furlong's duty at the time as a mentor to adequately supervise and support the student nurse.

The panel also took into account Mrs Furlong's reflective account dated 10 April 2017, in which Mrs Furlong appears to accept failings in her mentorship, which states:

> *'I know the students need more consistency and that I failed to give it to her but she was so rarely in placement.'*

The panel had regard to context and apparent systemic issues within Mrs Furlong's team. However, notwithstanding this, the panel concluded that Mrs Furlong failed to adequately supervise and support the student nurse under her mentorship.

Accordingly, the panel finds charge 1 proved.

Charge 2

2) Failed to send GP letters without delay.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included emails from Colleague A to Mrs Furlong, dated 16 March 2017 and 27 March 2017.

The panel considered Colleague A's evidence where she explained that the service standard was to send GP letters within seven days of seeing a patient, but that it was best practice to send them as soon as possible. It noted that Colleague A stated that this is to ensure prompt service for GP's and patients; and for letters to be complete and accurate. The panel was therefore of the view that Mrs Furlong had a duty to ensure the avoidance of unduly delay when sending GP letters.

The panel noted an example of Colleague A having to chase Mrs Furlong to send a GP letter three weeks after a patient had been seen. The email from Colleague A to Mrs Furlong dated 16 March 2017, states:

'Hi SALLY
Please can you do a letter for the GP on […] asap seeh on 22nd Feb
Thanks'

The panel considered that Colleague A explained that this was not a single oversight, which is supported by another example of Colleague A having to chase Mrs Furlong, in an email dated 27 March 2017:

> *'Hi Sally*
> *Letter needed for […] please ASAP'*

The panel accepted Colleague A's evidence highlighting delays to GP letters being sent and Mrs Furlong's failure to act upon it. The panel also noted the numerous opportunities provided to Mrs Furlong to receive administrative assistance to support her timely completion of documentation, which was refused.

Accordingly, the panel finds charge 2 proved.

Charge 3

3) Sent a letter/fax to Patient A's GP surgery when the letter/fax should have referred to Patient H who was registered at a different GP surgery.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included a complaint letter from a GP surgery dated 21 June 2017.

The panel considered Colleague A's evidence that the Trust received a complaint letter from a GP surgery on 21 June 2017 regarding a letter/fax sent about their patient, Patient A, who lived in a care home.

The panel considered the complaint letter, which indicated that the letter/fax requested alterations to two of Patient A's medications, but Patient A was not prescribed either of the

named medications. The complaint letter also indicated that when the GP practice investigated the matter, they learned that the letter/fax was referring to a different patient at the care home, Patient H, who was not registered with their practice. The panel noted that Mrs Furlong was specifically named in the complaint letter as having sent the letter/fax and her unwillingness to accept responsibility for the error.

The panel determined that there is credible evidence from an external source, which makes reference to Mrs Furlong's error in the letter/fax she sent to Patient A's GP surgery.

Accordingly, the panel finds charge 3 proved.

Charge 4

4) Failed to adequately document Patient I's care plan.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included Patient I's care plan completed by Mrs Furlong on 9 June 2017.

The panel considered Colleague A's evidence that Mrs Furlong failed to answer some important and necessary questions in Patient I's care plan. The panel noted that Colleague A indicated that this presents a risk, as important information missed can have a negative impact on patient care. In Colleague A's witness statement she states the following:

'The first was at question four, which references whether the care plan clearly identified the steps needed to achieve the goal.
[…]

Question five relates to the care plan addressing legal implications e.g. Deprivation of Liberty applications. This was missing.
[…]

The next question is number one under the risk assessment section. Sally had not put the patient's history in order i.e. made it clear what the most pertinent information to the risk was.'

The panel considered Patient I's care plan, which supported Colleague A's account. It determined that Mrs Furlong failed to include information in Patient I's care plan, which was essential to the patient's care.

The panel therefore concluded that Mrs Furlong failed to adequately document Patient I's care plan.

Accordingly, the panel finds charge 4 proved.

Charge 5

5) Failed to complete the core assessment for Patient B.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included Patient B's core assessment on 18 August 2017.

The panel considered Colleague A's evidence that Mrs Furlong failed to complete Patient B's core assessment. The panel noted that Colleague A stated the following in her witness statement:

'If core assessments are not completed in a timely fashion then it is difficult for the medics to make a diagnosis, which in turns means that if medication is needed there is a delay in this being made available to the patient hence potentially leading to harm e.g. further preventable deterioration.'

The panel observed that Patient B's core assessment had incomplete sections on RiO (the Trust's electronic patient record), which supported Colleague A's account. It determined that Mrs Furlong failed to include information in Patient B's core assessment essential to the patient's care.

The panel therefore concluded that Mrs Furlong failed to complete the core assessment for Patient B.

Accordingly, the panel finds charge 5 proved.

Charge 6

6) Failed to document adequate details of Patient C's depot injection.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and Colleague B. The panel also considered documentary evidence exhibited, which included Patient C's Progress Notes on RiO; Patient C's Depot Prescription and Administration Sheet; and an email sent to Colleague A dated 11 September 2017, relating to Patient C's depot injection.

The panel considered Colleague A's evidence where she stated that she received an email from another member of her team, which raised concerns that Mrs Furlong had administered a depot injection to Patient C but only written that she administered the

depot injection without including the necessary required details. The panel noted that Colleague A stated the following in her witness statement:

> *'When one gives a depot injection, one must record the medication, the dose, the site and the side it was given. This is because when the depot injections are given we rotate sides, so if for example in month one it was injected into the right buttock then in month two we would inject the depot into the left buttock. This is to prevent the patient from developing sores at the injection site. In addition, one must record the medication and the dose because if the patient was to go into crisis and was admitted to hospital, the hospital staff would not know what medication the patient had already been given or how much. This could result in the patient potentially being given too much of the depot antipsychotic medication.'*

The panel noted the email from a member of Mrs Furlong's team to Colleague A, which supported Colleague A's account that Mrs Furlong failed to provide details of the depot injection that was essential to the patient's care. The email dated 11 September 2017, states:

> *'Hi [Colleague A] –*
>
> *Just wondered if you would mind having a chat with Sally? I've just been looking through the progress notes and Sally has just written 'depot administered', not the actual medication, dose, site or side. There is a prescription card under Clinical Documentation which was dated 2016, so will make it difficult if she is admitted into hospital (say if Psych Liaison access the notes) as it isn't particularly clear what is being administered or the dose.*
>
> *Thanks'*

The panel considered that in Patient C's progress notes on RiO Mrs Furlong did not record details of the depot injections given to the patient on 1 August 2017 and on 11 September

2017. However, it noted that further details were provided by Mrs Furlong on Patient C's handwritten prescription depot sheet.

The panel took into account Colleague A and Colleague B's evidence as to the importance of detailed information being recorded on RiO, particularly when the patient is admitted to hospital or seen out of hours. The panel considered that Colleague A and Colleague B's evidence generally corroborated one another's account that this information must be uploaded to RiO and it is not satisfactory for Mrs Furlong to write this on a prescription sheet only.

The panel was therefore satisfied that there was clear corroborative evidence to determine that Mrs Furlong failed to document adequate details of Patient C's depot injection.

Accordingly, the panel finds charge 6 proved.

Charge 7

7) Provided a patient with incorrect advice regarding their scans.

This charge is NOT found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included a letter to an external Medical Centre, dated 2 October 2017, regarding Patient D.

The panel considered Colleague A's evidence where she explained that it was not correct for a nurse to advise on CT scans. The panel noted that Colleague A stated the following in her witness statement:

> *'There was an issue that had come to my attention separately. I cannot remember how I became aware of it but Sally had given a patient advice about their scan that*

was incorrect. During this meeting I reminded Sally that she should not be doing this. The doctors/medics are the ones who give patients their diagnoses following receipt of the scan. The CPNs are not experts in reading scans and we are also not competent in answering the questions that stem from receipt of a diagnosis. It is possible that the CPN could misinterpret the scan and or miss something that needs to be addressed, hence why this is left to the medics.'

The panel noted a letter from the Trust dated 2 October 2017, which provides details of Patient D's CT scan to an external Medical Centre. The panel noted that Mrs Furlong was not mentioned in this email as having given advice.

The panel found no other evidence, which makes reference to advice given by Mrs Furlong in relation to a patients scan. The panel also considered that Colleague A stated that she '*cannot remember'* how she became aware of the advice Mrs Furlong had given a patient about their scan. In the absence of any further evidence, the panel was not satisfied that there is sufficient evidence to determine that Mrs Furlong provided a patient with incorrect advice regarding their scans.

Therefore, the panel finds charge 7 not proved.

Charge 8

8) Failed to promptly request a letter be sent to a patient following an assessment thereby incurred a 2 month delay.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included an email from Colleague A to Mrs Furlong, dated 6 October 2017.

The panel considered Colleague A's evidence where she explained that Mrs Furlong had seen a patient in July 2017, but not arranged to write a letter to their GP until September 2017. The panel bore in mind Colleague A's explanation of service standard, as outlined in charge 2, that GP letters were to be sent within seven days of seeing a patient, but that it was best practice to send them as soon as possible.

The panel noted an email from Colleague A to Mrs Furlong, which supports her account that Mrs Furlong failed to promptly request a letter to be sent after seeing the patient in July 2017. The email from Colleague A to Mrs Furlong dated 6 October 2017, states:

> '*Hi Sally*
>
> *[…] asked me to pp your letters as you are off sick and there were a couple of issues I noted.*
>
> *I am concerned that a when you saw a patient in July the letter was not requested until the middle of September. It has taken two months to send a letter to the GP and trust protocol is 7 days*
> *[…]'*

The panel accepted Colleague A's evidence highlighting a two month delay to a patient's letter being sent as a result of Mrs Furlong's failure to promptly request this.

Accordingly, the panel finds charge 8 proved.

Charge 9

> 9) Having noted a patient to have low blood pressure;
> a) Failed to notify the patient's GP
> b) Failed to arrange an ECG

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included an email from Colleague A to Mrs Furlong, dated 6 October 2017.

The panel considered Colleague A's evidence where she describes having documented a patient's low blood pressure, Mrs Furlong failed to notify the patient's GP and also arrange an Echocardiogram (ECG). The panel noted that Colleague A stated the following in her witness statement:

> *'I cannot recall if the next issue was for the same patient or a separate patient. In Sally's progress notes it was recorded that the patient's blood pressure was low and they reported to Sally that they were feeling dizzy. This information had not been acted on by Sally. The patient was evidently not feeling well therefore Sally should have made the patient's GP aware of this information and requested an echocardiogram ("ECG") so that it could be addressed.'*

The email from Colleague A to Mrs Furlong dated 6 October 2017 stated the following, in respect of a patient's low blood pressure:

> *'… Also, when a blood pressure is low and they are saying they are dizzy are you not requesting a review by the GP and getting an ECG?'*

The panel found that Colleague A's evidence was not clear who the patient is and did not make reference to the patient's progress notes. The panel also considered that Colleague A stated that she '*cannot recall'* which patient the issue related to and it is unclear from her email the extent of the identified issue, in respect of the patient's blood pressure. The panel was not satisfied that there is sufficient evidence to determine the alleged actions not taken by Mrs Furlong, in respect of a failure to notify the patient's GP and arrange an ECG, after a documenting low blood pressure.

Therefore, in the absence of any further evidence, the panel finds charge 9a and 9b not proved.

Charge 10

10) In relation to Patient D;
a) Failed to seek a diagnosis
b) Incorrectly notified the patient that he was ‘under assessment’

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included an email from Colleague A to Mrs Furlong, dated 6 October 2017 and a letter to an external Medical Centre, dated 2 October 2017, regarding Patient D.

The panel considered Colleague A’s evidence where she explains that Mrs Furlong should have sought a diagnosis for Patient D following her examination, and should not have described him as being ‘*under assessment’*. The panel noted that Colleague A stated the following in her witness statement:

> *‘The last issue I noted was that Sally had not sought a diagnosis from the medics for patient Patient D. I recall that I had asked Sally to do this twice on separate occasions but this had not been actioned. Patient D had been seen and started on medication but the letter sent subsequent to his appointment with Sally stated that he was ‘under assessment’, which was incorrect. Having a diagnosis makes things easier for the patient. It helps them to understand what is happening with them and also means that if they need help others understand what is wrong as well. In addition, having a diagnosis makes it easier for patients to claim benefits if needed.’*

The email from Colleague A to Mrs Furlong dated 6 October 2017 stated the following, in respect of Patient D's diagnosis and assessment:

> *'also asked you in Supervision to get a diagnosis for Patient D before the letter was sent out as he was started on medication and therefore it can't go out as under assessment, but this had not been done.'*

The panel noted a letter from the Trust dated 2 October 2017 copied to Patient D, which provides details of Patient D's diagnosis and makes no reference to the patient being under assessment. The panel found no further reference to the alleged actions not taken by Mrs Furlong.

In the absence of any further evidence, the panel was not satisfied that there is sufficient evidence to determine that Mrs Furlong failed to seek a diagnosis for Patient D and incorrectly notified the patient that he was '*under assessment*'.

Therefore, the panel finds charge 10a and 10b not proved.

Charge 11

11) Failed to ensure a patient received their depot injection on the same day each month.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and Colleague B. The panel also considered documentary evidence exhibited, which included Patient C's Depot Prescription and Administration Sheet.

The panel noted Colleague A's evidence that depot injections must be given as prescribed and at the prescribed time intervals, otherwise there is a risk that the patient may not get

the correct doses in the allocated timeframe (which was 12 injections for the year, in Patient C's case). The panel also noted that Colleague B gave evidence that there is a '*window*' within which a depot injection could be given, but that this should be done in consultation with the prescriber i.e. not unilaterally by a nurse. The panel considered that Colleague A and Colleague B's evidence generally corroborated one another's account.

The panel accepted the evidence of Colleague A and Colleague B as credible overall and was of the view that it was Mrs Furlong's duty to ensure that Patient C receive their depot injections on the same day each month to ensure compliance with the Trust's standards of care.

The panel noted Patient C's prescription sheet completed by Mrs Furlong at the relevant time, which demonstrates that the patient received depot injections from Mrs Furlong on:

'4/7/17 […]
1/8/17 […]
11/9/17 […]
16/9/17 […]
6/11/17 […]'

The panel was therefore satisfied that there was clear evidence to determine that Mrs Furlong failed to ensure Patient C received their depot injection on the same day each month.

Accordingly, the panel finds charge 11 proved.

Charge 12

12) Requested a colleague administer a depot injection to Patient C on the wrong day.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included an email sent to Colleague A dated 13 November 2017, relating to Patient C's depot injection.

The panel considered Colleague A's evidence where she stated that she received an email from another member of her team, which raised concerns that Mrs Furlong had asked her to administer a depot injection to a patient before this was due. The panel noted that Colleague A stated the following in her witness statement:

> *'I produce at **Exhibit FM/17** a copy of an email I received from […] dated 13 November 2017 concerning a patient. From memory, Sally had asked […] to give a depot injection to the patient for her on 9 October 2017 however […] had pointed out to Sally that the injection was not due until 11 October 2017. […] had not heard anything further from Sally about this so she had not given the injection. The depot ended up being given to the patient a day later than it should have been i.e. 12 October 2017.'*

The panel noted the email from a member of Mrs Furlong's team to Colleague A, which supported Colleague A's account that Mrs Furlong instructed her colleague to administer the depot injection to Patient C on the wrong day. The email dated 13 November 2017, states:

> *'Hi […] –*
>
> *Just to confirm – Sally asked me to do […] depot on 9 October. When I looked at the dates on the prescription chart, I gave the depot prescription chart back to Sally stating that the depot would need to administered on Wed 11 Oct and not today as it was too early as the last time was administered on 11th Sept and to let me know if she was unable to do this. Sally said that it may be difficult for her as it is her clinic*

day but will see. I didn't hear anymore from her on that Monday or Wednesday so I believed she was able to find time to do the depot around her assessment clinics.'

The panel was therefore satisfied that there was clear evidence to determine that Mrs Furlong requested a colleague to administer depot injection to Patient C on the wrong day.

Accordingly, the panel finds charge 12 proved.

Charge 13

13) In relation to Patient R;

a) Failed to document 'needs and risks'

b) Failed to adequately document the 'mental state examination'

c) Failed to obtain the patient's signature on the care plan

d) Having failed to obtain the signature in charge 13 c) above, failed to document any reasons why the patient had not signed

e) Failed to book an appointment with the outpatient clinic

f) Failed to adequately complete areas of the RIO notes, including:

i) Advance care/recovery plans

ii) Crisis and contingency plan

iii) Risk assessment

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient R's Progress Notes on RiO; Patient R's Risk Summary; and Colleague C's Management Supervision Records for Mrs Furlong, dated 7 January 2018 and 5 February 2018.

The panel noted that Colleague C gave evidence that Mrs Furlong had repeated failures in her documentation and further duties regarding Patient R, which were raised with Mrs Furlong during supervision.

a) Failed to document 'needs and risks'

This charge is found proved

In relation to charge 13a, the panel noted that Colleague C stated the following in her witness statement in regards to the documentation of Patient R's 'needs and risks':

> *'On pages six and seven of Exhibit JW/7* [**Management Supervision Record, dated 7 January 2018]**, *Sally and I went through a progress note that she had completed for a patient ( ). Sally had not completed the section for 'needs and risks,' which is very important. Sally explained that she had mistakenly validated the note before completing it. This is a feasible explanation if it was late in the day and someone shut down their computer, but I would expect that member of staff to make a note to themselves of what they had done and return to complete the notes properly. I was not satisfied with her explanation.'*

The panel considered that Colleague C's evidence is supported by notes from Mrs Furlong's Management Supervision Record, dated 7 January 2018, in which Mrs Furlong appears to accept a failure in regards to documenting Patient R's needs and risks. The Management Supervision Record, states the following:

> *'Sally and I have audited a recent Progress Note. All headings were completed, except for 'Identified Needs and Risks'. Sally explained that she had validated the note mistakenly prior to completing it.*
> *Sally was able to identify room for improvement in the Progress Note.'*

The panel was therefore satisfied that there was clear evidence to determine that Mrs Furlong failed to document Patient R's 'needs and risks'.

Accordingly, the panel finds charge 13a proved.

b) Failed to adequately document the 'mental state examination'

This charge is found proved

In relation to charge 13b, the panel noted that Colleague C stated the following in her witness statement, in regards to the documentation of Patient R's *'mental state examination*':

> *'I also found that Sally's Mental State Examination ("MSE") for this patient had areas for improvement. A copy of this MSE forms part of Patient R. As an experienced member of staff Sally should have been aware how to correctly complete the progress notes and MSE. The same system is used across the Trust so she should have been familiar with it.*
>
> *In order to address these shortcomings Sally and I discussed what was missing. She was able to identify areas for improvement. On the system for MSE it tells you clearly what you need to consider e.g. appearance. However, Sally appeared to be struggling therefore I thought it would be easier if I printed off the electronic version so she had it in her pack of documents. I did this on this day. I also went through examples of MSEs that I had completed with Sally and gave her a couple to refer to in the future.'*

The panel had regard to Patient R's Progress Notes on RiO. It noted that Mrs Furlong had documented some information regarding the patient's mental state presentation. However, the panel determined that, on the balance of probabilities, this appears to be consistent with Colleague C's evidence that it was inadequately documented and lacking sufficient details.

Accordingly, the panel finds charge 13b proved.

c) Failed to obtain the patient's signature on the care plan

This charge is found proved

In relation to charge 13c, the panel noted that Colleague C stated the following in her witness statement in regards to Patient R's signature on the care plan:

> *'The care plan was not signed but there was no explanation as to why. When a care plan is devised the patient needs to agree to it because it is about their wellbeing and one way of documenting this is by printing out a hardcopy of the care plan for the patient to sign. If it has not been signed it is expected that the reasons for this are documented e.g. did the patient lack capacity or did they refuse? That this information was not available is worrying because as said before, care plan are meant to be developed with the patient so a signature provides evidence of their involvement.'*

The panel considered that Colleague C's evidence is supported by notes from Mrs Furlong's Management Supervision Record, dated 5 February 2018, which states the following:

> *'Sally needs to address the following by the end of the day:*
> *Where a care plan has been uploaded to clinical documentation, it is necessary to provide this narrative and the date of upload with the care plan.*
> *If the care plan is not signed, it must state why.'*

The panel noted that in the supervision discussion, Mrs Furlong did not contradict the assertion that Patient R's care plan not been signed. The panel therefore determined that, on the balance of probabilities, this appears to be consistent with Colleague C's evidence that Mrs Furlong failed to obtain the patient's signature on the care plan.

Accordingly, the panel finds charge 13c proved.

d) Having failed to obtain the signature in charge 13 c) above, failed to document any reasons why the patient had not signed

This charge is found proved

The panel had regard to its reasoning in charge 13c. It considered that in the supervision discussion, dated 5 February 2018, Mrs Furlong did not contradict the assertion that Patient R's care plan had not been signed, neither did she comment any reasons for this.

The panel therefore determined that, on the balance of probabilities, this appears to be consistent with Colleague C's evidence that Mrs Furlong failed to document any reasons why the patient had not signed care plan.

Accordingly, the panel finds charge 13d proved.

e) Failed to book an appointment with the outpatient clinic

This charge is found NOT proved

In relation to charge 13e, the panel noted that Colleague C stated the following in her witness statement in regards to Mrs Furlong booking an appointment for Patient R with the outpatient clinic:

> *'In relation to:*
> *a. Sally was supposed to book and appointment for this patient with the outpatient clinic but failed to do so.*
> *b. The risks involved are that the patient will not get the treatment they need which could lead to discomfort and possible hospitalisation. The progress notes are attached as exhibit JW/42.'*

The panel observed Patient R's Risk Summary on RiO, which states:

'CPN to discuss with Team Drs re OP appointment.'

The panel found no further reference to the alleged actions not taken by Mrs Furlong.
In the absence of any further evidence, the panel was not satisfied that there is sufficient evidence to determine that Mrs Furlong failed to book an appointment with the outpatient clinic.

Therefore, the panel finds charge 13e not proved.

f) Failed to adequately complete areas of the RIO notes, including:

- **i) Advance care/recovery plans**
- **ii) Crisis and contingency plan**
- **iii) Risk assessment**

This charge is found proved

In relation to charge 13f(i), 13f(ii) and 13f(iii), the panel noted that Colleague C stated the following in her witness statement in regards to different areas of Patient R's RiO notes documented by Mrs Furlong:

'Her Advance Care Plan/Recovery Plan 'field' had not been completed. This section helps us to know if there is a plan in place and what it is.
[…]
Not all the fields in the Crisis and Contingency Plan had been completed. As part of the Trust's minimum standards we need to list points of contact for the patient so they know who to contact should they find themselves in distress e.g. 'please let my aunt know' or if the person is likely to overdose when upset it could say 'all medications need to be removed from the home'.
[…]

I found that Sally's risk assessment for this patient was unsatisfactory.'

The panel considered that Colleague C's evidence is supported by notes from Mrs Furlong's Management Supervision Record, dated 5 February 2018, which states the following:

'Advance Care Plan/Recovery Plan field must be completed.
All fields in Crisis end Contingency Plan must be completed. It is not sufficient to note that crisis, numbers have been given in the field around what the service would do if they began to feel unwell. This field needs to be person centred and more detailed, with all numbers, contact names and service hours provided.

This has not been completed to minimum standards and is unsatisfactory. N/A is not an acceptable response to the questions. Sally needs to ensure that the risk assessment is person centred and provides information to all readers to alert them to risk. Sally needs to provide far more information. We have discussed what information needs to be provided and
Sally will reflect on this.
Sally will rewrite the risk assessment and discuss this with […] and […] on Monday.'

The panel noted that in the supervision discussion, Mrs Furlong did not object to the noted improvement points in relation to the following sections of her RiO notes; Advance care/recovery plans; Crisis and contingency plan; and Risk assessment. The panel therefore determined that, on the balance of probabilities, this appears to be consistent with Colleague C's evidence that Mrs Furlong failed to complete these sections adequately.

Accordingly, the panel finds charge 13f(i), 13f(ii) and 13f(iii) proved.

Charge 14

14) Failed to re-arrange a follow up appointment for Patient E.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a redacted contemporaneous caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload. The panel was satisfied that although redacted, the relevant comments in the caseload review correlated with the oral evidence given by Colleague C.

The panel noted that Colleague C stated the following in her witness statement, in relation to a follow up appointment for Patient E:

> *'I had found that in the progress notes that Sally's last entry was on 12 February 2018. In this it was documented that this patient had been started on Memantine and Sally was meant to follow up. An appointment had been booked for 2 March 2018 but this had been cancelled and there was no detail recorded as to the reason why.'*

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Patient E's follow-up appointment had been cancelled and Mrs Furlong did not rearrange this appointment. Notes from Colleague C's caseload review stated the following:

> *'Appointment on 2nd March was cancelled. No reason given. No Progress Note. What is happening?'*

The panel therefore accepted Colleague C's evidence and determined that Mrs Furlong failed to re-arrange a follow up appointment for Patient E.

Accordingly, the panel finds charge 14 proved.

Charge 15

15) In relation to Patient F;

a) Failed to document the 'mental state examination'

b) Failed to adequately complete areas of the RIO notes, including:

i) Behaviour

ii) Speech

iii) Presenting situation

iv) Current medication

In reaching this decision, the panel took into account the evidence of Colleague A. The panel also considered documentary evidence exhibited, which included Patient F's Progress Notes on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Mrs Furlong's documentation of Patient F's mental state examination and other crucial areas of the RiO notes:

'[…] However, the presenting situation within the core assessment section needed more information and the mental state examination ("MSE") had not been completed.
[…]

For 'Behaviour' Sally has simply put 'no concerns over self-presentation'. There are no comments about Patient F's self-care. It is important to document one's observations of how the patient is taking care of themselves e.g. are they appropriately dressed for the weather? This gives us insight into whether or not the patient is self-neglecting.

For 'Speech' Sally has put 'During assessment did not appear to struggle but ACE score 19/26'. This does not make sense. The patient did not appear to struggle but was her speech normal e.g. did she speak at an appropriate volume and speed? We sometimes get patients who, for example, speak very quietly because they think 'people' are listening to them – these things can give an indication of the patient's mental condition.
[…]

I produce at ***Exhibit JW/26*** *this patient's Presenting Situation entry by Sally for her assessment of 12 February 2018. When talking about what is missing, in the first line of the last box at the bottom of page one, it states that this patient went to a sleep clinic when an issue with her memory was observed. When was this? It states that her husband felt there had been a decline in her memory – again how long had this been going on for? There is no indication as the approximate date of onset or the time period over which this had occurred e.g. had it happened slowly or within a relatively short period of time? This information is important because that could give us an indication as to what the problem is e.g. Alzheimer's has a gradual decline whereas vascular dementia has a sudden and rapid decline. I can imagine what it means when it states she has lost her spark but in my view it is not enough. Sally has done the basics but a lot more is needed.*

On page three, under the 'current medication' section it is documented that Patient F has poor compliance due to sleeping late in the mornings. In the box just above this there is a section that has an 'i' to the left. This is part of the template and one can see that this prompts staff as to what should be included .e.g. medication, dose, frequency etc., none of which is recorded here. Towards the bottom of page two there is a 'comment' section, where it has been recorded that the patient has 'poor insight of how dependant she is on family and friends'. Again, what does this mean and how did Sally come to this conclusion? Insight is important – does the patient understand for themselves what is going on with their body?'

a) Failed to document the 'mental state examination'

This charge is found NOT proved.

In relation to charge 15a, the panel had regard to Patient F's Progress Notes on RiO. It noted that Mrs Furlong had documented some information regarding the patient's mental state examination on 12 February 2018. The panel bore in mind that Mrs Furlong's entry may not have been adequately documented to the Trust's standards, however, it determined that the entry could not be regarded as a complete failure to document.

Therefore, the panel finds charge 15a not proved.

b) Failed to adequately complete areas of the RIO notes, including:
i) Behaviour
ii) Speech
iii) Presenting situation
iv) Current medication

This charge is found proved.

In relation to charges 15b(i), 15b(ii),15b(iii) and 15b(iv) the panel had regard to Patient F's Progress Notes on RiO. It noted that Mrs Furlong had documented some information in the sections pertaining to Patient F's behaviour, speech, presenting situation and current medication. However, the panel determined that, on the balance of probabilities, the entries appeared to be consistent with Colleague C's evidence that it was inadequately documented and lacking sufficient details.

Accordingly, the panel finds charges 15b(i), 15b(ii), 15b(iii) and 15b(iv) proved.

Charge 16

16) Failed to arrange a home medic visit for Patient G.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload; and a letter to a GP surgery, dated 14 March 2018, regarding Patient G.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient G's medical appointment's following an assessment:

> *I produce at **Exhibit JW/27** a copy of this patient's care plan letter, written by […]. From reviewing this I can see that […] undertook this assessment with Sally, who was the named CPN, on 14 March 2018. It is part of our process that when staff are allocated to undertake an assessment in pairs it will be decided who would be doing the care coordinating and who would be taking notes. It is evident to me that […] was the one who had done the typing; one person does not do both. This patient scored very low on the ACE-III i.e. 45/100; there is no doubt that she suffered from dementia.*
>
> *All patients are entitled to a medic appointment for the delivery of a diagnosis and initiation of treatment, if appropriate. We may also request a medic visit if there are concerns around medication.*
> *[…]'*

The panel noted a letter to a GP surgery, dated 14 March 2018, which named Mrs Furlong as present at Patient G's assessment. The panel considered that this was consistent with Colleague C's evidence.

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Mrs Furlong failed to arrange a home medic visit, as the review took place over a week after the patient's assessment took place and the medic visit was still not arranged. Notes from Colleague C's caseload review stated the following:

'To chase home medic visit appointment'

The panel therefore accepted Colleague C's evidence and determined that Mrs Furlong failed to arrange a home medic visit for Patient G.

Accordingly, the panel finds charge 16 proved.

Charge 17

17) In relation to Patient Q:
a) Failed to document any discussion with the medic regarding the CT scan results
b) Failed to arrange a meeting with the patient to deliver their diagnosis

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload; and Patient Q's Progress Notes on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient Q's CT scan:

'In my review I questioned why there was no evidence of a discussion about this patient's CT scan, despite the fact that it was received in January 2018.

[…]

The patient had initially been […] patient but as Sally's caseload increased she took over this patient and received a full handover, she therefore should have been aware of the outstanding CT report. A CT report can be delayed, which is out of our hands. Once the results are back, it is expected that at the weekly meetings we have with the medics the CPN would say that the evidence has been received, here is the ACE-III and the CT scan. The medic will then make a diagnosis and the CPN will schedule a meeting with the patient for this diagnosis to be delivered. To schedule the meeting I would expect Sally to request our admin team to book the appointment into the medic's diary.'

a) Failed to document any discussion with the medic regarding the CT scan

In relation to charge 17a, the panel noted Patient Q's Progress Notes on RiO documented by Mrs Furlong. The panel found that Mrs Furlong made no reference to a discussion with a medic regarding the patient's CT scan results.

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Mrs Furlong failed to document any discussion with a medic regarding the patient's CT scan result. Notes from Colleague C's caseload review stated the following:

'Head CT scan received in January. Why has this not been discussed? Needs medic appointment to receive diagnosis.'

The panel therefore accepted Colleague C's evidence and determined that Mrs Furlong failed to document any discussion with a medic regarding Patient Q's CT scan result.

Accordingly, the panel finds charge 17a proved.

b) Failed to arrange a meeting with the patient to deliver their diagnosis

The panel had regard to its reasoning in charge 17a. The panel considered that it found sufficient evidence to determine that Mrs Furlong failed to document any discussion with a medic regarding the Patient Q's CT scan result. The panel considered that in the absence of a discussion with a medic, the process that follows according to Colleague C would not have happened:

> *The medic will then make a diagnosis and the CPN will schedule a meeting with the patient for this diagnosis to be delivered.*

The panel therefore concluded that, on the balance of probabilities, Mrs Furlong failed to arrange a meeting with the patient to deliver their diagnosis.

Accordingly, the panel finds charge 17b proved.

Charge 18

> 18) In relation to Patient N:
> a) Failed to arrange an ECG
> b) Failed to arrange a home visit wellbeing check

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload.

The panel noted that Colleague C gave evidence that an ECG was required as a matter of course when Patient N was prescribed dementia medication, and that it was Mrs Furlong's

responsibility to then arrange a home visit as this gives the opportunity to assess if there has been any further deterioration. Colleague C stated the following in her witness statement:

> *'In my caseload audit I have referred to the fact that this patient required an electrocardiogram ("ECG"). Prior to commencing treatment all patients commencing treatment need an ECG to make sure their cardiac function is able to tolerate medication. Many of the dementia medications can cause a slowing of heart rate so if a patient already has a slow heart rate they will not be suitable for treatment.*
> *I have also noted that Sally was to arrange a home visit to check on this patient' wellbeing. Wellbeing checks are important because they are an opportunity to assess if there has been any further deterioration. It is also good patient care; it helps the patients feel like they have not been abandoned. Receiving a diagnosis can be distressing so it is not uncommon to see signs of depression and self-neglect, so the wellbeing check is also about providing the patient that emotional and mental wellbeing support. If not done there is a risk that the patient's mood will deteriorate.'*

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Mrs Furlong failed to document any discussion with a medic regarding the patient's CT scan result. Notes from Colleague C's caseload review stated the following:

> *'Need ECG — please chase.*
> *Clinic appt. with Dr. Holmes cancelled and rebooked for February, so please make contact and arrange a home visit to check on wellbeing.'*

The panel therefore accepted Colleague C's evidence and determined that Mrs Furlong failed to arrange an ECG and failed to arrange a home visit wellbeing check.

Accordingly, the panel finds charge 18a and 18b proved.

Charge 19

19) Failed to arrange an appointment for a wellbeing check on Patient S.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient S' wellbeing check:

> *'I have noted that Sally needed to make a wellbeing check on this patient. I think my issue here was about the lack of timely communication. I should not have to be telling nurses to conduct these wellbeing checks; they should know based on their experience.'*

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Mrs Furlong to arrange an appointment for a wellbeing check on Patient S. Notes from Colleague C's caseload review stated the following:

> *'Visit booked for 06/04/18.*
> *Please make phone call to check on wellbeing*
> *w/c 26/03/18.'*

The panel therefore accepted Colleague C's evidence and determined that Mrs Furlong failed to arrange a home visit wellbeing check for Patient S.

Accordingly, the panel finds charge 19 proved.

Charge 20

20) In relation to Patient T:
a) Failed to conduct and/or document the core assessment
b) Failed to adequately document the risk assessment
c) Failed to adequately document the care plan

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 22 March 2018, conducted by Colleague C on Mrs Furlong's caseload; and Patient T's Risk Summary on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient T's core assessment, risk assessment and care plan:

'According to my caseload review there was no core assessment for this patient, and both her risk assessment and care plan were incomplete.'

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 22 March 2018. The panel considered that the caseload review supported her account that Mrs Furlong failed to conduct/document the core assessment, to adequately document the risk assessment and to adequately document the care plan. Notes from Colleague C's caseload review stated the following:

'No Core Assessment
Risk assessment incomplete

Care plan incomplete
All to be completed at next home visit 09/04/18.'

a) Failed to conduct and/or document the core assessment

In relation to charge 20a, the panel noted Colleague C's explanation of core assessment:

'A core assessment includes the nurse's assessment of the patient's presenting situation and their formulation, which are sections within the patient's notes. One assumes that the patient is not known to the services before and therefore completion of these sections gives us all the information that we need e.g. the patient's current situation, what has been happening and where are they now.'

The panel considered Patient T's Risk Summary on RiO documented by Mrs Furlong. The panel found that Mrs Furlong's entries were sparse and made no reference to the patient's presenting situation and their formulation.

The panel was therefore satisfied that there was clear corroborative evidence to determine that Mrs Furlong failed to conduct and/or document the patient's core assessment.

Accordingly, the panel finds charge 20a proved.

b) Failed to adequately document the risk assessment

In relation to charge 20b, the panel noted that Colleague C gave evidence in regards to the standard of Mrs Furlong's risk assessment:

*'I produce at **Exhibit JW/31** a copy of this patient's risk summary (five pages) for her visit with Sally on 14 March 2018. On page one, under Tier 1 there is a section for current risk factors for suicide/self-harm. Sally has written 'no previous history of*

suicidal ideation. Was admitted to a psychiatric about 40 years ago due to a breakdown ??'

It says there is no previous history. What does that mean? Breakdown is not a term that we use these days because it does not tell you anything. There is no mention of why this patient was admitted, how long was she admitted for, what treatment did she receive and did it work? In addition, this information is in the wrong place; this section is for current risk factors. Sally should have put this information further down the page under 'previous risk events'. Even if it were in the right place, all the entry tells me is that there was an incident in the past; there is not enough detail to appropriately inform care. Was there any self-harm?'

The panel considered Patient T's Risk Summary on RiO documented by Mrs Furlong. The panel found that Mrs Furlong's entries were sparse and mostly made reference to the patient's previous risk factors as opposed to risk factors at the relevant time.

The panel was therefore satisfied that there was clear corroborative evidence to determine that Mrs Furlong failed to adequately document the risk assessment.

Accordingly, the panel finds charge 20b proved.

c) Failed to adequately document the care plan

In relation to charge 20c, the panel noted that Colleague C gave evidence in regards to the standard of Mrs Furlong's care plan for Patient T:

'On page 5 of the assessment there is an area to complete issues on clinical management. Sally wrote, "Stormed out half way through assessment as she objected to being asked about her memory issues. Daughter reports that her mother is noncompliant with medication."

The area for clinical management should detail what our plan of action would be for the patient after the assessment. The issues surrounding medications should have been in the non-compliance section and if the non-compliance is also a risk then it should come under Section B.'

The panel considered Patient T's Risk Summary on RiO documented by Mrs Furlong. The panel found that Mrs Furlong's entry was sparse in the clinical management section and did not detail a plan of action for the patient.

The panel was therefore satisfied that there was clear corroborative evidence to determine that Mrs Furlong failed to adequately document the care plan.

Accordingly, the panel finds charge 20c proved.

Charge 21

21) Failed to adequately document Patient L's 'mental state examination' without prompting and assistance

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient L's Risk Summary on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient L's mental state examination:

'At the time of the meeting the MSE was not done for Patient L I sat with Sally and completed this assessment.
*The assessment is attached to Exhibit **JW/23.***

Sally forgot to put information in or placed information in the correct places, such as:

a. On page one under tier 1, she must be more specific when it comes to which family. This has to be specific.

b. On page two at the bottom, it states clinical management as low. This does not make sense, you would have to be specific on how the patient is being clinically managed or else other professionals will not know and there is a risk to the patient that they do not receive the clinical management they are supposed to get.

c. On page 3 under protective factors, Sally lists rarely left alone. This is also too broad and she needed to be specific such as does the patient have walking aids? Is there adequate lighting? Are then trip hazards?'

The panel noted Patient L's Risk Summary on RiO documented by Mrs Furlong. It had regard to the completed sections relevant to the patient's mental state examination.

The panel considered Colleague C's evidence that she sat with Mrs Furlong for the completion of this section. The panel therefore determined that, on the balance of probabilities, it is more likely than not Colleague C would have prompted Mrs Furlong while sitting with her.

Accordingly, the panel finds charge 21 proved.

Charge 22

22) Failed to adequately document Patient M's care plan without assistance

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient M's Risk Summary on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient M's care plan:

> *'In relation to Patient M:*
> *a. The care plan was lacking initially and I re-worked it with Sally. I am not in possession of the unedited version so cannot point out specifics in this instance.'*

The panel noted that it has only been presented with Patient M's edited Risk Summary on RiO. The panel found that it had no further evidence documented or orally pertaining to the inadequacies that was initially contained in the patient's care plan.

Therefore, in the absence of any further evidence, the panel finds charge 22 not proved.

Charge 23

> 23) In relation to HH:
> a) Failed to discuss medication with the doctor
> b) Failed to discharge the patient

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient HH's Progress Notes on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient HH:

> *'In relation to:*

a. Sally was supposed to discuss medication times with the [team] doctor as well to discharge the patient from us but this did not occur.
b. The risk to the patient is that there can be medication issues such overdosing or under-dosing.
c. If the patient is not discharged when they could have been, this could lead to overload of case work for employees and further stress on those employees.
d. I am not currently in possession of the progress notes in relation to this patient.'

The panel considered Patient HH's Progress Notes on RiO documented by Mrs Furlong, which indicated that this had not been done.

The panel was therefore satisfied that there was clear corroborative evidence to determine that Mrs Furlong failed to discuss medication for Patient HH with the doctor and failed to discharge the patient.

Accordingly, the panel finds charge 23a and 23b proved.

Charge 24

24) In relation to Patient F:
a) Failed to document details of the patient's memory
b) Failed to document details of the patient's anxiety

This charge is found NOT proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient F's Risk Summary on RiO.

The panel noted that Colleague C stated the following in her witness statement in regards to Mrs Furlong's completed formulation section in Patient F's Risk Summary:

> *'In relation to*
> *a. The formulation section lacks detail. It states that the patient memory is very poor but does not states how this presents and also that the patient is anxious but does not state what makes her anxious or how it presents.*
> *This part of the form is attached as* ***Exhibit JW/26.****'*

The panel considered Patient F's Risk Summary on RiO documented by Mrs Furlong, in which it found evidence to the contrary with details of how the patient's memory and anxiety presented. The panel acknowledged that this may have been a re-worked entry, however, it determined that the entry could not be regarded as a complete failure to document the details of Patient F's memory and anxiety.

Therefore, the panel finds charge 24a and 24b not proved.

Charge 25

> 25) In relation to Patient Z, failed to adequately document details including:
> a) Family and personal history
> b) Social history
> c) Formulation
> d) Pre-morbid history

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included Patient Z's Care Plan on RiO.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient Z:

> *'In relation to*
> *a. The assessment lists no family or personal history, no social history and no formulation. The forms are attached as* ***Exhibit JW/37****.'*

The panel considered Patient Z's Care Plan on RiO documented by Mrs Furlong, which indicated limited information in relation to the patient's family and personal history, social history, formulation and pre-morbid history. The panel determined that, on the balance of probabilities, the entry was more likely than not inadequately documented and lacking sufficient details.

Accordingly, the panel finds charge 25a, 25b, 25c and 25d proved.

Charge 26

> 26) Failed to complete the 'non-compliance' section of Patient S's notes

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleague C. The panel also considered documentary evidence exhibited, which included a caseload review, dated 1 June 2018, conducted by Colleague C on Mrs Furlong's caseload.

The panel noted that Colleague C stated the following in her witness statement, in regards to Patient S's progress notes completed by Mrs Furlong:

> *'Sally did not complete the non-compliance section of the assessment. This is the plan that is followed in the event that a patient does not comply with the plan. Really important because we need to plan how we are going to ensure the patient*

is taking medication as prescribed safely. If someone is not taking it because they do not think they need to, maybe need to plan how to educate around medication, have they got capacity to make decision, if non-concordant and suicidal, may be hoarding to commit suicide so need to demonstrate how we are managing this risk.'

The panel also noted that Colleague C conducted a caseload review of Mrs Furlong's caseload, on 1 June 2018. The panel considered that the caseload review supported her account that Mrs Furlong failed to complete the non-compliance section of the patient's notes. Notes from Colleague C's caseload review stated the following:

'Add non-compliance of medication plan.'

The panel considered there was no Progress Notes on RiO documented by Mrs Furlong for Patient S. The panel was therefore satisfied this supported Colleague C's evidence that Mrs Furlong failed to complete the 'non-compliance' section of Patient S's notes.

Accordingly, the panel finds charge 26 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to a lack of competence and, if so, whether Mrs Furlong's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Woolfson submitted that there requires to be evidence of a standard of practice which is unacceptably low, demonstrated by reference to a fair sample of work.

Ms Woolfson invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Ms Woolfson identified, by reference to the code, the specific relevant standards where in her submission Mrs Furlong's actions amounted to a lack of competence. Ms Woolfson submitted that the facts found proved show that Mrs Furlong's competence at the time was below the standard expected of a band 6 registered nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Holton v GMC* [2006] EWHC 2960 (Admin).

Submissions on impairment

Ms Woolfson 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. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *General Optical Council v Clarke* [2018] EWCA Civ 1463.

Ms Woolfson submitted that Mrs Furlong's fitness to practise is impaired on the grounds of public protection and public interest.

In her submissions on impairment, Ms Woolfson referred the panel to Dame Janet Smith's Fifth Shipman Report, as endorsed by Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011]* EWHC 927 (Admin). She submitted that the first three limbs of the test are engaged in this case.

Ms Woolfson submitted that the NMC is not aware of Mrs Furlong having worked as a nurse since leaving the Trust in 2018. She advised the panel that Mrs Furlong may have retired, although it is not known how fixed her intention to remain retired is. She submitted that Mrs Furlong was impaired at the time of these charges and there is no evidence that she has strengthened her practice since.

The panel accepted the advice of the legal assessor.

Decision and reasons on lack of competence

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:

1.2 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:

2.3 encourage and empower people to share in decisions about their treatment and care

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this you must:

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

8.2 maintain effective communication with colleagues

8.3 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

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

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

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

10.3 complete 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

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

24 Respond to any complaints made against you professionally

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice'

The panel bore in mind, when reaching its decision, that Mrs Furlong should be judged by the standards applicable to a band 6 CPN and not by any higher or more demanding standard.

The panel had regard to the facts found proved and determined that Mrs Furlong's actions demonstrated a lack of competence in basic fundamental elements of nursing. The panel was of the view that as an experienced nurse, the range and nature of the documentation errors/omissions and lack of support for a student nurse demonstrated an unacceptably low standard of professional competence in this area.

The panel also had regard to context within Mrs Furlong's team at Highlands, such as alleged bullying. However, the panel noted that no formal grievance had been submitted. The panel noted that Mrs Furlong had been given the opportunity to change locations, had further training, and was offered extensive support and assistance from the Trust in relation to her performance, aspects of which she declined. It considered that despite the various measures of support offered by the Trust, Mrs Furlong did not make any sustained improvements to the standard of her performance.

The panel also considered that the facts found proved are not indicative of an isolated incident, rather that they demonstrate a pattern of a lack of competence over a protracted period of time.

The panel determined that Mrs Furlong's actions exposed numerous patients to serious risk of unwarranted harm and also impacted on the follow up care patients received from other professionals.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mrs Furlong's practice was below the standard that one would expect from the average band 6 CPN acting in Mrs Furlong's role.

In all the circumstances, the panel determined that Mrs Furlong's performance demonstrated a lack of competence as a band 6 CPN when assessed across a fair sample of her work.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mrs Furlong's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *....'*

The panel determined that limbs a, b and c in the above test were engaged both in the past and likely to continue in the future.

Taking into account all of the evidence adduced in this case, the panel finds that patients were put at risk of serious harm as a result of Mrs Furlong's lack of competence. Mrs Furlong's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought it into disrepute.

The panel noted that it had not received any evidence to suggest that Mrs Furlong has demonstrated an understanding of how her actions put patients at a risk of serious harm or how this impacted negatively on the reputation of the nursing profession. The panel found that Mrs Furlong has not demonstrated any insight or remorse. In addition, the panel has not received any information to suggest that Mrs Furlong has taken any steps to strengthen her practice. The panel bore in mind that Mrs Furlong does not appear to have worked in a clinical setting since the referral.

The panel was of the view that there is a high risk of repetition based on the lack of evidence of any insight, remorse, or evidence that she has strengthened her practice. On the basis of all the information before it, the panel decided that there is a risk to the public if Mrs Furlong was allowed to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

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 concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds Mrs Furlong's fitness to practise is also impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Furlong's registration has been suspended.

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

Submissions on sanction

The panel noted that in the Notice of Hearing, dated 9 March 2022, the NMC had advised Mrs Furlong that it would seek the imposition of a conditions of practice order for 12 months with review, if it found Mrs Furlong's fitness to practise currently impaired.

Ms Woolfson invited the panel to take a number of matters into account. She advised the panel that for cases solely relating to a lack of competence, a striking off order is not available at this stage in NMC proceedings.

Ms Woolfson submitted that if the panel was to impose a conditions of practice order it would need to be sufficient to protect the public, satisfy public interest and would need to address the areas of competence Mrs Furlong's practice has been found to be lacking. She submitted that the panel should also be confident that any conditions imposed would be workable.

Ms Woolfson submitted that if the panel does not consider a conditions of practice order workable it should move to a suspension order. She submitted that in the absence of positive engagement from Mrs Furlong, although she should not be punished for not engaging, the panel may consider a suspension order appropriate.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Repetition of errors/omissions despite extensive support and assistance;
- Conduct which put patients at risk of suffering serious harm;
- The clinical incidents spanned an extended period of time;
- Lack of insight into failings;
- Unwillingness to change behaviour despite support and assistance.

The panel also took into account the following mitigating features:

- No previous regulatory concerns.

The panel had regard to contextual factors, namely Mrs Furlong's allegations of bullying. However, the panel noted that no formal grievance had been submitted by Mrs Furlong. It therefore determined that this was not a mitigating feature in the circumstances of this case.

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

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

The panel next considered whether placing conditions of practice on Mrs Furlong's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel noted that Mrs Furlong did not accept any fundamental issues with her practice, and that it did not receive any evidence of insight or remorse. In these circumstances, the panel was of the view that it had no information to suggest if Mrs Furlong would be willing to submit to and comply with conditions. The panel took into account the SG and the range and nature of the issues identified with Mrs Furlong's practice as a band 6 CPN. The panel noted the support and assistance that had already been offered by her employer, some of which had been declined. The panel considered that given there had been no sustained improvements in Mrs Furlong's practice, workable conditions could not be formulated, which would adequately protect the public and meet the public interest, even if there was a willingness to comply.

The panel bore in mind that in cases solely relating to a lack of competence, a striking off order is not available at this stage in NMC proceedings.

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:

- *In cases where the only 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 noted that the concerns in this case do not relate to an isolated incident and there has been significant repetition. The panel considered that some of the concerns within the lack of competence had the potential for patient harm and Mrs Furlong resigned before demonstrating that she had strengthened her practice. The panel also considered that it received no evidence that Mrs Furlong has demonstrated any insight or remorse. For these reasons, the panel determined that there remains a risk to patients from the short comings in Mrs Furlong's clinical practice associated with lack of competence.

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 that such an order may cause Mrs Furlong. 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 was appropriate in this case to mark the seriousness of the lack of competence and also to give Mrs Furlong the opportunity to reflect and undertake retraining should she wish to retain her place on the register.

At the end of the period of suspension, another panel will review the order. At the review 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:

- Evidence of insight and reflection;
- Evidence of training to address the specific issues identified with Mrs Furlong's practice;
- Character references;
- Reference from a recent employer;
- Confirmation of Mrs Furlong's intention in relation to her return to nursing.

This will be confirmed to Mrs Furlong in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Furlong's own interest 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 Woolfson. She submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest.

Ms Woolfson invited the panel to impose an interim suspension order for a period of 18 months.

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, for the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for any possible appeal period.

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

That concludes this determination.