Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
14-16 February 2022

Virtual Hearing

Name of registrant:	**Jennifer Ann Stevenson**
NMC PIN:	75E1549E
Part(s) of the register:	Registered Nurse- Sub Part 2- Adult (Level 2) - 9 July 1979 Registered Nurse- Sub Part 1- Adult Nurse – 16 January 1992
Area of registered address:	Shropshire
Type of case:	Misconduct
Panel members:	Dale Simon (Chair, lay member) Allwin Mercer (Registrant member) Frances McGurgan (Lay member)
Legal Assessor:	Martin Goudie QC
Hearings Coordinator:	Holly Girven
Nursing and Midwifery Council:	Represented by Stuart Dingle, Case Presenter
Mrs Stevenson:	Not present and unrepresented
Facts proved:	Charges 1, 2b, 3a, 3b, 4a, 4b, 4c, 5 and 6
Facts not proved:	Charge 2a
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 Stevenson was not in attendance and that the Notice of Hearing letter had been sent to Mrs Stevenson's registered email address on 6 January 2022.

Mr Dingle, 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.

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

In the light of all of the information available, the panel was satisfied that Mrs Stevenson 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 Stevenson

The panel next considered whether it should proceed in the absence of Mrs Stevenson. It had regard to Rule 21 and heard the submissions of Mr Dingle who invited the panel to continue in the absence of Mrs Stevenson. He submitted that Mrs Stevenson had voluntarily absented herself.

Mr Dingle referred the panel to the documentation from Mrs Stevenson which included an email dated 13 January 2022 in which Mrs Stevenson stated:

*'As I'm not renewing my pin due to retirement [*PRIVATE*] I do not want to attend meeting'* [sic]

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 Stevenson. In reaching this decision, the panel has considered the submissions of Mr Dingle, the communication from Mrs Stevenson, 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 Stevenson;
- Mrs Stevenson has confirmed she does not want to attend this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness is due to join the virtual hearing today to give live evidence and would be inconvenienced by an adjournment;
- The charges relate to events that occurred in 2017, 2018 and 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Stevenson in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge

the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Stevenson'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 Stevenson. The panel will draw no adverse inference from Mrs Stevenson's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Dingle, on behalf of the NMC, to amend the wording of charge 5.

The proposed amendment was to change the year stated in the charge from 2018 to 2019. It was submitted by Mr Dingle that the proposed amendment would more accurately reflect the evidence as the panel has been provided with the weight charts for Resident C from June 2019, not June 2018. The proposed amendment was as follows:

5) In June ~~2018~~ **2019** recorded Resident C's weight on three consecutive weeks without having weighed Resident C

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

The panel was satisfied that there would be no prejudice to Mrs Stevenson and no injustice would be caused to either party by the proposed amendment being allowed. The panel considered the evidence provided relates to Resident C's weight charts in 2019 and

during the internal investigation, Mrs Stevenson was asked about Resident C's weight charts in June 2019. It therefore concluded that it was in the interests of justice and appropriate to allow the amendment.

Details of charge

That you, a Registered Nurse:

1) During 2017 and 2018, failed to conduct, maintain and evaluate care plan reviews in line with the responsibilities of your role

2) In respect of Resident A, failed to review and update Resident A's care plan with information regarding changes to the Resident's care needs, on
   a) 9 May 2019; and
   b) 18 June 2019

3) In respect of Resident B, failed to review and update Resident B's care plan with information regarding changes to the Resident's care needs, on
   a) 11 May 2019; and
   b) 18 June 2019

4) In respect of Resident C, failed to review and update Resident C's care plan with information regarding changes to the Resident's care needs, on
   a) 9 April 2019
   b) 11 May 2019; and
   c) 18 June 2019

5) In June 2019 recorded Resident C's weight on three consecutive weeks without having weighed Resident C

6) Your actions as detailed at charge 5 above were dishonest in that you knew that you had not weighed Resident C

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

Background

The charges arose whilst Mrs Stevenson was employed as a registered nurse at Lady Foster Community Nursing Home (the Home), which was managed by English Care. Mrs Stevenson started working at the Home in 2011. Mrs Stevenson was the key nurse for three residents, Resident A, Resident B and Resident C.

In August 2018, the Home received an unannounced Care Quality Commission (CQC) inspection. At the time, the Home was using a paper-based system for care plans. The CQC reviewed a selection of care plans, which were mainly Mrs Stevenson's, although this was not intentional. The CQC identified a number of issues with the care plans they reviewed, including that they had not been updated.

Following the CQC inspection, the Home switched to an electronic system for care plans. This allowed management to audit when the care plans had been reviewed, how long this had taken and what new changes had been recorded. It is alleged that when management audited the care plans of residents Mrs Stevenson was responsible for, the care plans had not been updated adequately and she had taken between one and ten minutes to update the care plans, when it was expected to take at least 25 minutes.

It is further alleged that in June 2019, Mrs Stevenson recorded Resident C's weight as 54.5 kilograms for three weeks in a row. Resident C required two people to weigh them, and it is alleged that when other staff were asked, none could remember weighing Resident C with Mrs Stevenson.

The Home started an investigation into the concerns identified and Mrs Stevenson was interviewed on 23 July 2019 by Mr 1.

Decision and reasons on facts

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

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

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 witness called on behalf of the NMC:

- Mr 1: Quality Assurance Manager for English Care

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) During 2017 and 2018, failed to conduct, maintain and evaluate care plan reviews in line with the responsibilities of your role

This charge is found proved.

In reaching this decision, the panel took into account Mrs Stevenson's job description, the CQC report, Mr 1's written and oral evidence and the record of Mrs Stevenson's meeting with Mr 1 in July 2019.

The panel considered that in Mrs Stevenson's job description, one of the key tasks is:

> *'To assist with the creation and maintenance of Care Plans and to ensure that these are followed and evaluated at regular intervals.'*

The panel noted that Mr 1 stated that Mrs Stevenson was the key nurse for Resident A, Resident B and Resident C and had responsibility for maintaining their care plans. The panel was satisfied that she was responsible for conducting, maintaining and evaluating care plan reviews.

The panel noted that the CQC report identified a number of issues with the paper care plans they reviewed. For instance, the CQC report states that:

> *'This care plan was dated 18 months prior to our inspection and was incomplete. During the subsequent 18 months it had not been updated or the missing parts completed.'*

The panel noted that Mr 1 stated this example related to one of the residents Mrs Stevenson was responsible for. The panel considered that Mr 1 stated in his evidence that she had been provided with training on how to review care plans. The panel considered that Mr 1 stated that it was due to the issues identified by the CQC that the Home moved to an electronic system. The panel noted that during the meeting with the Home, she did not deny that she had issues with reviewing care plans.

The panel was satisfied that Mrs Stevenson did not conduct, maintain and evaluate care plan reviews in line with her role and therefore found this charge proved.

Charge 2a)

2) In respect of Resident A, failed to review and update Resident A's care plan with information regarding changes to the Resident's care needs, on
    a. 9 May 2019; and

This charge is found not proved.

In reaching this decision, the panel took into account Mr 1's written and oral evidence, and the documentary evidence provided.

The panel considered that the audits of the care plans for Resident A show that on 20 March 2019 Mrs Stevenson reviewed the care plan in one minute. The panel also noted that the care plan review provided is dated 20 March 2019, and not 9 May 2019. The panel considered that the Home's investigation report refers to 9 May 2019, but determined that the evidence was inconsistent and that it was not possible to ascertain the correct date.

The panel did consider that Mr 1 stated that all information should be recorded on the care plan and that care plans should be reviewed every four weeks, but determined that there is insufficient evidence that the care plan should have been reviewed on the specific date of 9 May 2019.

The panel found this charge not proved due to the discrepancies of the dates in the documentation as it determined it could not be satisfied that Mrs Stevenson failed to review and update the care plan on 9 May 2019.

Charge 2b)

2) In respect of Resident A, failed to review and update Resident A's care plan with information regarding changes to the Resident's care needs, on

b. 18 June 2019

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's written and oral evidence, and the documentary evidence provided.

The panel considered that the audits of the care plans for Resident A show that on 18 June 2019 Mrs Stevenson reviewed the care plan in in two minutes. The panel considered Mr 1's evidence that the review should take at least 25 minutes, and that during an internal audit he found that other nurses did take at least 25 minutes, which it considered to be credible in view of the amount of information to be reviewed. The panel further noted that the audits state that '*no areas have changed since last review*'.

The panel considered that Mr 1 stated in his evidence that there were changes that should have been recorded in Resident A's care plan, including that insulin stocks were low, they had an infection and bed sores. The panel considered that Mr 1's evidence in this regard was credible and consistent with the documentary evidence provided.

The panel noted that in her meeting with Mr 1 in July 2019, when asked why information hadn't been included in the care plans, Mrs Stevenson stated

> *'That's because everything goes onto the daily records, it all on there. They would also go on to his medical records and daily and weekly reports and at handover. I only get my information from the handover because after that I am always at work.'*

However, the panel considered that Mr 1 stated that all information should be recorded on the care plan and that care plans should be reviewed every four weeks.

The panel determined that Mrs Stevenson had a duty to review Resident A's care plan on the date specified in the charge and that there was information that should have been included.

Charge 3

3) In respect of Resident B, failed to review and update Resident B's care plan with information regarding changes to the Resident's care needs, on
    a. 11 May 2019; and
    b. 18 June 2019

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's written and oral evidence, and the documentary evidence provided.

The panel considered that the audits of the care plans for Resident B show that on one occasion Mrs Stevenson reviewed the care plan in four minutes, and another in five. The panel considered Mr 1's evidence that the review should take at least 25 minutes, and that during an internal audit he found that other nurses did take at least 25 minutes, which it considered to be credible in view of the amount of information to be reviewed. The panel further noted that the audits state that '*no areas have changed since last review*'.

The panel considered that Mr 1 stated in his evidence that there were changes that should have been recorded in Resident B's care plan, including issues with pain management and their behaviour. The panel considered that Mr 1's evidence in this regard was credible and consistent with the documentary evidence provided.

The panel noted that in her meeting with Mr 1 in July 2019, when asked why information hadn't been included in the care plans, Mrs Stevenson stated

'What am I supposed to do if there are no changes… I know she has been on a paracetamol but that won't do anything for her pain.'

However, the panel considered that Mr 1 stated that all information should be recorded on the care plan and that care plans should be reviewed every four weeks. The panel noted that Mrs Stevenson did not deny that she did not record the changes in Resident B's care plan.

The panel determined that Mrs Stevenson had a duty to review Resident B's care plan on the dates specified in the charge and that there was information that should have been included.

Charge 4

4) In respect of Resident C, failed to review and update Resident C's care plan with information regarding changes to the Resident's care needs, on
    a. 9 April 2019
    b. 11 May 2019; and
    c. 18 June 2019

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's written and oral evidence, and the documentary evidence provided.

The panel considered that the audits of the care plans for Resident C show that on one occasion Mrs Stevenson reviewed the care plan in eight minutes, and others in four minutes and seven minutes. The panel considered Mr 1's evidence that the review should take at least 25 minutes, and that during an internal audit he found that other nurses did take at least 25 minutes, which it considered to be credible in view of the amount of information to be reviewed. The panel further noted that one of the audits state that '*no*

areas have changed since last review', one states that '*Medicine-Medication'* has changed, and one that '*Personal Care-Activity/Social/Religion'* has changed.

The panel considered that Mr 1 stated in his evidence that there were changes that should have been recorded in Resident C's care plan, including whether their family had been involved in the review. The panel considered that Mr 1's evidence in this regard was credible and consistent with the documentary evidence provided.

The panel noted that in her meeting with Mr 1 in July 2019, when asked why information hadn't been included in the care plans, Mrs Stevenson stated

'I accept that, but that information is probably in the daily reports.'

However, the panel considered that Mr 1 stated that all information should be recorded on the care plan and that care plans should be reviewed every four weeks. The panel noted that Mrs Stevenson did not deny that she did not record the changes in Resident C's care plan.

The panel determined that Mrs Stevenson had a duty to review Resident C's care plan on the dates specified in the charge and that there was information that should have been included.

Charge 5

5) In June 2019 recorded Resident C's weight on three consecutive weeks without having weighed Resident C

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Mr 1, and the documentary evidence provided.

The panel considered that Mr 1 stated that Mrs Stevenson inputted Resident C's weight on 1 June, 9 June and 18 June 2019 as 54.5 kilograms. The panel noted these were the weights that were in Resident C's weight chart. The panel considered that Mr 1 stated that two people were required to weigh Resident C, and that when asked Mrs Stevenson could not remember who had assisted her to weigh Resident C.

The panel considered that in the Home's investigation, Mrs Stevenson stated:

> *'I'm pretty sure that I recorded the weight with someone, although it is possible that I tasked two other members of staff to do this but I cannot recall who that would be.'*

The panel noted that Mr 1 stated that no staff could remember assisting Mrs Stevenson to weigh Resident C. The panel considered that it was highly unlikely that Resident C remained the same weight on the three dates, in reaching this conclusion the panel took into account that Resident C had never stayed at the same weight on two consecutive occasions when they had previously been weighed. The panel did consider that when Resident C was weighed again on 19 June 2019 there was a difference between that which Mrs Stevenson had recorded the day before, but considered that the difference was not significant enough to indicate that the weight on 18 June 2019 must be incorrect.

The panel determined that on at least two of the occasions (9 and 18 June 2019), Mrs Stevenson had not weighed Resident C before inputting the weight. The panel therefore finds this charge proved on the basis that on at least two occasions, Mrs Stevenson inputted Resident C's weight without having weighed them.

Charge 6

6) Your actions as detailed at charge 5 above were dishonest in that you knew that you had not weighed Resident C

This charge is found proved.

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

The panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel considered that it has found it proved that Mrs Stevenson inputted Resident C's weight without having weighed them. The panel determined that Mrs Stevenson would have known when inputting Resident C's weight that she had not weighed Resident C.

The panel then went on to consider whether Mrs Stevenson's conduct was dishonest by applying the standards of ordinary decent people. The panel determined that ordinary, decent people would find it dishonest to record a weight that you had not taken. The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Stevenson'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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Stevenson's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Dingle invited the panel to take the view that the facts found proved amount to misconduct. 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.

Mr Dingle identified the specific, relevant standards where Mrs Stevenson's actions amounted to misconduct. He submitted that she breached the Code and in addition fell below the standards expected of her that were outlined in her job description. He submitted that Mrs Stevenson's conduct was serious, fell below the standards expected and amounted to misconduct.

Submissions on impairment

Mr Dingle 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Dingle submitted that the panel should make a finding of impairment in order to protect the public and to uphold the public interest. He stated that Mrs Stevenson's conduct put residents at risk of harm. He further stated that she has acted dishonestly. Mr Dingle submitted that Mrs Stevenson has not demonstrated any insight or remorse and there is no evidence that she has strengthened her practice.

Mr Dingle submitted that there is a significant risk of repetition. He submitted that a finding of impairment is necessary to maintain public confidence in the nursing profession and the NMC as its regulator.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included the cases of *Roylance* and *Grant.*

Decision and reasons on misconduct

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

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

> ***'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

8 Work co-operatively

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Stevenson's conduct was serious, and noted that residents were put at risk of harm and that Mrs Stevenson had acted dishonestly.

The panel found that Mrs Stevenson's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Stevenson'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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

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

The panel finds that residents were put at risk of harm as a result of Mrs Stevenson's misconduct as there was a risk due to the care plans not being kept up to date and due to Resident C's weight being recorded without them having been weighed. The panel considered that the residents in this case were vulnerable. Mrs Stevenson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel has found it proved that Mrs Stevenson acted dishonestly.

Regarding insight, the panel considered that Mrs Stevenson has not engaged with this hearing other than to confirm she would not be attending. The panel determined that during the meeting on 23 July 2019, Mrs Stevenson showed very limited insight and did not accept that she had recorded Resident C's weight without having weighed them.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Stevenson has taken steps to strengthen her practice. The panel considered that it has been provided with no evidence to demonstrate that Mrs Stevenson has strengthened her practice. The panel also noted that Mr 1 stated in evidence that Mrs Stevenson was offered training and support regarding the care plans whilst working at the Home but that she did not accept any additional support. The panel noted that Mrs Stevenson has stated that she does not wish to return to nursing as she is retiring.

The panel is of the view that there is a risk of repetition due to Mrs Stevenson's lack of insight and in the absence of any evidence that Mrs Stevenson has strengthened her practice. The panel also noted that Mrs Stevenson's misconduct occurred over a sustained period of time despite support being offered. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

Having regard to all of the above, the panel was satisfied that Mrs Stevenson'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 Stevenson's registration has been suspended.

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

Submissions on sanction

Mr Dingle informed the panel that in the Notice of Hearing, dated 6 January 2022, the NMC had advised Mrs Stevenson that it would seek the imposition of a suspension order for a period of 12 months if it found Mrs Stevenson's fitness to practise currently impaired.

Mr Dingle outlined the aggravating factors that he submitted are present, including Mrs Stevenson's failure to engage with the regulatory process, her dishonesty, the lack of evidence of remediation, remorse or insight and her attempt to blame other people. He also submitted that the residents were put at risk of harm and that she was an experienced nurse. He submitted that the panel may find that the limited amount of actual harm caused, the lack of repetition and the absence of any previous regulatory concerns are mitigating features.

Mr Dingle submitted that due to the aggravating features and the risk identified, taking no action or imposing a caution order would not be appropriate. He submitted that Mrs Stevenson's misconduct is not at the lower end of the spectrum.

Mr Dingle submitted that a conditions of practice order would not sufficiently protect the public. He stated that the SG states that a conditions of practice order may be appropriate when the registrant has shown a willingness to respond to training, which he submitted Mrs Stevenson has not demonstrated.

Mr Dingle submitted that a suspension order was appropriate and proportionate. He stated that due to the seriousness of Mrs Stevenson's misconduct, including the dishonesty, a suspension order was necessary. He informed the panel that Mrs Stevenson has not been subject to an interim order. He submitted that whilst a conditions of practice order may be appropriate should Mrs Stevenson engage, it is not currently sufficient.

Decision and reasons on sanction

Having found Mrs Stevenson'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:

- Mrs Stevenson has failed to engage
- There is a lack of evidence of any remediation, remorse or insight
- During the Home investigation, Mrs Stevenson attempted to disperse blame for her conduct
- Mrs Stevenson's actions put patients at a risk of harm
- Mrs Stevenson's misconduct took place over an extended period of time

The panel considered whether there are any mitigating features in this case, but due to Mrs Stevenson's lack of engagement and in the absence of any mitigation presented it was not satisfied that any were present.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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 Stevenson'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 Stevenson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Stevenson'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 took into account the SG, in particular:

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

- *Conditions can be created that can be monitored and assessed.*

The panel considered that due to Mrs Stevenson's lack of engagement, it was not possible to formulate workable conditions as there is no indication that she would comply with any conditions imposed.

Furthermore, the panel concluded that the placing of conditions on Mrs Stevenson's registration would not adequately address the seriousness of this case and would not protect the public due to the dishonesty found proved. The panel considered that it is difficult to address dishonesty through conditions of practice, particularly due to Mrs Stevenson's lack of engagement.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where the following relevant are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel considered that a suspension 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 further determined that a suspension order was necessary to protect the public. The panel considered that Mrs Stevenson has demonstrated a lack of insight or remorse, as evidenced by the record of the investigation meeting at the Home and Mr 1's evidence, and that there is a risk of repetition. The panel considered the NMC's guidance on

dishonesty, and considered that Mrs Stevenson's dishonesty was related to patient care and that Resident C was vulnerable. The panel considered that it had found it proved that Mrs Stevenson had acted dishonestly by recording a weight she had not taken on at least two occasions, which the panel determined could indicate some premeditation. The panel determined that the dishonesty in this case was serious, and that a suspension order was required in order to protect the public.

The panel carefully considered whether a striking-off order would be appropriate but, taking account of all the information before it, the panel concluded that it would be disproportionate. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Stevenson's case to impose a striking-off order. The panel considered that a suspension order was sufficient to protect the public and maintain the public interest.

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct, and to allow Mrs Stevenson sufficient time to engage with the NMC and provide evidence of any insight and remediation.

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

Any future panel reviewing this case would be assisted by:

- Mrs Stevenson's engagement with the NMC and attendance at any review hearing;
- Evidence of any training completed that may address the concerns identified;
- Testimonials from Mrs Stevenson's colleagues, whether from paid or unpaid work; and
- A reflective piece addressing the concerns in this case and the impact of her actions on patients, colleagues and the wider nursing profession.

This will be confirmed to Mrs Stevenson 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 Stevenson's own interest until the suspension order takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Dingle. He submitted that an interim suspension order was necessary to protect the public and was otherwise in the public interest due to the panel's finding of impairment.

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, the public protection issues identified, and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive suspension order. The panel therefore imposed an interim suspension order for a period of 18 months to allow sufficient time for any appeal period.

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

That concludes this determination.