Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 24 – Thursday 27 January 2022

Virtual Hearing

Name of registrant:	**Raminder Kaur Ajmani**
NMC PIN:	80F0137E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nurse – February 2002 Health Visitor – September 1991 Community Practitioner Nurse Prescriber – February – 2001 Registered Midwife – Lapsed
Area of registered address:	West Sussex
Type of case:	Lack of competence
Panel members:	Deborah Jones (Chair, Lay member) Susan Field (Registrant member) Christine Moody (Lay member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Sherica Dosunmu
Facts proved:	All
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months) with a review**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Mrs Ajmani was not in attendance and that the Notice of Meeting had been sent to Mrs Ajmani's registered email address on 20 October 2021.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, informed Mrs Ajmani that this meeting would be heard on a date on or after 22 November 2021, and advised her of her right to request that the matter be dealt with by way of a hearing rather than a meeting.

In the light of all of the information available, the panel was satisfied that Mrs Ajmani has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered Health Visitor, between September 2018 and June 2019 at Oxleas NHS Foundation Trust failed to demonstrate the standards of knowledge, skill and judgement to practise without supervision as a Band 6 Health Visitor in that you:

1) Between October 2018 and 30 June 2019 you:
a) On more than one occasions failed to manage your time effectively; **[PROVED]**
b) On more than one occasions failed to complete patient records within a timely manner as set out in Schedule A; **[PROVED]**
c) Failed to ensure that one or more of your patient records were up to date and/or completed on RiO, the Trust's electronic clinical record system by 30 June 2019; **[PROVED]**

2) In respect of Patient A, you:

a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 17 June 2019, approximately 7 months following your visit; **[PROVED]**
b) Did not enter Patient A onto the correct care pathway following your visit and/or on 17 June 2019; **[PROVED]**
c) Did not ensure that a Health Visitor was allocated to Patient A; **[PROVED]**
d) Did not ensure that Mother A was contacted following the visit and/or offered support; **[PROVED]**
e) Did not create a care plan following your visit and/or when completing a record of your visit; **[PROVED]**

3) In respect of Patient B, you:
a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 7 June 2019, approximately 7 months following your visit; **[PROVED]**
b) Did not enter Patient B onto the correct care pathway following your visit and/or on 7 June 2019; **[PROVED]**
c) Did not ensure that a Health Visitor was allocated to Patient B;
d) Did not ensure that Mother B and/or Father B was contacted following the visit and/or offered support; **[PROVED]**
e) Did not create a care plan following your visit and/or when completing a record of your visit; **[PROVED]**

4) In respect of Patient C, you:
a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 17 June 2019, approximately 7 months following your visit; **[PROVED]**
    ii) Did not record sufficient information about Patient C's assessment and/or care needs and/or family history and circumstances; **[PROVED]**
b) Did not enter Patient C onto the correct care pathway following your visit and/or on 17 June 2019; **[PROVED]**
c) Did not ensure that a Health Visitor was allocated to Patient C; **[PROVED]**

d) Did not ensure that Mother C and/or Father C was contacted following the visit and/or offered support; **[PROVED]**

5) In respect of Patient D, you:

a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 7 June 2019, approximately 7 months following your visit; **[PROVED]**
    ii) Did not record the reason for Patient D being referred to a paediatrician and/or dietician; **[PROVED]**
    iii) Did not record sufficient information about Patient D's weight and/or care needs and/or support to be provided; **[PROVED]**

b) Did not enter Patient D onto the correct care pathway following your visit and/or on 7 June 2019; **[PROVED]**

c) Did not ensure that a Health Visitor was allocated to Patient D; **[PROVED]**

d) Did not inform the paediatrician and dietician of the patient's weight after your visit; **[PROVED]**

6) In respect of Patient E, you:

a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 19 June 2019, approximately 6 months following your visit; **[PROVED]**
    ii) Did not refer to Mother E's mental health in your assessment; **[PROVED]**
    iii) Did not record sufficient or any information about Patient E's assessment and/or family circumstances and/or concerns raised by others; **[PROVED]**
    iv) Incorrectly recorded that there were no current concerns about Patient E, or words to that effect, when there were; **[PROVED]**

b) Did not enter Patient E onto the correct care pathway following your visit and/or on 19 June 2019; **[PROVED]**

c) Did not ensure that a Health Visitor was allocated to Patient E; **[PROVED]**

d) Did not ensure that Mother E was contacted following the visit and/or offered support; **[PROVED]**

e) Did not create a care plan following your visit and/or when completing a record of your visit; **[PROVED]**
f) Did not refer Mother E and/or Patient E to relevant third parties and/or health professionals; **[PROVED]**
g) Did not assess the risk to Patient E in regards to Mother E's alcohol use and/or mental health issues, or alternatively, did not record this; **[PROVED]**

7) In respect of Patient F, you:
a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 19 June 2019, approximately 5 months following your visit; **[PROVED]**
    ii) Did not record sufficient or any information about Patient F's assessment and/or family circumstances; **[PROVED]**
b) Did not enter Patient F onto the correct care pathway following your visit and/or on 19 June 2019; **[PROVED]**

8) In respect of Patient G, you:
a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 7 June 2019, approximately 7 months following your visit; **[PROVED]**
b) Did not enter Patient G onto the correct care pathway following your visit and/or on 7 June 2019; **[PROVED]**
c) Did not ensure that a Health Visitor was allocated to Patient G; **[PROVED]**

9) In respect of Patient H, you:
a) Failed to maintain accurate records in that you:
    i) Did not complete the record until 28 June 2019, approximately 2 months following your visit; **[PROVED]**
b) Did not enter Patient H onto the correct care pathway following your visit and/or on 28 June 2019; **[PROVED]**
c) Did not ensure that a Health Visitor was allocated to Patient H; **[PROVED]**

d) Did not undertake a sufficient assessment of Patient H or alternatively, did not record sufficient information about Patient H's assessment and/or family circumstances; **[PROVED]**

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

Background

The NMC received a referral from Oxleas NHS Foundation Trust (the Trust) on 27 June 2019, in relation to concerns raised while Mrs Ajmani was working as a Health Visitor at the Trust. Mrs Ajmani commenced employment with the Trust on 12 September 2018 to cover a fixed six month maternity leave with an end date of 31 March 2019. Mrs Ajmani's contract at the Trust was subsequently extended for a further three months.

Mrs Ajmani's role as a health visitor at the Trust involved the delivery of a Healthy Child Programme, which is a programme designed to offer health and advice, including wellbeing and parental issues, development reviews and screening for families with children up to four years old.

Mrs Ajmani was assigned a preceptor, Colleague A, to support her in practice as she had returned to clinical practice following a break of 10 years. [PRIVATE]

RiO is the Trust's electronic clinical record system, which contains the progress notes from Health Visitors appointments. According to the Trust's record keeping policy, '*record entries must be made at the time an event of care has occurred or as soon as possible afterwards i.e. before the end of 'a shift'*. On 5 October 2018, Mrs Ajmani attended a full day of face to face RiO training, followed by the completion of self-directed eLearning to achieve compliance with the Trust's training. She was not issued an iPad or IT swipe card to access RiO until she had attended RiO training.

The referral alleges that Mrs Ajmani fell behind with accurate record keeping of patient contact on RiO, which resulted in a backlog of patient records to complete. On 26

October 2018, during a one to one supervision meeting with her Line Manager, Ms 1, Mrs Ajmani reported connectivity issues with her iPad used to access RiO. A request was subsequently sent to IT to resolve the issue and Mrs Ajmani was later issued a team laptop to assist. During this meeting, Mrs Ajmani was allocated extra time in her diary for record keeping.

On 23 November 2018, concerns were raised about Mrs Ajmani's record keeping when Colleague A attended a supervision one to one meeting with Ms 1. Mrs Ajmani was allocated a preceptor, Colleague A with whom she worked on a one to one basis for her first month in post. However, Ms 1 took over her supervision in December 2018 as it is alleged Mrs Ajmani required increased levels of support.

As a result of ongoing record keeping concerns, on 26 November 2018 in a one to one supervision meeting with Ms 1, Mrs Ajmani was allocated reduced visits in her diary to enable her to get up to date with record keeping.

In December 2018 Mrs Ajmani was given further one to one training by Ms 1. [PRIVATE]

The Trust commenced an informal capability process with Mrs Ajmani in December 2018 due to continued concerns about Mrs Ajmani's record keeping. It is alleged that between October 2018 and June 2019, Mrs Ajmani's patient records remained uncompleted on RiO despite support. A number of further supervision meetings took place between December 2018 and May 2019, in which Mrs Ajmani's record keeping was constantly flagged up as an area for concern.

On 31 May 2019, Mrs Ajmani was sent 62 sets of incomplete records to complete, some of which dated back to October 2018. At this stage, the Trust's Operational Manager, Ms 2, decided that a formal capability process was required and she met with Mrs Ajmani on 6 June 2019 to inform her of this. The formal capability meeting was held on 14 June 2019, however, Mrs Ajmani left the employment of the Trust before a formal capability process could be put in place.

Following the formal capability meeting on 14 June 2019, Mrs Ajmani agreed to complete all the records by 19 June 2019. Mrs Ajmani completed 35 sets of records by this date and most of the remaining sets of records by 27 June 2019. Mrs Ajmani left the Trust on 30 June 2019. It is alleged that Mrs Ajmani left the Trust with six records still uncompleted. Mrs Ajmani's record keeping concerns related to 64 patients between September 2018 and June 2019.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Colleague A: Health Visitor who was Mrs Ajmani's assigned preceptor at the Trust;
- Ms 1: Operational Lead at the Trust and Mrs Ajmani's Line Manager at the time;
- Ms 2: Head of Health Visiting at the Trust and Operational Manager at the time;

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel was assisted by the fact that there was considerable documentary evidence that supported what the witnesses were stating in their witness statements.

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

Charge 1a

1) Between October 2018 and 30 June 2019 you:
a) On more than one occasions failed to manage your time effectively;

This charge is found proved.

In reaching this decision, the panel took into account the written statements of Colleague A, Ms 1 and Ms 2. The panel also considered the documentary evidence exhibited, which included the Trust's Supervision Records and Mrs Ajmani's Diary on RiO from October 2018 to June 2019.

The panel considered that the written witness statements of Colleague A, Ms 1 and Ms 2 were consistent with the evidence from the Trust's Supervision Records and the patients' RiO records, which indicated that Mrs Ajmani failed to complete accurate records of patient contact on RiO from October 2018 to June 2019.

In addition, the panel noted that Mrs Ajmani's Diary on RiO evidenced protected time allocated to Mrs Ajmani to enable her to get up to date with record keeping. The panel was of the view that a reasonable amount of time had been allocated to Mrs Ajmani.

The panel also noted that Mrs Ajmani had been assigned a preceptor, had a reduced workload, had received support with her IT issues and had received practical support from her Line Manager in uploading Word documents to RiO.

The panel was therefore satisfied that, in these circumstances, Mrs Ajmani failed to manage her time effectively by not completing patient records within an acceptable timeframe between October 2018 and June 2019, while reasonable time and support was given.

Accordingly, the panel found charge 1a proved.

Charge 1b

> 1) Between October 2018 and 30 June 2019 you:
> b) On more than one occasions failed to complete patient records within a timely manner as set out in Schedule A;

This charge is found proved.

In reaching this decision, the panel took into account the written statements of Colleague A, Ms 1 and Ms 2. The panel also considered the documentary evidence exhibited, which included the Trust's RiO record for patients.

The panel accepted the written evidence of Colleague A, Ms 1 and Ms 2, which indicated that following Mrs Ajmani's appointments with patients from October 2018 to 30 June 2019, Mrs Ajmani failed to complete patient records in the Trust's RiO system.

The panel had regard to the dates of Mrs Ajmani's visits to the patients in Schedule A and the dates of her completed patient notes on RiO. The panel noted that the patient notes for the majority of Mrs Ajmani's patients were not completed on RiO until June 2019, up to seven months after the visits.

The panel was satisfied that there was clear corroborative evidence to determine that Mrs Ajmani failed to complete patient records in a timely manner.

Accordingly, the panel found charge 1b proved.

Charge 1c

1) Between October 2018 and 30 June 2019 you:
c) Failed to ensure that one or more of your patient records were up to date and/or completed on RiO, the Trust's electronic clinical record system by 30 June 2019;

This charge is found proved (deleting the word 'or')

In reaching this decision, the panel took into account all of the evidence before it and in particular the written statements of Ms 2.

The panel noted that in Ms 2's witness statement she described that Mrs Ajmani's record keeping issues had been escalated to her. Ms 2 stated that, in her capability meeting with Mrs Ajmani on 14 June 2019, she told Mrs Ajmani that she needed to ensure all patient records were entered onto RiO by the time she left the Trust on 30 June 2019. Ms 2 stated that there were six records outstanding on 27 June 2019 and they were not completed before Mrs Ajmani left the Trust.

The panel saw no reason to doubt Ms 2's evidence, which was corroborated in the patient records on RiO exhibited to Ms 2's witness statement. It noted that 62 patient records were not kept up to date.

The panel concluded on the balance of probabilities that Mrs Ajmani failed to ensure that one or more patient records were up to date and completed on RiO by 30 June 2019.

Accordingly, the panel found charge 1c proved.

Charge 2

2) In respect of Patient A, you:
a) Failed to maintain accurate records in that you:

i) Did not complete the record until 17 June 2019, approximately 7 months following your visit;

b) Did not enter Patient A onto the correct care pathway following your visit and/or on 17 June 2019;

c) Did not ensure that a Health Visitor was allocated to Patient A;

d) Did not ensure that Mother A was contacted following the visit and/or offered support;

e) Did not create a care plan following your visit and/or when completing a record of your visit;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient A, which included the Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient A on 9 November 2018. However, Patient A's notes were not recorded on RiO by Mrs Ajmani until 17 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel noted the following evidence from Ms 2 with regard to process of allocation of patients onto the correct pathways following an initial assessment:

> *'I have been asked to clarify whether the Registrant would have known what pathway to have put the patients on following her visit. It is the Health Visitor who decides which pathway a patient should go on and agrees this the family, based on the outcome of the assessment at the contact. I can confirm that the Registrant would have known what pathway to have put the patients on following the visits. The Registrant was trained on how to change a referral pathway and given guidance. The instructions are also in the health visiting standard operating*

procedure. If the Registrant was required help to change the referral pathway, she could have asked the admin hub or the admin in the base. The Registrant could have also asked any other Health Visitor as they would have been available to assist. When a patient is put on a referral pathway, they are added to a Health Visitors caseload. Changing a referral pathway is done by using a drop-down menu. A Health Visitor's caseload. If the patients had been put on the correct pathway of Universal Plus pathway, other Health Visitors having contact with the families of patients would be alerted that there were additional needs. A Health Visitor would record the pathway onto a patient's health records, in the progress notes with the care plan and on referral pathway. The families of the patients would then receive allocated Health Visitors and the planned interventions within the care plans. This is particularly important when the allocated Health Visitor needs to take over the care of a patient.'

The panel also noted the following evidence from Ms 2 with regard to Patient A:

'The Registrant should have put the record onto Rio following the appointment and put him on a Universal Plus instead of a Universal pathway. There should have been mandated contacts with a Health Visitor and the mother should have been contacted offering support.
[…]

Health Visitors lead the delivery of the Healthy Child Programme for Children aged zero to four years which is an evidence-based programme of care. The Healthy Child Programme consists of three case pathways, namely Universal pathway which is for every child; Universal Plus pathway for children and families where there are additional needs for example postnatal depression or feeding problems; and Universal Partnership Plus Pathway for children with complex needs including safeguarding concerns.
[…]

By not ensuring a patient is entered in the correct pathway, meant fewer contacts with Health Visitors.

[…]

The patient was entered onto the incorrect pathway which was a Universal Pathway. If the patient had been put on the correct pathway, he would have been put on a care plan offering support and allocated a named Health Visitor. The named Health Visitor would have contacted the mother to offer a follow up appointment. The patient was a new baby who had cardiac problems, therefore with that there is a worry about faltering growth. We would have wanted to invite the patient in for a follow up appointment to check his weight at the very least, to see whether he was thriving. After a follow up appointment, any support would be assessed depending on the patient and mother's needs.'

2a) Failed to maintain accurate records in that you:

i) Did not complete the record until 17 June 2019, approximately 7 months following your visit;

In relation to charge 2a(i), the panel considered that following Mrs Ajmani's appointment with Patient A on 9 November 2018, there are no recorded entries for Patient A on RiO until 17 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient A's records in any form prior to 17 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate patient records for Patient A, in that she did not complete the record until 17 June 2019. The panel therefore finds charge 2a(i) proved.

b) Did not enter Patient A onto the correct care pathway following your visit and/or on 17 June 2019;

In relation to charge 2b, the panel noted that there is an entry from Mrs Ajmani on 17 June 2019 on RiO which indicates that Patient A was not entered onto the correct pathway. Patient A, who was a baby with cardiac problems, was entered onto Universal

Pathway by Mrs Ajmani rather than Universal Plus Pathway, with notes stating '*contact HV services if needed*'.

The panel had regard to Ms 2's explanation about the categorisation of the pathways and determined that Mrs Ajmani did not enter Patient A on the correct pathway either following her visit and on 17 June 2019. The panel therefore finds charge 2b proved.

c) Did not ensure that a Health Visitor was allocated to Patient A;

The panel had regard to its reasoning in charge 2b, and considered that being put on the wrong pathway resulted in Patient A not being allocated a Health Visitor. The panel also noted that it had not been presented with any evidence indicating that Patient A was allocated support by a health visitor following Mrs Ajmani's visit on 9 November 2018. The panel therefore finds charge 2c proved.

d) Did not ensure that Mother A was contacted following the visit and/or offered support;

The panel had regard to its reasoning in charge 2c and considered that being put on the wrong pathway resulted in Patient A not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Mother A was contacted and allocated support following Mrs Ajmani's visit on 9 November 2018. The panel therefore finds charge 2d proved.

e) Did not create a care plan following your visit and/or when completing a record of your visit;

The panel had regard to its reasoning in charge 2d and considered that Mrs Ajmani did not follow correct procedures following her visit on 9 November 2018. The panel accepted the evidence of Ms 2 that no appropriate care plan was created, both following her visit and also when completing the RiO record. The panel therefore finds charge 2e proved.

Charge 3

3) In respect of Patient B, you:

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;

b) Did not enter Patient B onto the correct care pathway following your visit and/or on 7 June 2019;

c) Did not ensure that a Health Visitor was allocated to Patient B;

d) Did not ensure that Mother B and/or Father B was contacted following the visit and/or offered support;

e) Did not create a care plan following your visit and/or when completing a record of your visit;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient B, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient B on 2 November 2018. However, Patient B's notes were not recorded on RiO by Mrs Ajmani until 7 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient B:

> *'The Registrant's appointment took place on 2 November 2018 but the record was not completed until 7 June 2019. There was therefore seven months without the information on Rio. The Registrant should have put the client on a Universal Plus pathway due to the additional health needs and updated the record immediately.*

[…]

It was important to put this patient on the correct pathway. This is because the patient would have needed to be on Universal Plus with his additional health needs from birth trauma that he sustained and the paralysis following the birth. […]

The Registrant did not put the patient on the correct pathway and did not ever make the referral to the correct pathway. The correct care was not provided to the patient. The Registrant should have followed up with the patient and his family, however no follow up appointment was scheduled. There should have been at least one follow up appointment whether that be a Health Visitor going to visit the family or the family being invited to the clinic. The appointment would have been to see how the patient is and the Health Visitor would have liaised with the Community Paediatrician.'

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;

In relation to charge 3a(i), the panel noted that following Mrs Ajmani's appointment with Patient B on 2 November 2018, there are no recorded entries for Patient B on RiO until 7 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient B's records in any form prior to 7 June 2019.

Therefore, the panel determined that Mrs Ajmani failed to maintain accurate records for Patient B, in that she did not complete the record until 7 June 2019. The panel therefore finds charge 3a(i) proved.

b) Did not enter Patient B onto the correct care pathway following your visit and/or on 7 June 2019;

In relation to charge 3b, the panel noted that there is an entry from Mrs Ajmani on 7 June 2019 on RiO which indicates that Patient B was not entered onto the correct pathway. Patient B, who was a baby who suffered sustained paralysis from birth trauma, was entered onto Universal Pathway by Mrs Ajmani rather than Universal Plus Pathway, with notes stating '*Universal Service agreed with mother*'.

The panel had regard to Ms 2's explanation of Patient B's additional health needs and the process of the correct allocation of pathways on RiO and it determined that Mrs Ajmani did not enter Patient B on the correct pathway either following her visit and on 7 June 2019. The panel therefore finds charge 3b proved.

c) Did not ensure that a Health Visitor was allocated to Patient B;

The panel had regard to its reasoning in charge 3b and considered that being put on the wrong pathway would result in Patient B not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient B was allocated support by a health visitor following Mrs Ajmani's visit on 2 November 2018. Further, it had regard to Ms 2's evidence which stated, '…*no follow appointment was scheduled*'. The panel therefore finds charge 3c proved.

d) Did not ensure that Mother B and/or Father B was contacted following the visit and/or offered support;

The panel had regard to its reasoning in charge 3c and considered that being put on the wrong pathway would result in Patient B not being contacted by a health visitor. The panel also noted that it had not been presented with any evidence indicating that either Mother B or Father B were contacted and allocated support following Mrs Ajmani's visit on 2 November 2018. The panel therefore finds charge 3d proved.

e) Did not create a care plan following your visit and/or when completing a record of your visit;

The panel had regard to its reasoning in charge 3d and considered that Mrs Ajmani did not follow correct procedures following her visit on 2 November 2018. The panel accepted the evidence of Ms 2 that no appropriate care plan was created, both following her visit and also when completing the RiO record. The panel therefore finds charge 3e proved.

Charge 4

4) In respect of Patient C, you:

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 17 June 2019, approximately 7 months following your visit;

ii) Did not record sufficient information about Patient C's assessment and/or care needs and/or family history and circumstances;

b) Did not enter Patient C onto the correct care pathway following your visit and/or on 17 June 2019;

c) Did not ensure that a Health Visitor was allocated to Patient C;

d) Did not ensure that Mother C and/or Father C was contacted following the visit and/or offered support;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision the panel took into account all of the witness statements and the documentary evidence exhibited for Patient C, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient C on 8 November 2018. However, Patient C's notes were not recorded on RiO by Mrs Ajmani until 17 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient C:

'*If Patient C had been put on the correct pathway of Universal Plus pathway, the care given to her and her parents would have been different. There would have been a follow up appointment due to the parent's mental health and physical health difficulties. It was clear that the family were vulnerable, and the parents had long term health care conditions and there was a history of mental ill health. If the mother's health deteriorated it is likely to have had a direct impact on her parenting ability. The patient's mother had asthma and chronic anxiety whilst the father had epilepsy.*

In my original statement I state that there could be financial and social impact on the family. The assessment was not clear in the records, the records were quite scant. It would have been expected that the assessment would have explored the parent's long term physical health conditions and the impact on work. The assessment should have taken a holistic approach looking at the life of the family. The parenting ability of the parents should have been looked at to see whether the (sic) meet the basic care needs of the patient, looking at the stimulation and emotional warmth and if there is a safe environment. Essentially the wider family and social factors should have been considered, for example how were the parents coping, how the father's work was and how the mother's maternity leave was going. Questions regarding whether there were any benefits they needed, housing needs (whether they were staying in temporary accommodation), or any recent arrears should have been explored.

The information recorded by the Registrant was not detailed as what would have been expected for a new birth contact. The visit was a new birth contact and usually new birth visits can take up to an hour to an hour and a half. Around an hour is the amount of time the Registrant would have spent with the family. After a Health Visitor does a new birth visit, and additional needs are identified, they would put the family on a Universal Plus pathway and allocate themselves to the family. They would undertake subsequent contacts with the family as it is important that the family do not have to go over what they have shared with someone else. If a Health Visitor had picked up concerns about the parents, then the same Health Visitor would be able to see any deterioration and see whether the care and interactions with the parents had changed with the baby at the subsequent visit.

[…]

The Registrant did not put the patient on the correct pathway and did not ever make the referral to the correct pathway… '

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 17 June 2019, approximately 7 months following your visit;

In relation to charge 4a(i), the panel noted that following Mrs Ajmani's appointment with Patient C on 8 November 2018, there are no recorded entries for Patient C on RiO until 17 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient C's records in any form prior to 17 June 2019.

Therefore, the panel determined that Mrs Ajmani failed to maintain accurate records for Patient C, in that she did not complete the record until 17 June 2019. The panel therefore finds charge 4a(i) proved.

ii) Did not record sufficient information about Patient C's assessment and/or care needs and/or family history and circumstances;

In relation to charge 4a(ii), the panel carefully considered Patient C's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health visitors when dealing with vulnerable families.

The panel noted that Patient C was entered onto the Universal Pathway by Mrs Ajmani, despite vulnerabilities present at the time of her visit. The panel accepted Ms 2's evidence as to what would be expected in an assessment in such circumstances, which relate to a vulnerable family and that this record was insufficient. The panel therefore determined that Mrs Ajmani did not record sufficient information about Patient C's assessment and care needs and family circumstances. The panel therefore finds charge 4a(ii) proved.

b) Did not enter Patient C onto the correct care pathway following your visit and/or on 17 June 2019;

In relation to charge 4b, the panel noted that there is an entry from Mrs Ajmani on 17 June 2019 on RiO which indicates that Patient C was not entered onto the correct pathway. The family of Patient C were vulnerable, with her parents having long term health care conditions and a history of mental ill health, however Patient C was entered onto Universal Pathway by Mrs Ajmani rather than Universal Plus Pathway, with patient notes stating '*Universal Service agreed with mother*'.

The panel had regard to Ms 2's explanation of Patient C's family circumstances, which stated that, if Patient C's mother's health deteriorated, this likely would have had a direct impact on her parenting ability. The panel also had regard to Ms 2's explanation of the process of allocating the correct pathways on RiO. The panel therefore determined that Mrs Ajmani did not enter Patient C on the correct pathway either following her visit and on 17 June 2019 and finds charge 4b proved.

c) Did not ensure that a Health Visitor was allocated to Patient C;

The panel had regard to its reasoning in charge 4b and considered that being put on the wrong pathway would result in Patient C not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient C was allocated support by a health visitor following Mrs Ajmani's visit on 8 November 2018. The panel therefore finds charge 4c proved.

d) Did not ensure that Mother C and/or Father C was contacted following the visit and/or offered support;

The panel had regard to its reasoning in charge 4c and considered that being put on the wrong pathway would result in Patient C not being contacted by a health visitor. The panel also noted that it had not been presented with any evidence indicating that either

Mother C or Father C were contacted and allocated support following Mrs Ajmani's visit on 8 November 2018. The panel therefore finds charge 4d proved.

Charge 5

5) In respect of Patient D, you:

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;

ii) Did not record the reason for Patient D being referred to a paediatrician and/or dietician;

iii) Did not record sufficient information about Patient D's weight and/or care needs and/or support to be provided;

b) Did not enter Patient D onto the correct care pathway following your visit and/or on 17 June 2019;

c) Did not ensure that a Health Visitor was allocated to Patient D;

d) Did not inform the paediatrician and dietician of the patient's weight after your visit;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient D, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient D on 22 November 2018. However, Patient D's notes were not recorded on RiO by Mrs Ajmani until 7 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient D:

'*At paragraph 84 of my original statement, I stated that the Registrant should have been clearer and more explicit in the details recorded regarding this patient. The issues was that there were concerns about the patients' weight, however the progress of the patient's growth was not recorded. The Registrant wrote in the records that the patient's weight was 3.62kg and was steady gain, however this does not provide enough information. She would have needed to record the patient's previous weight a month ago to compare whether her weight had gone up or down. The Registrant would have needed to record the growth progress in detail using centiles and the World Health Organisation growth charts.*

When looking at the Registrant's plan, she wrote "Universal Plus service agreed with mother", however, does not include any detail in the plan for example whether she was going to weigh the patient monthly, invite the family into the clinic, provide the mother with feeding support or liaise with paediatrician and dietitian.

The patient's care was impacted because there was no records and the patient had not been put on the correct pathway. Any other Health Visitor who would have come into contact with the patient and her family would not have known the patient's latest weight. Another Health Visitor also would not have known that the patient had been assessed under the Universal Plus pathway and that she was under care of a paediatrician and dietician. The patient was under a paediatric consultant and dietician at the hospital because there were concerns about the patient's weight. The health professionals at the hospital would not have been provided with the details of the patient's weight journey or how often the Registrant agreed to weigh the patient.

It was important that the Registrant explained why the patient was seeing a paediatrician and dietician. This is because an explanation would have explained to everyone working with the family that there was enough concern with the patient's feeding and growth that she was under the care of specialists (tertiary care at the hospital). It would have been important to know of any care plans by the paediatrician and dietician. Our service and the hospital would have been seeing the patient and weighing her at set intervals, therefore it would have been important for us to work together with the hospital to share information such as results from weighing

appointments as well as care plans. The Registrant should have let the paediatrician know how much the patient weighed after her visit.
[…]

The Registrant did not ever make the referral to the correct pathway. When the Registrant completed the record for this patient seven months after the appointment, she identified that the patient should be put on the Universal Plus Pathway, however she did not change the referral pathway on RiO. As explained in paragraph 6, when a patient is put on a Universal Plus Pathway, they are added to a Health Visitor's caseload. However, because the patient was not put on the Universal Plus Pathway, they were not added to the Registrant's caseload. The patient would have sat on the Universal Pathway list and been invited for a one-year review with a nursery nurse, when she should have been seen at home by the Registrant or another a Health Visitor'.

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;

In relation to charge 5a(i), the panel noted that following Mrs Ajmani's appointment with Patient D on 22 November 2018, there are no recorded entries for Patient D on RiO until 7 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient D's records in any form prior to 7 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate records for Patient D, in that she did not complete the record until 7 June 2019. The panel therefore finds charge 5a(i) proved.

ii) Did not record the reason for Patient D being referred to a paediatrician and/or dietician;

In relation to charge 5a(ii), the panel carefully considered Patient D's notes recorded by Mrs Ajmani on RiO. The panel noted that Mrs Ajmani recorded that Patient D should be entered onto the Universal Plus Pathway and she made reference to a paediatrician review in which she recorded:

> *'Had Paediatrician (Paed) + Dietician review 2-3/52 ago - currently weekly wt at OVH until review.'*

The panel determined that there was no information recorded by Mrs Ajmani indicating the reason for a paediatrician or dietician review. The panel therefore finds charge 5a(ii) proved.

> **iii) Did not record sufficient information about Patient D's weight and/or care needs and/or support to be provided;**

In relation to charge 5a(iii), the panel carefully considered Patient D's assessment notes recorded by Mrs Ajmani on RiO.

The panel noted that Mrs Ajmani recorded that Patient D should have been entered onto the Universal Plus Pathway by Mrs Ajmani. However, the panel accepted Ms 2's evidence that Mrs Ajmani should have recorded clearer and more explicit details, including more information about the patient's weight, previous recordings, details of what was discussed with Patient D's mother, as well as future support to be offered such as weighing the patient monthly, inviting the family into clinic, feeding support to the mother and liaising with paediatrician and dietician. The panel therefore determined that Mrs Ajmani did not record sufficient information about Patient D's weight and care needs and the support to be provided. The panel therefore finds charge 5a(iii) proved.

> **b) Did not enter Patient D onto the correct care pathway following your visit and/or on 17 June 2019;**

In relation to charge 5b, the panel noted that there is an entry from Mrs Ajmani on 7 June 2019 on RiO which indicates that the '*Universal Plus service [was] agreed with*

mother'. However, the panel accepted Ms 2's evidence that this allocation was not properly carried out on RiO.

Patient D was under the care of a paediatrician and dietician due to concerns with their weight, however, because Mrs Ajmani did not follow the correct process on RiO the patient remained on the default Universal Pathway. The panel therefore determined that Mrs Ajmani did not enter Patient D on the correct pathway either following her visit or on 7 June 2019 and finds charge 5b proved.

c) Did not ensure that a Health Visitor was allocated to Patient D;

The panel had regard to its reasoning in charge 5b and considered that being put on the wrong pathway would result in Patient D not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient D was allocated support by a health visitor following Mrs Ajmani's visit on 22 November 2018. The panel therefore finds charge 5c proved.

d) Did not inform the paediatrician and dietician of the patient's weight after your visit;

The panel had regard to its reasoning in charge 5c and considered that Mrs Ajmani did not follow correct procedures following her visit on 22 November 2018. The panel accepted the evidence of Ms 2 that Mrs Ajmani should have recorded clearer and more explicit details, including more information about the patient's weight, previous recordings, details of what was discussed with Patient D's mother, as well as future support to be offered such as weighing the patient monthly, inviting the family into clinic, feeding support to the mother and liaising with paediatrician and dietician. The panel also noted that it had not been presented with any evidence indicating that Mrs Ajmani informed the paediatrician and dietician of Patient D's weight. The panel therefore finds charge 5d proved.

Charge 6

6) In respect of Patient E, you:

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 19 June 2019, approximately 6 months following your visit;

ii) Did not refer to Mother E's mental health in your assessment;

iii) Did not record sufficient or any information about Patient E's assessment and/or family circumstances and/or concerns raised by others;

iv) Incorrectly recorded that there were no current concerns about Patient E, or words to that effect, when there were;

b) Did not enter Patient E onto the correct care pathway following your visit and/or on 19 June 2019;

c) Did not ensure that a Health Visitor was allocated to Patient E;

d) Did not ensure that Mother E was contacted following the visit and/or offered support;

e) Did not create a care plan following your visit and/or when completing a record of your visit;

f) Did not refer Mother E and/or Patient E to relevant third parties and/or health professionals;

g) Did not assess the risk to Patient E in regards to Mother E's alcohol use and/or mental health issues, or alternatively, did not record this;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient E, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient E on 20 December 2018. However, Patient E's notes were not recorded on RiO by Mrs Ajmani until 19 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient E:

'The records for this patient lacked the necessary details. It appears to me that the Registrant had not read the documents before she went to visit family. The mother had previously been seen by Bromley Home Treatment Team which is one of the mental health teams (a high-level intensive team). The team's concerns were considerable, however the Registrant wrote within the records "no current concerns". The Registrant also wrote "contact HV services as needed" which relates to the universal plan and not the Universal Plus plan. HV is a widely used abbreviation for health visiting. From this entry, it appears that the Registrant did not have any intention of following up with the family after the visit. The Registrant should have been thinking about referrals for this family, such as the Bromley Children project which is an early intervention family service.

After the visit, the Registrant should have put the patient on the Universal Plus pathway, however this was not done. I think that the Registrant either did not read the records before her visit or did not relate the content of the previous records to her visit, particularly around how she needed to assess the mother and the family, and how the mother was coping. At the time following the Registrant's visit, she should have created the record and changed the referral to Universal Plus pathway. When the Registrant entered the record on 19 June 2019 she did not change the referral pathway on RiO. Again, if the Registrant was unsure how to change the referral pathway on RiO, she could have asked for assistance.

[…]

I would have expected the Registrant to take several matters into account. For example, the Registrant should have asked the mother about alcohol; whether she was getting out of the house; and whether she was taking the three year old to pre-school. The Registrant should have also asked how the mother was coping and what support she was getting. The Registrant should have been thinking about what support to put in place. She had noted "Universal Plus service- see mother's notes" in the records, therefore I would have expected some referrals to have been put in, as well as a follow up contact to see how the mother is getting on, liaising with the Bromley Home Treatment Team to see

whether they had had any further contact and what their worries were. The Bromley Home Treatment Team had written about the children in the records and were clearly worried about the children and the impact the mother's mental health was having on them.

I had concerns about the Registrant's assessment because I would have expected the Registrant to have asked the mother exploratory questions around what had happened, whether things had changed, whether there was anything that was different from before, if anything had triggered her alcohol use before, how the children are doing (not just the baby). Considering there were two children under the age of five and given the mother's recent mental health crisis, I really would be expecting such questions to be asked. The Registrant had a lack of analysis because she states within the records "Universal Plus service- see mother's notes", therefore she must have recognised that something needed to be done or that she needed to put them on a different pathway. However, it could be that the Registrant did not get the meaning (what it could possibly mean for the lived experiences of the children) and what she needed to do to work with the family and put in the care plan.

I refer to the Registrant placing the mother on a Universal Plus pathway in the record, however the referral was kept as Universal on RiO. The Registrant should have gone into the referrals, changed the referral pathway to Universal Plus and allocated it to herself so that it was added to her caseload. As explained in paragraph 6, the Registrant was given the necessary training to change the referral, pathway.'

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 19 June 2019, approximately 6 months following your visit;

In relation to charge 6a(i), the panel noted that following Mrs Ajmani's appointment with Patient E on 20 December 2018, there are no recorded entries for Patient E on RiO until 19 June 2019. The panel also noted that it was not presented with any evidence

indicating that Mrs Ajmani had completed Patient E's records in any form prior to 19 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate records for Patient E, in that she did not complete the record until 19 June 2019. The panel therefore finds charge 6a(i) proved.

ii) Did not refer to Mother E's mental health in your assessment;

In relation to charge 6a(ii), the panel carefully considered Patient E's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health visitors when dealing with vulnerable families.

The panel noted that Mother E had been seen by Bromley Home Treatment Team (a high-level intensive mental health team) following a mental health crisis, who reported considerable concerns about Mother E, Patient E and the patient's siblings.

The panel noted that Patient E was entered onto the Universal Pathway by Mrs Ajmani, despite vulnerabilities present at the time of her visit. The panel accepted Ms 2's evidence as to what would be expected in an assessment in such circumstances, which should have included an assessment of how Mother E was coping. The panel also noted that there was no reference to Mother E's mental health completed on RiO by Mrs Ajmani and therefore finds charge 6a(ii) proved.

iii) Did not record sufficient or any information about Patient E's assessment and/or family circumstances and/or concerns raised by others;

In relation to charge 6a(iii), the panel carefully considered Patient E's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health visitors when dealing with vulnerable families.

The panel noted that Mother E had been seen by Bromley Home Treatment Team (a high-level intensive mental health team) following a mental health crisis, who reported considerable concerns about Mother E, Patient E and the patient's siblings.

The panel noted that Patient E was entered onto the Universal Pathway by Mrs Ajmani, despite vulnerabilities present at the time of her visit where she noted that there were *'no current concerns*'. The panel accepted Ms 2's evidence as to what would be expected in an assessment in such circumstances. Therefore, the panel determined that Mrs Ajmani recorded insufficient information about Patient E's assessment and family circumstances and concerns raised by others. The panel therefore finds charge 6a(iii) proved.

iv) Incorrectly recorded that there were no current concerns about Patient E, or words to that effect, when there were;

The panel had regard to its reasoning in charge 6a(iii) and determined that Mrs Ajmani incorrectly recorded that there were '*no current concerns'* about Patient E, when there were. The panel therefore finds charge 6a(iv) proved.

b) Did not enter Patient E onto the correct care pathway following your visit and/or on 19 June 2019;

In relation to charge 6b, the panel noted that there is an entry from Mrs Ajmani on 19 June 2019 on RiO which indicates that Patient E was allocated to the Universal Plus Pathway, however, the panel accepted Ms 2's evidence that this allocation was not properly carried out on RiO.

Patient E had previously been seen by the Bromley Home Treatment Team, one of the high-level intensive mental health teams, who had considerable concerns about Patient E. However, because Mrs Ajmani did not follow the correct process on RiO the patient remained on the default Universal Pathway. The panel therefore determined that Mrs Ajmani did not enter Patient E on the correct pathway either following her visit or on 19 June 2019 and finds charge 6b proved.

c) Did not ensure that a Health Visitor was allocated to Patient E;

The panel had regard to its reasoning in charge 6b and considered that being put on the wrong pathway would result in Patient E not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient E was allocated support by a health visitor following Mrs Ajmani's visit on 20 December 2018. The panel therefore finds charge 6c proved.

d) Did not ensure that Mother E was contacted following the visit and/or offered support;

The panel had regard to its reasoning in charge 6c and considered that being put on the wrong pathway would result in Patient E not being contacted by a health visitor. The panel also noted that it had not been presented with any evidence indicating that Mother E was contacted and allocated support following Mrs Ajmani's visit on 20 December 2018. The panel therefore finds charge 6d proved.

e) Did not create a care plan following your visit and/or when completing a record of your visit;

The panel had regard to its reasoning in charge 6d, the panel considered that Mrs Ajmani did not follow correct procedures following her visit on 20 December 2018. The panel accepted the evidence of Ms 2 that no appropriate care plan was created, both following her visit and also when completing the RiO record. The panel therefore finds charge 6e proved.

f) Did not refer Mother E and/or Patient E to relevant third parties and/or health professionals;

The panel had regard to its reasoning in charge 6d and considered that Mrs Ajmani did not follow correct procedures following her visit on 20 December 2018. The panel accepted the evidence of Ms 2 that Mrs Ajmani should have undertaken sufficient

assessment of Patient E, made referrals, followed up contact to see how Mother E and Patient E were and liaised with the Bromley Home Treatment Team to understand their concerns and if they had any further contact. The panel also noted that it had not been presented with any evidence indicating that Mrs Ajmani made any referrals for Mother E and Patient E to third parties and health professionals. The panel therefore finds charge 6f proved.

g) Did not assess the risk to Patient E in regards to Mother E's alcohol use and/or mental health issues, or alternatively, did not record this;

In relation to charge 6g, the panel carefully considered Patient E's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health visitors when dealing with vulnerable families.

The panel noted that Patient E was entered onto the Universal Pathway by Mrs Ajmani, despite vulnerabilities present at the time of her visit where she noted that there were *'no current concerns*'. The panel accepted Ms 2's evidence as to what would be expected in an assessment in such circumstances. The panel determined that it had no evidence as to whether Mrs Ajmani had assessed the risk to Patient E in regards to Mother E's alcohol use or mental health issues but as she did not record any such assessment, the panel finds charge 6g proved in the alternative.

Charge 7

7) In respect of Patient F, you:

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 19 June 2019, approximately 5 months following your visit;

ii) Did not record sufficient or any information about Patient F's assessment and/or family circumstances;

b) Did not enter Patient F onto the correct care pathway following your visit and/or on 19 June 2019;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient F, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient F on 18 January 2019. However, Patient F's notes were not recorded on RiO by Mrs Ajmani until 21 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient F:

> *'The client is a one year old child, There are concerns about the late record keeping and the records were not read prior to or after the home visit. This affected the assessment that took place.*
> *[…]*
>
> *On the mother's record, there are a number of vulnerability and risks:*
>
> - *previously known to children's social care due to neglect;*
> - *an older child with global developmental delay; and*
> - *a stillbirth in 2017.*
>
> *The Registrant noted that the house was "messy, stale smelling + lots of clutter." In the record, the Registrant stated that the family were UP however this referral was never made on Rio and the family remained on a universal pathway unallocated. This has been allocated to a Health Visitor and placed on the correct pathway since this investigation began. Another professional (not from health visiting) had been into the home and had concerns about the state of the home and contacted the duty Health Visitor about their concerns. The duty Health Visitor that took the call was not aware that the family should have been on a UP*

pathway and therefore information was not shared which has delayed the professionals working together to consider a children's social care referral. […]

The Registrant never put the patient on the correct pathway. The patient was allocated to the correct pathway by Aderonke or I, because she would have eventually received care from another Health Visitor. There would have been a delay in this patient being put on the correct pathway. The patient would have received care from a Health Visitor much later after the Registrant's visit, perhaps in the summer of 2019.''

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 19 June 2019, approximately 5 months following your visit;

In relation to charge 7a(i), the panel noted that following Mrs Ajmani's appointment with Patient F on 18 January 2019, there are no recorded entries for Patient F on RiO until 19 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient F's records in any form prior to 19 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate records for Patient F, in that she did not complete the record until 19 June 2019. The panel therefore finds charge 7a(i) proved.

ii) Did not record sufficient or any information about Patient F's assessment and/or family circumstances;

In relation to charge 7a(ii), the panel carefully considered Patient F's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health visitors when dealing with vulnerable families.

The panel noted that Patient F was entered onto the Universal Pathway by Mrs Ajmani, despite vulnerabilities and concerns present at the time of her visit. The panel accepted

Ms 2's evidence as to what would be expected in an assessment in such circumstances, which relate to a vulnerable family and that this record was insufficient. The panel therefore determined that Mrs Ajmani did not record sufficient information about Patient F's assessment and family circumstances. The panel therefore finds charge 7a(ii) proved.

b) Did not enter Patient F onto the correct care pathway following your visit and/or on 19 June 2019;

In relation to charge 7b, the panel noted that there is an entry from Mrs Ajmani on 19 June 2019 on RiO which indicates that the '*Universal Plus service [was] agreed with parent*'. However, the panel accepted Ms 2's evidence that this allocation was not properly carried out on RiO and therefore the patient remained on the default Universal Pathway. The panel therefore determined that Mrs Ajmani did not enter Patient F on the correct pathway either following her visit or on 19 June 2019 and finds charge 7b proved.

Charge 8

8) In respect of Patient G, you:
a) Failed to maintain accurate records in that you:
i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;
b) Did not enter Patient G onto the correct care pathway following your visit and/or on 7 June 2019;
c) Did not ensure that a Health Visitor was allocated to Patient G;

This charge is found proved in its entirety (with the deletion of the word 'or' in sub charge b)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient G, which included the Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient G on 22 November 2018. However, Patient G's notes were not recorded on RiO by Mrs Ajmani until 7 June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient G:

> *'This is the mother of Patient D. Similar to the concerns regarding Patient D the Registrant should have put the patient on the Universal Plus pathway on RiO.*
>
> *The Registrant never put the patient on the correct pathway and the correct care was not provided to the patient. The impact on other professional would have been identical to the impact described when discussing patient D.'*

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 7 June 2019, approximately 7 months following your visit;

In relation to charge 8a(i), the panel noted that following Mrs Ajmani's appointment with Patient F on 22 November 2018, there are no recorded entries for Patient F on RiO until 7 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient F's records in any form prior to 7 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate records for Patient F, in that she did not complete the record until 7 June 2019. The panel therefore finds charge 8a(i) proved.

b) Did not enter Patient G onto the correct care pathway following your visit and/or on 7 June 2019;

In relation to charge 8b, the panel noted that there is an entry from Mrs Ajmani on 7 June 2019 on RiO which indicates that the '*Universal Plus service [was] agreed with*

mother'. However, the panel accepted Ms 2's evidence that this allocation was not properly carried out on RiO and therefore the patient remained on the default Universal Pathway. The panel therefore determined that Mrs Ajmani did not enter Patient G on the correct pathway either following her visit or on 7 June 2019 and finds charge 8b proved.

c) Did not ensure that a Health Visitor was allocated to Patient G;

The panel had regard to its reasoning in charge 8b and considered that being put on the wrong pathway would result in Patient G not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient G was allocated support by a health visitor following Mrs Ajmani's visit on 22 November 2018. The panel therefore finds charge 8c proved.

Charge 9

9) In respect of Patient H, you:
a) Failed to maintain accurate records in that you:
i) Did not complete the record until 28 June 2019, approximately 2 months following your visit;
b) Did not enter Patient H onto the correct care pathway following your visit and/or on 28 June 2019;
c) Did not ensure that a Health Visitor was allocated to Patient H;
d) Did not undertake a sufficient assessment of Patient H or alternatively, did not record sufficient information about Patient H's assessment and/or family circumstances;

This charge is found proved in its entirety (with the deletion of the word 'or' in all relevant sub charges)

In reaching this decision, the panel took into account all of the witness statements and the documentary evidence exhibited for Patient H, which included Trust's RiO records.

The panel noted that Mrs Ajmani is recorded on RiO as having visited Patient H on 5 April 2019. However, Patient H's notes were not recorded on RiO by Mrs Ajmani until 28

June 2019. The panel observed that RiO is the Trust's electronic clinical record system which is used by all health visitors and it accepted the recordings on RiO as reliable.

The panel also noted the following evidence from Ms 2 in regards to Patient H:

> *'The client is a mother. She had a traumatic delivery and was described in the notes as socially isolated and showing signs of anxiety. Her baby was born with congenital bilateral talipes, which requires treatment by putting the feet into cast that are replaced weekly for five to eight weeks.*
>
> *The Registrant saw the family on 5 April 2019 and entered the record on 28 June 2019.*
>
> *On 14 May 2019, the client's GP contacted duty to request a Health Visitor to observe baby feeding. The Duty Health Visitor asked mother to attend clinic. Due to the Registrant not completing the visit notes until June 2019, the Duty Health Visitor was unaware of the child being in cast and was asked to come into clinic.'*

a) Failed to maintain accurate records in that you:

i) Did not complete the record until 28 June 2019, approximately 2 months following your visit;

In relation to charge 9a(i), the panel noted that following Mrs Ajmani's appointment with Patient H on 5 April 2019, there are no recorded entries for Patient H on RiO until 28 June 2019. The panel also noted that it was not presented with any evidence indicating that Mrs Ajmani had completed Patient H's records in any form prior to 28 June 2019.

Therefore the panel determined that Mrs Ajmani failed to maintain accurate records for Patient H, in that she did not complete the record until 28 June 2019. The panel therefore finds charge 9a(i) proved.

b) Did not enter Patient H onto the correct care pathway following your visit and/or on 28 June 2019;

In relation to charge 9b, the panel noted that there is an entry from Mrs Ajmani on 28 June 2019 on RiO which indicates that the '*Universal Plus service [was] agreed*'. However, the panel accepted Ms 2's evidence that this allocation was not properly carried out on RiO and therefore the patient remained on the default Universal Pathway. Patient H is a mother who had a traumatic delivery and was described in the patient notes as socially isolated and showing signs of anxiety. Patient H's baby was born with congenital bilateral talipes, which requires treatment by putting the feet into casts. The panel therefore determined that Mrs Ajmani did not enter Patient H on the correct pathway either following her visit or on 28 June 2019 and finds charge 9b proved.

c) Did not ensure that a Health Visitor was allocated to Patient H;

The panel had regard to its reasoning in charge 9b and considered that being put on the wrong pathway would result in Patient H not being allocated a health visitor. The panel also noted that it had not been presented with any evidence indicating that Patient H was allocated support by a health visitor following Mrs Ajmani's visit on 5 April 2019. The panel therefore finds charge 9c proved.

d) Did not undertake a sufficient assessment of Patient H or alternatively, did not record sufficient information about Patient H's assessment and/or family circumstances;

In relation to charge 9d, the panel carefully considered Patient H's notes, as recorded by Mrs Ajmani on RiO. The panel also had regard to Ms 2's explanation of the role of health hisitors when dealing with vulnerable families.

The panel noted that Patient H was entered onto the Universal Pathway by default, despite vulnerabilities present at the time of her visit. The panel accepted Ms 2's evidence as to what would be expected in an assessment in such circumstances, which relate to a vulnerable family and that this record was insufficient. The panel determined that it had no evidence as to whether Mrs Ajmani had assessed the risk to Patient H, but as she did not record any such assessment, the panel finds charge 9d proved in the alternative.

Fitness to Practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and, if so, whether Mrs Ajmani'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 Ajmani's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

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.'*

The NMC 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.

The NMC identified the specific, relevant standards where Mrs Ajmani's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three stage process:

- Is there evidence that Mrs Ajmani was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mrs Ajmani's competence at the time was below the standard expected of a registered health visitor.

The NMC requires the panel to bear in mind its overarching objective to protect 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.

In their submissions on impairment, the NMC refer to Dame Janet Smith's Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011]* EWHC 927 (Admin). The NMC submits that the first three limbs of the test are engaged in this case: that Mrs Ajmani's actions in respect of the charges involved placing patients and vulnerable families at serious risk of harm; her actions have brought the nursing profession into disrepute; an informed member of the public would see Mrs Ajmani's actions as conduct which falls far below the standard expected of a registered nurse; and by failing to provide safe care, Mrs Ajmani breached a fundamental tenet of the profession.

The NMC invited the panel to find Mrs Ajmani's fitness to practise impaired on the grounds of public protection and public interest. The NMC submits that in the absence of any evidence to demonstrate insight, remorse or remediation, Mrs Ajmani is liable to repeat the behaviour of the kind found proved in the future.

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:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are responded to

To achieve this you must:

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

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:

8.2 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

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

8.6 share information to identify and reduce risk

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

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

The panel bore in mind, when reaching its decision, that Mrs Ajmani should be judged by the standards of the average registered health visitor and not by any higher or more demanding standard.

The panel had regard to the facts found proved and determined that Mrs Ajmani's actions demonstrated a lack of competence in basic fundamental elements of nursing and of health visiting practice. The panel was of the view that as an experienced health visitor, Mrs Ajmani was aware of her responsibility to ensure that her records were up to date and completed accurately, however, she demonstrated an unacceptably low standard of professional competence in this area. The panel also considered that Mrs Ajmani demonstrated a lack of competence in that she failed to assess patients accurately and allocate them to the correct pathway. The panel determined that Mrs Ajmani's actions exposed numerous patients and vulnerable families to serious risk of unwarranted harm and also impacted on the follow up care patients received by other professionals.

The panel also noted 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 sustained period of time. It had regard to the witness statements, all of which comment on the training, support and assistance offered from the Trust to improve Mrs Ajmani's standard of performance with her record keeping.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mrs Ajmani's practice was significantly below the standard that would be expected of the average registered health visitor acting in Mrs Ajmani's role.

In all the circumstances, the panel determined that Mrs Ajmani's performance demonstrated a lack of competence.

Decision and reasons on impairment

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. 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 in the future.

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

The panel noted that it had not received any evidence to suggest that Mrs Ajmani has demonstrated an understanding of how her actions put patients and vulnerable families at a risk of harm or how this impacted negatively on the reputation of the nursing profession. The panel found that Mrs Ajmani has not developed any insight or demonstrated any remorse. In addition, the panel has not received any information to suggest that Mrs Ajmani has taken any steps to remediate her practice. The panel bore in mind that Mrs Ajmani has failed to engage with the NMC since August 2019 and does not appear to have worked in a clinical setting since then.

Further, the panel noted that Mrs Ajmani was subject to previous regulatory proceedings in relation to record keeping and time management issues whilst working as a health visitor following concerns being raised in 2007. Mrs Ajmani was readmitted to the NMC register on 30 January 2018 after completing a Return to Practise Course, with a health visitor module.

The panel was of the view that there is a high risk of repetition based on the lack of evidence of any insight, remediation or remorse; previous regulatory proceedings in relation to similar concerns; and the fact that Mrs Ajmani recently completed retraining for similar concerns. On the basis of all the information before it, the panel decided that there is a risk to the public if Mrs Ajmani 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 health visiting 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 Ajmani'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 Ajmani'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 with a review. The effect of this order is that the NMC register will show that Mrs Ajmani'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.

Representations on sanction

The panel noted that in the Statement of Case attached to the Notice of Meeting, dated 20 October 2021, the NMC had advised Mrs Ajmani that it would seek the imposition of a suspension order for 12 months with a review if the panel found Mrs Ajmani's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Ajmani'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:

- No engagement with the NMC.
- No evidence of insight, remorse or remediation.
- Conduct which put vulnerable patients at risk of suffering harm and impacted follow up care.
- Repetition of conduct over a significant period of time, since 2007.
- Subject to previous regulatory proceedings for similar concerns.

The panel also took into account the following mitigating feature:

- No known direct patient harm.

The panel had regard to contextual factors but considered that a significant amount of support was offered to Mrs Ajmani by management and other members of staff at the Trust. 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 not protect the public or satisfy 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 Ajmani'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 Ajmani'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 a conditions of practice order on Mrs Ajmani'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 and determined that there are conditions that could be formulated as the issues identified relate directly to Mrs Ajmani's clinical practice. However, the panel noted that it had not been provided with any information regarding Mrs Ajmani's current circumstances and in particular whether she is currently working. The panel did not receive any evidence of remediation or insight and was not aware if Mrs Ajmani would be willing to submit to and comply with conditions. In these circumstances the panel concluded that workable conditions could not be formulated, which would adequately protect the public and meet the public interest and uphold proper standards.

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:

- No evidence of harmful deep-seated personality or attitudinal problems;
- 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 a significant history of repetition of similar concerns dating back to 2007. Further, the panel also noted that since these risks were identified, Mrs Ajmani has had a significant period of time to address them, but as of yet, has not done so to the panel's knowledge.

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

The panel noted the hardship such an order will inevitably cause Mrs Ajmani. 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 to protect the reputation of the profession.

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

Any future panel reviewing this case would be assisted by a statement from Mrs Ajmani indicating her intentions for future practice either as a nurse or health visitor. If she intends to return to practice then the reviewing panel would be further assisted by:

- Engagement with the NMC and her attendance at the next review
- A reflective piece addressing her failings and the impact of her actions on health visiting practice and the wider profession
- A clear plan detailing how Mrs Ajmani will or has addressed her clinical failings and strengthened her practice
- Testimonials from any employment paid or voluntary.

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

Representations on interim order

The panel took account of the written representations made by the NMC that an interim order is required to protect patients and is also in the public interest. The NMC submit that an interim suspension order for 18 months is necessary to cover any possible appeal period.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover 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 Ajmani is sent the decision of this hearing in writing.

That concludes this determination.