Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 13 August 2025 – Thursday 21 August 2025

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

Name of Registrant:	Patience Kandenga
NMC PIN:	18A1835E
Part(s) of the register:	Nurses part of the register – sub part 1 Registered Nurse (RNC) – Children (18 March 2018)
Relevant Location:	Bournemouth
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia CBE (Chair, Lay member) Emma Quinn (Registrant member) Kamaljit Sandhu (Lay member)
Legal Assessor:	Nicholas Baldock
Hearings Coordinator:	Antonnea Johnson (13 – 21 August 2025) Abigail Addai (21 August 2025)
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Patience Kandenga:	Present and represented by Mr Jon Trussler, Royal College of Nursing (RCN)
Facts proved:	Charges 1a)v), 1b)i), 1b)ii),1e)i), 1e)ii), 1e)iii), 2a), 2b)
Facts proved (by way of admission):	Charges 1a)i), 1a)ii), 1a)iii), 1a)iv), 1b)iii), 1b)iv), 1b)v), 1b)vi), 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v), 1f), 3a)

Facts not proved:	Charges 1a)vi),1d), 3b)
Fitness to practise:	Stage not reached
Sanction:	Stage not reached
Interim order:	Conditions of Practice Order (12 months)

Preliminary matters - Day one

At the outset of the hearing, Mr Brahimi, on behalf of the Nursing and Midwifery Council (NMC), addressed the panel on the cause for the delays to the start of the hearing. He submitted that it was understood that the NMC had circulated the relevant evidence bundles, including seven hours of Closed Circuit Television (CCTV) footage relating to concerns raised about the care given to Patient A, which had been sent to all parties including you and your Royal College of Nursing (RCN) representative in 2023. Both Mr Trussler, your representative, and you advised the panel that you had received the bundles three days before the hearing. However, you had only received the CCTV footage on Tuesday 12 August 2025 at 16:20 and were unable to access and view the footage prior to the commencement of the hearing due to access permissions and device compatibility.

Mr Brahimi submitted that it would be in the interests of justice for you and Mr Trussler to have sight of the CCTV footage.

Mr Brahimi advised the panel of the intended collaboration with you, Mr Trussler and the Hearings Coordinator to troubleshoot the technical issues to allow you access to the CCTV footage. He submitted that some time was needed to assist you and suggested a postponement of the hearing would be appropriate in order to facilitate this.

Mr Brahimi submitted that when access to the CCTV footage was obtained by you and Mr Trussler, it would be fair and just for you to be given the requisite time to review the footage and for Mr Trussler to then take instructions from you.

Mr Brahimi therefore submitted opening the case and dealing with preliminary matters on day two of the hearing.

Decision and reasons on postponement – Day one

In considering this matter, the panel had regard to all information before it together with the submissions of counsel.

The panel accepted the advice of the legal assessor.

The panel referred to Rule 32 and had regard to the public interest in the expeditious and proper disposal of these proceedings, the inconvenience to any party and the overall principle of justice and fairness to the registrant.

The panel was of the view that a postponement for the remainder of the day was fair to you and Mr Trussler and would allow you the opportunity to access and review the evidence in its entirety.

The panel noted that the day's postponement may cause potential inconvenience to Witness 1 but was of the view that the aforementioned reasons outweighed this, and that in any event the Hearing coordinator would keep Witness 1 informed and check on their availability through the days ahead.

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

At the outset of the hearing, Mr Brahimi made a request for this case be held partly in private on the basis that some of the evidence cannot be adduced without reference to [PRIVATE] and references to/viewing of CCTV footage which gives rise to issues of privacy. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Trussler, on your behalf, indicated that he supported the application in respect of [PRIVATE], and the CCTV footage.

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

The panel decided it would be appropriate to go into private session in respect of [PRIVATE], that include references to the viewing of CCTV footage as and when such issues are raised in order to preserve their dignity and privacy.

Details of charge

'That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

    a) Created inaccurate records in that you recorded:

        i) That you had administered water at 01.30 and 03.30 when you had not;

        ii) That their oxygen saturations and heart rate were being continuously monitored by way of probe between 02.49 and 05.00 when they were not;

        iii) That they were receiving oxygen at 03.00 and 04.00 when they were not;

        iv) Vital sign observations which had not been taken adequately, or in the alternative, had not been taken at all;

        v) No clinical concerns when they had had one or more seizures;

        vi) Having carried out a medication check and found no issued when their Gabapentin was out of date

b) Provided a poor standard of care in that you:

   i) Failed to deliver them sufficient water;

   ii) Removed their continuous oxygen and heart rate monitor;

   iii) Failed to carry out vital sign observations adequately or, in the alternative, failed to carry them out at all;

   iv) Slept while on waking duty;

   v) Used your personal mobile phone while on duty;

   vi) Failed to carry out instructions in their care plan when they experienced seizures

c) Failed to make accurate and contemporaneous records of:

   i) The times and frequency of the administration of water;

   ii) Oxygen saturations;

   iii) The delivery of oxygen;

   iv) Vital sign observations;

   v) Seizures

d) Administered medication that had expired.

e) Followed poor manual handling practices in that you:

i) Failed to use a hoist in lifting them out of bed;

ii) Failed to follow their care plan for positioning them in bed;

iii) Failed to follow standard procedures in removing their nasal cannula.

f) Failed to wear a mask or gloves when providing care.

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate
b) you intended to mislead others.

3) In relation to Patient B:

a) Between the 30 December 2020 and 25 April 2021, failed to complete a prescribed safety checklist;

b) On the 19 January 2021 failed to report that medication was out of stock.

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

Background

The allegations relate to your employment by Thornbury Community Service as a registered paediatric nurse, based in the community.

You joined the register on 18 March 2018 and commenced employment as a Community Nurse through Thornbury Community Services in September 2020.

Thornbury Community Services is an agency that provides at home care to vulnerable adults and children with complex clinical care needs. It is of note that all services are provided within patients' homes with the intention of bridging acute care monitoring and treatment, otherwise delivered in a hospital setting, with the patient at home.

On 20 May 2021 the Nursing and Midwifery Council (NMC) received a referral from Parent A about concerns relating to the care of Patient A. On 29 December 2020, you provided care to Patient A for the first time. You started the shift with an additional 30 minutes in order to allow time for you to review Patient A's care plan.

The following regulatory concerns resulted in allegations being made against you in relation to your practice, specifically that during your night shift at Patient A's home between 22– 23 March 2021 you:

- Documented that you had administered water to Patient A hourly, but did not do this;
- Documented that Patient A's saturations were being monitored every hour via an oxygen and heart rate probe, when this was not the case;
- Removed Patient A's saturation probe;
- Documented that Patient A had received oxygen every hour between 22:00 – 05:00, when this was not the case;
- Inappropriately removed Patient A's nasal cannula;
- Documented observations for Patient A when you had not completed the observations adequately or at all;
- Did not document Patient A's seizures; and did not wear gloves or a mask when caring for Patient A;
- Administered out of date medication to Patient A; and
- Did not follow Patient A's care plan when moving them.

On 12 May 2021, Witness 1 audited Patient B's package of care documentation. It was at this time that Witness 1 noticed that you had:

- Documented that Patient B's Co-Amoxiclav was out of stock, but did not escalate this; and
- Did not complete shift safety checklists for Patient B on several occasions between 30 December 2020 – 21 March 2021.

Internal investigation meetings were held with you on 6 and 27 May 2021. Following the local investigation, Witness 4 held a breach of contract meeting with you. The outcome of those meetings was that your contract of employment was terminated on 28 June 2021.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Brahimi to amend the wording of charge 1a)vi).

The proposed amendment was to amend a typographical error. It was submitted by Mr Brahimi that the proposed amendment would provide clarity and more accurately reflect the evidence.

‘That you, being a registered nurse:

1. Between 22 and 23 March 2021, in relation to Patient A:

    a. Created inaccurate records in that you recorded:

        vi) Having carried out a medication check and found no ~~issued~~ **issues,** when their Gabapentin was out of date

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

The panel heard from Mr Trussler who had no objections to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to improve accuracy.

Details of charge (as amended)

'That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

    a) Created inaccurate records in that you recorded:

        i) That you had administered water at 01.30 and 03.30 when you had not;

        ii) That their oxygen saturations and heart rate were being continuously monitored by way of probe between 02.49 and 05.00 when they were not;

        iii) That they were receiving oxygen at 03.00 and 04.00 when they were not;

        iv) Vital sign observations which had not been taken adequately, or in the alternative, had not been taken at all;

v) No clinical concerns when they had had one or more seizures;

vi) Having carried out a medication check and found no issues, when their Gabapentin was out of date

b) Provided a poor standard of care in that you:

i) Failed to deliver them sufficient water;

ii) Removed their continuous oxygen and heart rate monitor;

iii) Failed to carry out vital sign observations adequately or, in the alternative, failed to carry them out at all;

iv) Slept while on waking duty;

v) Used your personal mobile phone while on duty;

vi) Failed to carry out instructions in their care plan when they experienced seizures

c) Failed to make accurate and contemporaneous records of:

i) The times and frequency of the administration of water;

ii) Oxygen saturations;

iii) The delivery of oxygen;

iv) Vital sign observations;

v) Seizures

d) Administered medication that had expired.

e) Followed poor manual handling practices in that you:

i) Failed to use a hoist in lifting them out of bed;

ii) Failed to follow their care plan for positioning them in bed;

iii) Failed to follow standard procedures in removing their nasal cannula.

f) Failed to wear a mask or gloves when providing care.

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate

b) you intended to mislead others.

3) In relation to Patient B:

a) Between the 30 December 2020 and 25 April 2021, failed to complete a prescribed safety checklist;

b) On the 19 January 2021 failed to report that medication was out of stock.

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

Preamble

Before making any findings on the facts, the panel had regard to your previous experience as a registered nurse working in collaboration with the general Paediatric and Neonatal

teams. The panel was made aware that you worked in a ward environment as a newly qualified nurse where you had gained two and a half years' experience, and would have been accustomed to receiving support from colleagues with varied experience and authority, whom you could go to for advice. The panel noted that although a relatively experienced nurse, you had spent a limited amount of time working providing one-to-one care as a nurse in the community where you did not have the same levels of support. It noted that in your reflective statement you had stated, *'…I believe I had not yet acquired enough experience as a nurse for me to fully comprehend the responsibilities that I had taken on and what was expected of me…'.*

You further told the panel that you held a sincere belief that your judgement during the shifts in question were based on providing good care to your patients. The panel also heard you say that you departed from care plans prescribed to you because you felt you knew the patients well and knew how to provide them with personalised care. Finally, you told the panel that you did all of this working alongside the parents with whom you had a close working relationship.

The panel had regard to all the documentary evidence and noted 'Thornbury Community Services Care Plan for Patient A' in addition to the Patient A's 'Suction, Dystonia and Seizure Checklist', 'Risk Assessment document relating to the Moving and Handling of Patient A', '*Meeting Minutes from Investigation meeting with Ms Kandenga on 27 May 2021'*, 'Patient A's Observation Checklist' and CCTV footage.

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

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

Decision and reasons on facts proved by admission

During the course of the hearing, the panel heard from Mr Trussler, who informed the panel that you made admissions to charges 1a)i), 1a)ii), 1a)iii),1a)iv), 1b)iii), 1b)iv), 1b)v), 1b)vi), 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v), 1f) and 3a). The panel therefore finds these charges proved by way of admission.

Decision and reasons on facts - disputed charges

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

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

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

- Witness 1: Clinical Nurse Manager at Thornbury Community Services at the time of the incidents
- Witness 2/ Parent A: Parent of Patient A, a service user, at Thornbury Community Services
- Witness 3: Clinical Lead (Paediatrics) for Thornbury Community Services
- Witness 4: Divisional Chief Nurse for Acacium Group, parent company of Thornbury Community Services

The panel also heard evidence from you under affirmation.

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

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

Charge 1)

'That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

a) Created inaccurate records in that you recorded:

v) No clinical concerns when they had had one or more seizures;'

This charge is found proved.

In reaching this decision, the panel took into account 'Patient A's Observation Checklist', 'Thornbury Community Servies Care Plan', the oral evidence from Witness 1 which was contemporaneous with the documentary and oral evidence from Witness 3. It was of the view that the evidence before it clearly established that all seizures were to be considered a clinical concern and appropriately documented.

The panel also considered your oral evidence in which you stated seizures were *'a normal part of Patient A's condition'*, and that you thought Patient A was presenting *'normally'*

during the night 23 March 2021 and that you did not feel it necessary to document them as a matter of concern.

The panel had regard to 'Thornbury Community Services Care Plan - Seizure Management (Process)' record which states, *Please monitor me for signs of seizure presentation...'* and *'…Document all observations and actions in record of events and MAR chart ensuring in timely and accurate fashion...'.* The panel determined that you had sufficient time to review Thornbury Community Services' care plan at the start of your shift and that you should have been aware that seizures should always be regarded as a clinical concern and should have documented them in Patient A's 'Observation Checklist' despite your personal view that seizures were part of Patient A's condition. The panel also noted no entries on the 'Suction, Dystonia and Seizure Checklist' which required a detailed recording of seizures. It also had sight of your handwritten note on 23 March 2021 stating, *'no overnight clinical concerns'*.

The panel therefore found this charge proved.

Charge 1)

'That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

a) Created inaccurate records in that you recorded:

vi) Having carried out a medication check and found no issued when their Gabapentin was out of date'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Parent A, in addition to reviewing the 'Daily Checklist' and your oral evidence. The panel first had regard to the fact that Gabapentin is a controlled drug which always requires a second check before being administered. The panel heard evidence from Parent A who said that they had been advised of the expiry of Gabapentin by Patient A's [PRIVATE]. The panel also considered the evidence in the daily checklist from 22 March 2021 which had been ticked and signed for by you suggesting that the Gabapentin was in date and administered. The panel noted in your oral evidence that you stated, *'…I recall the medication was not expired…'*.

On the balance of probabilities, given the conflicting accounts before it, and the absence of the bottle of medication with its labelling or direct evidence from [PRIVATE], the panel finds that the NMC has not discharged its burden of proof and therefore finds this charge not proved.

Charge 1

'That you, being a registered nurse:

b) Provided a poor standard of care in that you:

i) Failed to deliver them sufficient water;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence from Witness 1 and Witness 3, in conjunction with reviewing 'Patient A's Suction, Dystonia and Seizure Checklist - Fluid Balance Chart' and Patient A's 'Thornbury Community Services Care Plan'. The panel noted that Patient A had been prescribed water enterally to be administered via Patient A's gastrostomy as a bolus of 20 mls every hour.

Taken together, this clearly establishes a duty upon you as part of Patient A's care plan. The panel next considered your hand written entry in Patient A's fluid balance chart which noted you had administered 30mls of water as a bolus, on 22 March 2021 at 23:30, on 23 March 2021 at 01:30, 03:30 and 05:30 totalling 120mls every other hour. This fell 20 mls short of the prescribed minimum of 140 mls in Patient A's care plan. During the internal investigation you also admitted administering a bolus of 90 mls and 30 mls which again amounted to 120 mls and fell short of the prescribed minimum.

You made admissions to this in your oral evidence in which you stated, *'…the care plan had been updated and water was to be given to Patient A every other hour'*. You also said in oral evidence *'I never gave him water every hour…I gave 120 that was not sufficient and I admit it was a poor standard of care'*.

In light of the above, the panel found the water you gave to Patient A was not as per the minimum prescribed in the care plan and was therefore insufficient. It therefore found this charge proved.

Charge 1

'That you, being a registered nurse:

b) Provided a poor standard of care in that you:

ii) Removed their continuous oxygen and heart rate monitor;'

This charge is found proved.

In reaching this decision, the panel took into account Patient A's care plan which states, *'I have a low heart rate 40-60bpm when asleep and above 60bpm when awake. At times of dystonic episodes or seizures my heart rate can escalate to over 200bpm.'* This information clearly identifies the risks to Patient A if they are not continuously monitored

whilst asleep. The panel also had regard to Witness 1's oral evidence in which she stated, *'…There was no other way to monitor Patient A's stats* [sic]*'.*

It also viewed the CCTV footage and concluded that there was clear evidence that you had removed the oxygen and heart rate monitor and that you made no attempts to reattach it during your shift which was in line with your admission during your oral evidence. The panel also referred to the *'Meeting Minutes from Investigation Meeting with Ms Kandenga on 27 May 2021'*, where you were asked why you removed the monitor and you stated, *'Because he didn't want it, I felt that he, there is a way of his communication that he doesn't want this that is how I felt at this time?* [sic]*'.* You were then asked during the investigation meeting '*How often does Patient A require his heart rate and oxygen levels monitored by the saturation monitor as per the care plan?'* You replied, *'I think if he is asleep he needs monitoring, but if he is awake it is to his discretion.'*

The panel was concerned about the risks this represented to Patient A and had regard to the care plan, which clearly says, '*I require continuous monitoring visually and need to be monitored via my saturation monitor as I fall asleep and when I am asleep.'* For the panel this represents another example of where you departed from the care plan and took discretionary action. After viewing the CCTV footage it accepted that Patient A was without his monitor between 02:46 and 05:00 on 23 March 2021 and appeared to be asleep or attempting to settle to sleep.

In light of the above, the panel found this charge proved.

Charge 1

'That you, being a registered nurse:

d) Administered medication that had expired.'

This charge is found NOT proved.

The panel noted that this sub-charge depends on the same set of facts relating to charge 1a)vi) and therefore considered the relevant evidence relating to them together before reaching a determination in respect of each sub-charge.

Consistent with its conclusion on charge 1a)vi) found that on the balance of probabilities, given the conflicting accounts in addition to the absence of the bottle in question, the lack of direct evidence from the school and having regard to the records, the NMC has not discharged its burden of proof.

Therefore, the panel finds this charge not proved.

Charge 1

'That you, being a registered nurse:

e) Followed poor manual handling practices in that you:

i) Failed to use a hoist in lifting them out of bed;'

This charge is found proved.

In reaching this decision, the panel took into account the CCTV footage, your oral evidence, the evidence from Witnesses 1 and 3 and the documentary evidence before it. The panel bore in mind the care plan which states, *'…Never pick me up please use my hoist and the sliding sheets to do any manual handling…'*. It also noted your attendance and certification for the 'Core Skills Certificate of Attendance…Moving & Handling' on 24 September 2020.

Taken alongside your oral evidence in which you agreed that lifting Patient A was a departure from the prescribed care plan, the panel came to the conclusion that this was

another example of where you say you acted in Patient A's best interest but departed from your duty under the care plan which the panel considers to be clear and specific. You went on to say that you may have relied on your maternal instincts*, 'I used my intuition, it's not evidenced based…I felt he needed to feel a physical touch', and '…putting him in the hoist upsets him and I have to calm him before he settles'.* You further stated that Patient A was 21 kilograms at the time and that you had lifted him before and therefore you felt confident in handling him in this way without causing him or you any harm. Despite your assertions, the panel concluded that you had a clear understanding of the risk to both you and Patient A as you had stated during oral evidence, *'I could have dropped him, I could have hurt myself and I could harm him'.*

It concluded that the CCTV footage along with the accounts from Witnesses 1 and 3 and your admission to lifting Patient A were contemporaneous. In light of the above, the panel found that you were in fact following poor manual handling practises and therefore finds this charge proved.

Charge 1

'That you, being a registered nurse:

e) Followed poor manual handling practices in that you:

ii) Failed to follow their care plan for positioning them in bed;'

This charge is found proved.

In reaching this decision, the panel took into account Thornbury Community Services digital Risk Assessment form completed on 27 February 2020 which notes a sliding sheet as the appropriate equipment to use when moving Patient A. The panel also had regard to Patient A's care plan which states, *'…I will be trialling sliding sheets, they are not yet in the home but when they are please can they be used…'* and noted contradictions between it

and the risk assessment. However, the panel also had regard to 'Thornbury Community Services Care Plan for Patient A - Manual Handling' which states as a goal *'to be safely and effectively supported by manual handling'*. The panel therefore found there to be a duty to use safe, standard manual handling techniques when positioning Patient A. For the avoidance of doubt, the panel found no difference between positioning and repositioning.

The panel found, having viewed the CCTV footage, you had demonstrated poor manual handling practises by using Patient A's sleeping bag to move them. In oral evidence, you accepted that there were risks to Patient A in that way.

In its consideration, the panel concluded that there was a duty for you to adhere to safe manual handling practises which you did not do. In light of the above, the panel finds this charge proved.

Charge 1

'That you, being a registered nurse:

e) Followed poor manual handling practices in that you:

iii) Failed to follow standard procedures in removing their nasal cannula.'

This charge is found proved.

In reaching this decision, the panel took into account the CCTV footage and the written and oral evidence from Witness 3. The panel considered the account of Witness 3's review of the CCTV footage and noted she did not say you had caused any harm to Patient A. The panel bore in mind that Witness 3 had identified and documented in her CCTV review, that Patient A's head was rebounding onto the pillow as you removed the cannula from his head, suggesting the cannula was still attached to Patient A's head. The

panel also considered your oral evidence in which you stated, *'…it was half off and he wanted it off…'* and *I do not see myself hurting him…'.* The panel also gave consideration to your oral evidence in which you agreed that basic care required you to be gentle and lift Patient A's head to remove the nasal cannula.

Having had regard to all the evidence before it, including our own careful review of the CCTV footage, the panel concluded that the removal of the cannula required a degree of delicacy which you did not demonstrate. It also regarded your actions as reflecting a poor standard of nursing in that there was a risk of harm.

In light of the above, the panel found this charge proved.

Charge 2

'That you, being a registered nurse:

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate'

This charge is found proved.

When considering the issue of dishonesty, the panel applied the test set out in the case of *Ivey*:

'*1. The Panel must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his/her belief is a matter of evidence going to whether he/she held the belief, it is not an additional requirement that his/her belief must be reasonable; the question is whether it is genuinely held;*

1. *Once his/her actual state of mind as to knowledge or belief as to facts is established, the question whether his/her conduct was honest or dishonest is to be determined by the Panel by applying the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what he/she has done is, by those standards, dishonest.*'

The Panel noted that the allegations related to all elements of charge 1a) as either admitted or found proved. However it accepted the advice of the Legal Assessor that although a finding of dishonesty in relation to one or more of those elements was enough, it would be appropriate to indicate which element was found proved as dishonest and which were not. Mr Brahimi and Mr Trussler agreed with that advice.

In general the panel carefully considered your evidence that at the time of the allegations you used a jotter as an informal way to note events which you would later transcribe into Patient A's records. It also found that during your oral evidence you demonstrated an understanding of the necessity to make accurate entries of Patient A's overnight care and condition. The panel further had regard to your acknowledgment, in the *'Meeting minutes from investigation meeting with Ms Kandenga on 27 May 2021'*, in which you stated, *'I jot sometimes, probably I do try and rely on my memory, which is something I can now tell I cannot do that [sic]. It is not something I should rely on. Now I think we can see in the documentation, that relying on your memory can lead to incorrect documentation'.*

Having had regard to the evidence before it, the panel determined that it was more likely than not that you knew you had created inaccurate entries (which the Panel has found they were) on Patient A's record by using the jotter and partially relying on your memory. The panel noted that this action was likely a repercussion of you rushing to complete Patient A's records at the end of your shift.

Having considered the facts generally, the panel went on to consider dishonesty in charge 2a) specifically in relation to charges 1a)i) to 1a)v) individually. The panel noted that these

sub-charges arise from the same set of facts and therefore could consider them together before reaching a determination in respect of each sub-charge.

In relation to charges 1a)i) to 1a)iv) the Panel found that the test of dishonesty was met. Having found that you knew the entries were inaccurate the panel has determined that a reasonable person would consider them dishonest in all the circumstances. Those circumstances include the duty on you to keep accurate records as part of Patient A's care plan.

The panel went on to consider the charge of dishonesty in relation to charge 1a)v). It considered Patient A's care plan has a clearly set out action plan and noted that by you omitting an entry into Patient A's record, you had not told the whole truth about Patient A's overnight condition and in particular seizures which the panel is satisfied did take place.

The panel was of the view that you had intentionally omitted making the entry in Patient A's record. However, the panel has decided that you had a genuine belief there was no clinical concern that required recording as you considered seizures as part of Patient A's 'normal' condition and a regular occurrence.

The panel therefore accepts that on the balance of probabilities, you were not acting dishonestly and therefore finds this charge not proved.

The panel did not need to consider the charge of dishonesty in relation to charge 1a)vi) given that it was found not proved.

Charge 2

'That you, being a registered nurse:

2) Your actions at 1) a) were dishonest in that:

b) you intended to mislead others.'

This charge is found proved.

The panel adopted the same procedural approach to this charge as it did to that on 2a) and repeats and adopts the findings made in relation to it.

The panel was of the view that you knowingly gave a false impression to the reader of the relevant records that the important duties that you were supposed to have completed had been completed, when you knew they had not. After careful consideration, the panel found the only explanation to be that you intended to create a false impression to the reader, and therefore found that you dishonestly intended to mislead. As a result, the panel was of the view that the charge of dishonesty (applying the test as advised above) as it relates to charges 1a) to 1a)iv) are found proved.

For the same reasons as set out above in relation to 1a)v) dishonest misleading is not proved.

Charge 3

'That you, being a registered nurse:

3) In relation to Patient B:

b) On the 19 January 2021 failed to report that medication was out of stock.'

This charge is found NOT proved.

In reaching its decision the panel took into account the evidence before it which included Patient B's Medicine Administration Chart (MAR Chart) and your oral evidence. The panel gave careful consideration to your account that Patient B had been prescribed 14 days of Co-Amoxiclav however, only 7 days of this had been dispensed. You said, once the first 7

days of tablets had run out, the GP decided not to continue with the remaining 7 days but instead to resume with the patient's normal prescription of Azithromycin. The panel also had regard to your account during your oral evidence in which you stated that Azithromycin was Patient B's regular and continuous antibiotic and could not be given to the patient whilst they were taking Co-Amoxiclav. The panel found your evidence to have aligned with the dates of the medication being prescribed contemporaneous with the MAR chart.

The highest that the NMC put its case was that there was an implied duty to report the lack of stock to the Regional Clinical Lead (RCL). The panel did not accept that submission.

Therefore, it found this charge not proved.

Submissions on interim order

The panel took account of the submissions made by Mr Brahimi. He submitted that the NMC is asking for an interim conditions of practice order for a period of 18 months. Mr Brahimi submitted that this will cover the appeal period should an appeal be lodged. He submitted that an interim conditions of practice order is important given the panel have found the dishonesty and misleading charges proved. He invited the panel to make the interim conditions of practice order on the grounds of public protection and in the wider public interest because of the risk of harm identified, your record keeping and the way you manoeuvred Patient A.

Mr Trussler did not oppose the application.

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

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 in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The panel took into account the submissions from both parties and its finding on fact. It noted that you were in charge of a vulnerable child who was non-verbal and had mobility issues. Taking all the charges together, the panel determined that this raises concerns about whether you understood the gravity of the regulatory concerns and the charges found proved, which go to basic nursing practice.

The panel next took into account the dishonesty charges which was also found proved. It noted that the charges relates to you exercising your own discretion and not following the duties and responsibilities in the care plan and going on to make dishonest records in that regard. In light of this, the panel concluded that you had departed from the fundamental tenets of the nursing profession.

In respect of proportionality, the panel began with the least restrictive sanction, namely an interim conditions of practice order. It determined that it could find workable, appropriate and proportionate conditions which would adequately protect the public and address the public interest concerns.

The panel determined that the following conditions would be workable and proportionate whilst covering the risk it identified:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also,

‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer’s contact details.

2. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

4. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

5. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

6. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from your line manager.

7. You must ensure that you are supervised by a Band 5 nurse at any time you are working. Your supervision must consist of:

   - Working at all times while being directly observed by a registered nurse of a Band 5 or above.

8. You must keep a personal development log on a monthly basis, including written reflections from a Registrant who has supervised you. The log must include actions you have undertaken to address learning and practice related to:
   - Duty of Candour
   - The Manoeuvring and Handling of Patients
   - Record Keeping

9. You must keep a personal reflective practice profile recording written reflections on a monthly basis. The profile must include actions you have undertaken to address

learning and practice related to:

- Duty of candour
- The Manoeuvring and Handling of Patients
- Record Keeping

The panel decided to make this order for a period of 12 months.