Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Tuesday, 7 October 2025

Virtual Hearing

Name of Registrant:	**Abiodun Folasade Adejumo**
NMC PIN:	03J0403O
Part(s) of the register:	Nursing – Sub Part 1 RN1: Adult Nurse, Level 1 (10 October 2003)
Relevant Location:	Edinburgh
Type of case:	Misconduct
Panel members:	Susan Ball (Chair, registrant member) Anne Murray (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Hala Helmi
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Mary Kyriacou, Case Presenter
Mrs Adejumo:	Present and represented by Christie Wishart, Thompsons Solicitors
Order being reviewed:	Conditions of practice order (36 months)
Fitness to practise:	Impaired
Outcome:	**Conditions of practice order (9 months) to come into effect at the end of 10 October 2025 in accordance with Article 30(1)**

Decision and reasons on review of the substantive order

The panel decided to confirm the current conditions of practice order.

This order will come into effect at the end of 10 October 2025 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive conditions of practice order originally imposed for a period of 36 months by a Fitness to Practise Committee panel on 7 September 2022.

The current order is due to expire at the end of 10 October 2025.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, a registered nurse and registered manager of Standard Care Recruitment Limited ["Standard Care"]:

1) *Failed to ensure Care Manager X was registered with the Scottish Social Services Council ["SSSC"] appropriate to his role within six months of commencing employment.*

2) *In around January 2018, failed to take any or any appropriate action on learning the Disclosure Scotland was considering including Care Manager X on their adult's list.*

3) *Did not ensure one or more service users' care plans and/or care records were of adequate quality, in that:*

    a) *On an unknown date, there was no care plan included within Service User B's care folder;*

b) On one or more unknown dates, carers attending Service User D did not record:

i) The time their visit concluded,
ii) What care had been provided,
iii) When medication had been administered,
iv) Their full names, only marking their initials;

c) Service User D's records did not contain:
i) Personal details for Service User D,
ii) Emergency contact details,
iii) Details of Service User D's GP,
iv) Details of what needed to be completed on each visit.

4) Did not ensure adequate systems were in place to allow service users and/or their families to raise concerns about Standard Care directly with you.

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

a) On an unknown date in around October 2018, Service User B's catheter was left closed;

b) On one or more occasions on unknown dates, carers pulled Service User B up by his armpits rather than using a hoist;

c) On around 1 September 2018, Service User D's son had to teach carers how to use the bath seat as she had not been given a bath for around 10 days;

d) On one or more occasion carers did not ensure Service User D was wearing her falls bracelet;

6) *Did not ensure carers followed advice or instructions of medication professionals in that in around October 2018 Service User B was moved from his bed against the instructions of his Marie Curie Nurses.*

7) *On or around 25 October 2018, following Care Manager X's dismissal, failed to promptly make a formal report of his misconduct to:*

   a) The Care Inspectorate;
   b) SSSC.

8) *On one or more of the following occasions, failed to ensure service users were visited by carers at their scheduled times or at all:*

a) On 26 October 2018 no carer attended Service User B;

b) On an unknown date in or around October 2018, no carer attended Service User B until 11:40pm;

c) On 25 October 2018, no carer attended Service User C;

d) …

e) On 16 August 2018, no carer attended Service User D for the morning visit;

f) On 29 August 2018, a carer attended Service User D:

i) At 2:49pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
ii) At 5:49pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

g) On an unknown date, a carer attended Service User D at 3:14pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

h) On 31 August, carers attended Service User D at:

i) 9:15am for the morning visit, which was scheduled for around 8:00am,
ii) 2:24pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
iii) 4:47pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

i) On 8 October 2018, a carer attended at 2:52pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

j) On 25 October 2018, no carer attended Service User D to assist with her bedtime routine;

k) On 26 October 2018 no carer attended Service User D for the first two scheduled visits of the day;

l) On 27 October 2018 no carer attended Service User D for the morning visit;

m) On 27 October 2018, Service User D was not attended to until 2:15pm;

n) On 27 October 2018, you did not attend the evening visit until 10:00pm;

o) On 28 October 2018, you was late attending Service User D;

p) On 29 October 2018, no carer had attended Service User D until 9:20pm;

q) On 26 October 2018, no carer attended Service Users E and F until 2:15pm;

r) On 25 October 2018, no carer attended Service User G's visit scheduled for 5:00pm until 9:35pm;

s) On 26 October 2018, no carer attended Service User G's visit scheduled for 9:30am until 10:40am.

9) Did not notify the care inspectorate of one or more of the late and/or missed visits to service users referred to in charge 8 above.

10) On or after 29 October 2018, did not follow the contingency plan when closing Standard Care.

11) Did not ensure you had unfettered access to:

a) Standard Cares' office

b) Care files of service users

12) Did not ensure you had adequate knowledge of the service provided by Standard Care to ensure patient safety.

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

The original panel determined the following with regard to impairment:

'Whilst the panel did not have any evidence of any actual harm caused to the service users as a result of your misconduct, the panel was satisfied that the service users were put at significant risk of harm by your misconduct. Service users were left on numerous occasions with no care provided, which required family members to step in to support. Furthermore, your Care Manager continued in his role without being properly registered with the SSSC and without the checks required by Disclosure Scotland. By your own admission you did not ensure that you had adequate knowledge of the service being provided by your own agency to ensure patient safety.

The panel found that while you demonstrated remorse and had good insight into the impact of your failures on service users, your insight into the impact of your conduct on colleagues and the wider profession was still developing. Much of your reflection focussed on the difficulties that your relationship with your Care Manager caused. The panel accepted that you were working in challenging circumstances. However,

the panel was of the view that you had not reflected fully on your own competence in managing the difficulties that arose, or on your own limitations and managerial capabilities.

The panel carefully considered the evidence before it in determining whether you have taken steps to remediate and strengthen your practice. The panel acknowledges that you stated you are up-to date with your training and that you have been practising as a nurse since these allegations arose. However, the panel had no evidence before it that you had completed recent relevant training related to, for example, leadership and management, safer recruitment processes or relevant regulatory frameworks. You provided a positive testimonial from your line manager in your current nursing role but this did not attest to your managerial skills.

The panel is therefore of the view that there is a risk of repetition should you be in a similar managerial situation again. It considered that you have not fully reflected on the role you played in respect of the serious failings at the agency, despite the significant passage of time. Further the panel considered that you have not reflected fully on your own limits and capabilities when faced with the challenges the agency presented. You have described the significant impact these proceedings have had on you but you do not appear to have fully considered how you would do things differently if faced with a similar challenging situation. Rather, you have responded by stating you will never set up an agency again. The panel recognised that you have not had a managerial role since 2018 and have stated you have no intention of returning to such a role. However, the panel is of the view that this further emphasises that your practice remains impaired. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

of all the circumstances of your case, would expect a regulator to take action to uphold proper professional standards, given the significant failures identified. The provision of regular and reliable care to elderly and vulnerable service users is fundamental to the effective provision of care services and your failure to run the agency competently in this respect means that a finding on public interest grounds is also required.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds your fitness to practise impaired on the grounds of public interest.

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

The original panel determined the following with regard to sanction:

'Having found your 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:

- *Your conduct put vulnerable service users at risk of harm;*
- *A number of service users were impacted by your actions; and*
- *Your poor management skills were demonstrated on multiple occasions.*

The panel also took into account the following mitigating features:

- *You made admissions to the majority of the charges, when the allegations first came to light;*
- *There is no evidence of general incompetence as a nurse;*

- *Your insight is developing;*
- *You have demonstrated genuine remorse for your failings;*
- *You have practised for 38 years without there being a complaint to your regulator, other than on this occasion; and*
- *The events laid out in the charges happened at a time of considerable personal stress.*

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the failings that need to be addressed before you could practice without restriction. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified, given the potential harm to a number elderly and vulnerable patients on a number of occasions. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the guidance about when the conditions of practice order may be appropriate and determined that the following points were applicable in your case:

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practicable conditions which would address the failings highlighted in this case. The panel considered that there was no indication that you would be unwilling to comply with a conditions of practice order.

The panel noted that the concerns were centred around your poor managerial skills. It also had regard to the fact that these incidents happened a long time ago and that, other than these incidents, you have had an otherwise unblemished career of 38 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel determined that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case, because a conditions of practice order is the least restrictive order that would sufficiently address the concerns identified in your practice, protect the public and meet the public interest.

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

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

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 not set up an agency or business that provides any nursing or care to clients.*

2. *You must not take on any new managerial nursing or care position that requires you to directly line manage other members of staff unless you are supervised by a line manager. In this situation, your supervision must consist of fortnightly meetings to discuss your managerial responsibilities. These should include (but are not restricted to):*
    - *your monitoring of your line reports' performance and capabilities*
    - *communication with relevant stakeholders to maintain patient safety*
    - *the effectiveness of any care plans that are completed by your team*
    - *upholding regulatory responsibilities as appropriate.*

3. *If you are employed in any managerial role requiring you to directly line manage other members of staff, you must keep a reflective practice profile. The profile will:*
    - *Detail each line report for whom you are responsible*
    - *Set out the actions you have taken to ensure that your line report practises safely and effectively*
    - *Be signed by your own line manager each time*

- *Contain feedback from those who are your direct line reports on the effectiveness of the support you have given them in fulfilling their roles.*

4. *You must keep us 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.*

5. *You must keep us 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.*

6. *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.*
   e) *Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.*

7. *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.*

8. *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.*

The period of this order is for 36 months. It determined that a period of 36 months would allow you to continue to practise in your current role as a nurse while at the same time giving you opportunity to develop your insight. Further, it will allow you to undertake any relevant training you may wish to complete should you decide you wish to take on any new managerial position in the future. The panel also considered that an order of 36 months meant that you would not be required to return to the NMC for frequent reviews if you decided that you did not wish to take up any managerial position. The panel was satisfied that in the event that you have fulfilled the requirements of the conditions of practice order earlier, then you can request an early review.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.'

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to

practise as a registrant's ability to practise safely, kindly and professionally. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel heard live evidence from the following witness called on your behalf:

- Witness 1: A company director which you were involved in.

Witness 1 gave evidence in relation to a company which he had been a director of and your involvement with the company.

The panel has had regard to all of the documentation before it, including the NMC bundle, and a bundle of documents including reflections from you. It has taken account of the submissions made by Ms Kyriacou on behalf of the NMC.

Ms Kyriacou submitted that this is the first effective review of that order after earlier hearings were postponed. The order arose from concerns about your conduct while running a home care agency, which led to a referral to the NMC in 2018. The agency had provided care for elderly and vulnerable service users in Edinburgh before you closed it following a series of complaints and staffing issues.

Ms Kyriacou reminded the panel that the original panel found you had failed to ensure proper systems were in place, resulting in poor management and placing service users at risk of harm. Although there was no evidence of actual harm, the failings exposed vulnerable people to significant risk. The original panel accepted that you showed remorse and some insight into the impact of your actions, but found that your insight, and therefore the outcome of your own managerial shortcomings and the wider impact on the profession remained limited. Your fitness to practise was therefore found to be impaired on the grounds of both public protection and public interest.

Ms Kyriacou highlighted that the original panel had identified both aggravating and mitigating factors. The aggravating features included the risk posed to vulnerable service

users and repeated management failings. Mitigating factors included your genuine remorse, developing insight, and an otherwise unblemished nursing career. That panel considered the conditions of practice to be appropriate and proportionate, and advised that any future review would be assisted by your attendance, a detailed reflective piece, evidence of professional development and training, and positive testimonials.

Ms Kyriacou submitted that while you have provided positive testimonials and a reflective piece, there remains limited evidence of completion of the specific training previously identified, such as leadership, safer recruitment, and regulatory compliance. She submitted that your reflections continue to focus heavily on the challenges you faced with your care manager rather than demonstrating full accountability for your own managerial failings or recognition of your limitations.

Ms Kyriacou drew the panel's attention to a document suggesting that you may currently be working as a nurse manager, which could indicate a breach of your conditions of practice order. Although, Witness 1 stated that you did not carry out managerial duties. Ms Kyriacou submitted that if you have indeed undertaken such a role, this may amount to non-compliance with your conditions. She concluded by reminding the panel of its powers to extend, vary, or revoke the order, or, if there is sufficient evidence of breach, to consider a more serious sanction, namely a strike off order. Ms Kyriacou went onto submit that if the panel found that there were no breach in the conditions, then the NMC remains neutral and left the decision to the panel.

The panel also had regard to the submissions of Ms Wishart, made on your behalf. She directed the panel's attention to the positive testimonials you have submitted, highlighting that patients and their families have recognised the safe, effective, and compassionate care you consistently provide. She submitted that these testimonials demonstrate your commitment to professional standards and your ability to practise safely.

Ms Wishart reminded the panel that you have shown genuine remorse and insight from an early stage. Your written reflections clearly evidence a deep understanding of the issues that led to these proceedings, and you have taken full accountability for your actions. Ms Wishart said that you have done everything asked of you by previous panels, and your development has been clearly demonstrated.

Ms Wishart submitted that your current manager is satisfied with your performance and supports your return to unrestricted practice. There have been no concerns raised about your clinical work or conduct, and you have maintained the confidence of both colleagues and service users. On that basis, Ms Wishart submitted that public protection and the wider public interest are no longer live.

Ms Wishart referred the panel to the clarification provided by Witness 1. She drew attention to the appraisal summary document of 12 June 2025, where she clarified that the final two pages of that document, which included a reference to you working as a nurse manager, was a historic record from 2018 and unrelated to your 12 June 2025 appraisal summary document. She reminded the panel that the email exchanges between the NMC and herself on 8 November 2022 and 10 September 2025 confirmed this point, and it was her understanding that the NMC accepted that clarification. Ms Wishart submitted that you have therefore not worked in breach of the conditions.

Ms Wishart also submitted that condition 3, which required compliance in relation to management duties, was unnecessary, as you have not worked in a managerial role since 2018.

Ms Wishart submitted that the conditions currently in place have served their purpose and should now be lifted entirely. The previous panel had indicated that you needed to demonstrate development, and that has now been achieved. There is no evidence of ongoing risk, and you have done all you reasonably can to address the concerns. However, if the panel is minded to impose a further restriction, Ms Wishart submitted that it should be a conditions of practice order for a further six months.

Ms Wishart stated that there is no further evidence you could realistically provide, and that a striking-off order would be wholly disproportionate and inappropriate in light of your progress, insight, and continued safe practice.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel took into account the evidence of Witness 1 and the documentary evidence and concluded that you had not breached the conditions by working in a managerial position in any capacity during the life of the conditions of the practice order.

The panel accepted that you are a safe and competent nurse in your current Band 5 role and that there are no concerns regarding your clinical practice. However, the panel found that your fitness to practise remains impaired.

The panel took into account the documents that you have submitted, including the evidence of the training which you have undertaken, your reflective accounts, your testimonials, and the practice feedback. However, it noted that your reflective statement was largely a chronology of events and did not demonstrate sufficient insight into your accountability and professional responsibility as a registered nurse at the time of the incidents. The panel noted that your reflective statement had failed to address how you would work differently, to ensure that proper systems were in place, to prevent the repetition of the poor management practice on your part that placed service users at risk of harm. It also noted that you have not shown full understanding of the potential risk to patients, the point at which you should have recognised that risk, or the actions you could have taken to prevent it.

The panel was of the view that while you have shown some insight and remorse, it concluded that you have not yet demonstrated a comprehensive understanding of your duty to safeguard patients and uphold professional standards in all settings. The panel concluded that there is a real risk of repetition and therefore it determined that a finding of current impairment remains necessary in order to protect the public.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and

upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing a further conditions of practice order on your registration would still be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you have been complying with current substantive conditions of practice

The panel was of the view that a further conditions of practice order is sufficient to protect patients and the wider public interest. In this case, conditions could be formulated which would protect patients during the period they are in force.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response given the period of good practice since the last hearing and your journey towards reflection and insight.

Accordingly, the panel determined, pursuant to Article 30(1)(a) to extend the conditions of practice order for a period of nine months, which will come into effect on the expiry of the current order, namely at the end of 10 October 2025. It decided to continue the following conditions which it considered are appropriate and proportionate in this case:

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 not set up an agency or business that provides any nursing or care to clients.

2. You must not take on any new managerial nursing or care position that requires you to directly line manage other members of staff unless you are supervised by a line manager. In this situation, your supervision must consist of fortnightly meetings to discuss your managerial responsibilities. These should include (but are not restricted to):
    - your monitoring of your line reports' performance and capabilities
    - communication with relevant stakeholders to maintain patient safety
    - the effectiveness of any care plans that are completed by your team

- upholding regulatory responsibilities as appropriate.

3. If you are employed in any managerial role requiring you to directly line manage other members of staff, you must keep a reflective practice profile. The profile will:
    - Detail each line report for whom you are responsible
    - Set out the actions you have taken to ensure that your line report practises safely and effectively
    - Be signed by your own line manager each time
    - Contain feedback from those who are your direct line reports on the effectiveness of the support you have given them in fulfilling their roles.

4. You must keep us 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.

5. You must keep us 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.

6. 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.

e. Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

7. 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.

8. 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.

The period of this order is for 9 months. This period is proportionate to reflect the seriousness of the misconduct and the lack of sufficient evidence of insight and reflection. This duration would also allow you to continue to practise in your current role as a nurse while at the same time giving you opportunity to further develop and demonstrate your insight and learning.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the next review hearing.
- A comprehensive reflective piece that demonstrates:

    - your understanding of the impact of your misconduct on others, particularly service users.
    - A recognition of your level of competence in relation to managing staff.
    - your understanding of your role and responsibility as a registered nurse when supervising patient care.
- Evidence of professional development, including documentary evidence of training that relates to leadership and management.
- Recent references and testimonials from any paid or unpaid work.
- Any evidence you may have collated that attests to your mentoring of staff or support for colleagues' professional development.

This decision will be confirmed to you in writing.

That concludes this determination.