Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 9 January 2023 – Tuesday 17 January 2023

Virtual Hearing

Name of Registrant:	**Maria Izabella Zilahi**
NMC PIN	16B0059C
Part(s) of the register:	Registered Nurse – Adult
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Rachel Childs (Chair, lay member) Jim Blair (Registrant member) Brian Stevenson (Lay member)
Legal Assessor:	John Bromley-Davenport KC
Hearings Coordinator:	Daisy Sims Dylan Easton (13 January 2023)
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Ms Zilahi:	Not present on days 1&2, present on days 4&5 and represented by Emily Mattin throughout
Facts proved by admission:	1(a), 1(b), 1(c), 3, 5, 6(b)(iii), 6(c), 7(a), 7(b), 7(c) 8(a), 8(b), 8(c) 9, 10 and 11
Facts proved:	2
Facts not proved:	4, 6a, 6b(i) and 6b(ii)
Fitness to practise:	Impaired
Sanction:	Strike-off order

Interim order: Interim suspension order (18 months)

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

At the outset of the hearing, Ms Mattin, on your behalf, made a request that the following adjournment application be held entirely in private due to the health and medical issues of [PRIVATE]. Ms Mattin referred the panel to a doctors' letter regarding [PRIVATE] and submitted that this provides evidence [PRIVATE]. Ms Mattin submitted that [PRIVATE] privacy outweighs the principle of open justice.

Ms Mattin also made this application on the basis that an element of the following adjournment application will reference her personal matters.

This application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dr Joshi, on behalf of the NMC, did not oppose this application.

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

Having heard that there will be reference to [PRIVATE] and Ms Mattin's personal matters, the panel determined to hold the entirety of the adjournment application in private.

Decision and reasons on application for an adjournment

[PRIVATE]

Details of charge (as amended)

That you a registered nurse, whilst employed at Kings Lodge Nursing Home;

1) On 19 June 2016;
   a) Left your shift 15 minutes early at 7.45a.m.

   b) Handed your Fob to Colleague A.

   c) Asked Colleague A to clock you out at around 8a.m.

2) Your actions in charges 1 b) & 1 c) above were dishonest in that you sought to conceal that you left your shift 15 minutes early.

That you, a registered nurse, whilst employed at Kings Lodge Nursing Home ("the Home") on 29 December 2018;

3) Did not ensure/check that a sensor mattress was in place for Resident A in the lounge/ under Resident A's chair

4) Did not ensure that Resident A's clip-on alarm was attached to her body.

5) Did not ensure that Resident A was supervised by a member of staff in the lounge.

6) Following Resident A's fall;

   a) Did not conduct a full assessment of Resident A to identify whether Resident A had suffered a fracture.

   b) Moved Resident A to her bed using a hoist;

      i) Without first having carried out a full assessment of Patient A to identify if she had suffered any fracture.

      ii) Without any clinical justification.

iii) Without calling emergency services.

c) Waited 30 minutes before calling emergency services.

7) Inaccurately recorded in Resident A’s Accident and Incident Report Form, that you;

    a) Moved Resident A into her bed after calling 999/emergency services.

    b) Moved Resident A into her bed after being advised to do so by a 999 operator/emergency services.

    c) Had called 999/emergency services within 30 minutes of finding/discovering Resident A had fell

8) Inaccurately recorded in Resident A’s Multidisciplinary notes, that you;

    a) Moved Resident A into her bed after calling 999/emergency services.

    b) Moved Resident A into her bed after being advised to do so by a 999 operator/emergency services.

    c) Had called 999/emergency services within 30 minutes of finding/discovering Resident A had fell.

9) Between 29 December 2018 & 4 January 2019 on one or more occasion, inaccurately told Colleague B, that emergency services/paramedics had advised you to move/hoist Resident A to her bed after she had suffered a fall.

10) Your actions in one or more charges 7 a), 7 b), 8 a) & 8 b) above were dishonest, in that you falsified records in an attempt to conceal that you had not followed the correct falls procedure/Falls Management Policy at the Home.

11) Your actions in charge 9 above were dishonest in that you make false declarations in an attempt to conceal that you had not followed the correct falls procedure/Falls Management Policy at the Home.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Dr Joshi, on behalf of the NMC, to amend the wording of the preamble to charge 1.

The proposed amendment was to the wording of the preamble of Charge 1 to state *'whilst employed at Kings Lodge Nursing Home'* rather than at *'Tilford Nursing Home'*. It was submitted by Dr Joshi that the proposed amendment would more accurately reflect where Ms Zilahi was working:

> 'That you a registered nurse, whilst employed at ~~Tilford Nursing Home~~ **Kings Lodge Nursing Home**;'

Ms Mattin did not object 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 Ms Zilahi and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

You joined the NMC register on 2 February 2016 and was referred to the NMC on 28 January 2019 by her previous employer Kings Lodge Nursing Home ('Kings Lodge') due to concerns about her practice.

The first concern from the Home allegedly occurred on 19 June 2016. It is alleged that you gave a false impression that you had completed a full shift at work when you had allegedly left 15 minutes earlier than permitted.

You attended an investigatory meeting on 8 July 2016 at the Home and subsequently attended a disciplinary hearing at the Home on Thursday 28 July 2016 following these concerns. You received a formal warning on 5 August 2016 for using another member of staff to clock you out when you had already left the building. Your employer viewed this as fraud.

The referrer also raised concerns regarding an incident that occurred on 29 December 2018 involving the care of Resident A and your actions following a fall suffered by this resident. Resident A, who was [PRIVATE], fell in the lounge of the Home. You allegedly failed to assess her condition correctly and arranged for her to be hoisted back into her bed. It later became clear that Resident A was in considerable pain and distress. Paramedics were called and she was transferred to hospital where it became clear that she had suffered a fracture in her shoulder and her leg.

You allegedly informed both relatives and senior staff in the Home that you had telephoned the ambulance service as soon as Resident A had fallen and that they had advised you to move Resident A back into her bed. It is further alleged that you falsified documentation relating to the incident. You allegedly maintained this account until a recording of the 999 call was obtained and it became clear that you had not been given this advice and the decision to move her had been your own.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Mattin who informed the panel that you made admissions to 1(a), 1(b), 1(c), 3, 5, 6(b)(iii), 7(a), 7(b), 8(a), 8(b), 9, 10 and 11 in her completed Case Management Form (CMF). During evidence, you also admitted to charges 6(c), 7(c) and 8(c).

The panel therefore finds charges 1(a), 1(b), 1(c), 3, 5, 6(b)(iii), 6(c), 7(a), 7(b), 7(c) 8(a), 8(b), 8(c) 9, 10 and 11 proved, by way of your admissions.

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 Dr Joshi on behalf of the NMC and by Ms Mattin on your behalf.

The panel has drawn no adverse inference from your non-attendance for the first two days of the hearing.

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: Home Manager at ‘Kings Lodge’;
- Witness 2: Relative of Resident A;
- Witness 3: Relative of Resident A.

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 Ms Mattin.

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

Charge 2

> 2) Your actions in charges 1 b) & 1 c) above were dishonest in that you sought to conceal that you left your shift 15 minutes early.

This charge is found proved.

In reaching this decision, the panel took into account all the information before it, including the Investigatory Meeting Minutes, dated 8 July 2016, and your oral evidence.

The panel took into account that the purpose of the fob referred to in charge 1 is to clock in and to clock out and to accurately record the time of entering and leaving the building. You told the panel that you gave your fob to a colleague to clock out at 8:00am when you had in fact left at 7:45am.

The panel considered your evidence that other individuals would similarly leave early and that you did not see it as wrong. However, it determined that this should not have affected your behaviour as a registered nurse, and that this is something that you should have questioned as a registered professional.

The panel does not accept your evidence that you were '*naïve*' and only realised that what you were doing was wrong once it was explained to you in the investigatory meetings. The panel considered the Investigatory Meeting Minutes, dated 8 July 2016 and that your first explanation to the manager for your decision to ask a colleague to clock out for you was that you '*don't want to lose money*'.

Further, the panel considered the following passage from these meeting minutes:

> *'I'm very sorry that I made this mistake, I wish I never done it, I didn't want to fraud the company and I knew that before I had left about 5 times so I was thinking if I ask again it would be a problem'*

In light of this passage, the panel determined that you thought that you would not get permission to leave early as you had done this too many previous occasions.

In your responses to Witness 1 after the incident, you said you were '*ashamed'* in an email dated 1 August 2016 and that you accepted that your behaviour was *'fraudulent'* in a handwritten letter. The panel determined that you must have known what you were doing was dishonest and your actions were deliberate in misrepresenting the time at which you left Kings Lodge.

In light of this the panel determined that, on the balance of probabilities, your actions in charges 1b and 1c above were dishonest in that you sought to conceal that you left your shift 15 minutes early.

The panel found charge 2 proved.

Charge 4

> 4) Did not ensure that Resident A's clip-on alarm was attached to her body.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it, including the evidence from Witness 1, Witness 2, Witness 3 and the documentation around Resident A's Care/Risk Management Plan, dated 5 April 2018.

The panel acknowledged that the oral evidence of Witness 3 and paragraph 7 of Witness 2's statement referred to a clip-on alarm. While the panel was satisfied that both Witness 2 and 3 would have been very familiar with the specifics of the safety measures put in place to prevent Resident A from falling, the fact that there was no mention of such a clip-on alarm in the documentation means that there is insufficient evidence to prove that you failed in your responsibility to attach it to Resident A's clothing. The panel also noted that in Witness 1's oral evidence, he could not recall a clip-on alarm.

The panel noted that the requirement for a clip-on alarm was not documented in Resident A's Care/Risk Management Plan, nor in any of the other documentation is there a reference to a clip-on alarm. As this was not included in Resident A's care plan, the panel determined that it was not clear that there was a duty or responsibility placed upon you to ensure that the clip-on alarm was attached to Resident A.

In light of the above reasoning, the panel determined that, on the balance of probabilities, that there is insufficient evidence that you did not ensure that Resident A's clip-on alarm was attached to her body.

The panel found charge 4 not proved.

Charge 6a

6) Following Resident A's fall;

a) Did not conduct a full assessment of Resident A to identify whether Resident A had suffered a fracture.

This charge is found NOT proved

In reaching this decision, the panel took into account all the evidence before it, including your oral evidence.

The panel did not reject your evidence that you conducted a full assessment of Resident A to identify whether Resident A had suffered a fracture. You described to the panel an extensive physical assessment process including touch and palpation as well as verbal exchanges with Resident A. You told the panel that there was a scratch on Resident A's left elbow, that Resident A was moving limbs and trying to get up so you had therefore concluded that the injuries were minor.

There was no evidence before the panel from any other eyewitnesses to contradict your description of the assessment you completed. The panel noted the opinion of Witness 1 that you had not completed a full assessment of Resident A after her fall but, as he had not been present at the time, the panel concluded that it could not prefer this evidence to your own description of the checks you had undertaken.

The panel was concerned by the lack of documentation for the assessment you completed. However, it determined that there is not enough evidence to determine that you did not conduct this assessment and therefore could not find this charge proved on the balance of probabilities.

The panel found charge 6a not proved.

Charge 6b(i)

6) Following Resident A's fall;

b) Moved Resident A to her bed using a hoist;

i) Without first having carried out a full assessment of Patient A to identify if she had suffered any fracture.

This charge is found NOT proved

In reaching this decision, the panel took into account all the evidence before it, including your oral evidence.

The panel did not reject your evidence; and for the same reasons outlined in charge 6a, the panel did not find this charge proved.

Charge 6b(ii)

6) Following Resident A's fall;

b) Moved Resident A to her bed using a hoist;

ii) Without any clinical justification.

This charge is NOT proved

In reaching this decision, the panel took into account all the information before it, including your oral evidence and the Post Falls Procedure documentation provided by Kings Lodge.

The panel took into account your account of events during your oral evidence. From your full assessment of Resident A and the conclusion you reached from this assessment (namely that Resident A had not suffered any serious injury), the panel noted that you had closely followed the Post Falls Procedure. The panel did not reject your evidence that you only saw minor injuries in your assessment of Resident A. It noted that your actions could be justified given the conclusions from your assessment.

While the panel determined that the decision to move such an elderly resident, [PRIVATE], was in hindsight incorrect, it did not have sufficient evidence that there was no clinical justification whatsoever for the decision you took to return her to her bed.

Having found that there was limited but some clinical justification in moving resident A into bed, the panel therefore found charge 6b(ii) not proved.

Decision and reasons on application for evidence to be heard in private

At the outset of the submissions on misconduct and impairment, Ms Mattin made a request that any evidence you may give that concerns your own health or [PRIVATE] is conducted in private. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dr Joshi did not object to this application.

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 determined that it would go into private session as and when such issues are raised in order to maintain your privacy.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

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

The panel heard evidence from you under affirmation on misconduct and impairment.

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

Dr Joshi identified the specific, relevant standards where your actions amounted to misconduct:

'***1 Treat people as individuals and uphold their dignity***

2 Listen to people and respond to their preferences and concerns

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

5 Respect people's right to privacy and confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health care and ongoing treatment sensitively and in a way they can understand

8 Work co-operatively

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

10 Keep clear and accurate records relevant to your practice

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

20 Uphold the reputation of your profession at all times

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

20.2 act with honesty and integrity at all times …

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

Dr Joshi drew the panel's attention to the following section of the Code:

'The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals.'

Dr Joshi stated that you only admitted the truth about the 999-phone call once it had been obtained by Kings Lodge during an internal investigation. He submitted that the panel must consider whether you would have admitted to this if a recording of this phone call had not been obtained.

Dr Joshi reminded the panel that the family of Resident A will never know the truth about the incident that occurred on 29 December 2018 and so a finding of impairment is necessary in the public interest.

Dr Joshi also reminded the panel of the seriousness of dishonesty and stated that honesty is a fundamental tenet of the nursing profession.

Ms Mattin referred the panel to her written submissions on misconduct and impairment. She stated that she does not seek to minimise the impact of your actions on Resident A's family and the wider profession.

Ms Mattin submitted that charge 5 does not meet the threshold for serious misconduct despite you accepting that you had responsibility for ensuring that Resident A was supervised.

Ms Mattin submitted that charges 6(b)(iii) and 6(c) do not constitute misconduct in light of the panel's determination of the clinical assessment you conducted on Resident A.

Ms Mattin informed the panel that you have not had any previous disciplinary action taken against you nor have there been any findings of dishonesty.

Ms Mattin submitted that you have demonstrated substantial and genuine remorse for your actions. She further submitted that your admissions demonstrate insight into your actions. Insight was also evident in your oral and written evidence to the panel.

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

2 Listen to people and respond to their preferences and concerns

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

5 Respect people's right to privacy and confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health care and ongoing treatment sensitively and in a way they can understand

8 Work co-operatively

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

10 Keep clear and accurate records relevant to your practice

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

20 Uphold the reputation of your profession at all times

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

20.2 act with honesty and integrity at all times …

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel determined that charge 6b(iii) and 6c did not amount to misconduct due to its previous findings at the facts stage. It previously found that there was insufficient evidence to find that you had not completed an assessment and had moved Resident A without any clinical justification. Therefore, it follows that your failure to call emergency services within 30 minutes after this could not amount to misconduct, given that you had concluded that an ambulance was not necessary.

However, the panel was of the view that your actions amount to a serious failure in your duty of candour. The panel determined that there was serious dishonesty maintained over an extended period of time which was only admitted finally when you were faced with evidence of the 999-phone call. The panel also determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse in that you

failed to ensure that Resident A’s sensor mat was in situ and did not ensure that appropriate staff were in place in the lounge. The standard of care you offered Resident A therefore fell well below the standard expected.

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

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

> *‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.’*

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

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

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

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

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

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

The panel finds that Patient A was put at risk and was caused physical and emotional harm as a result of your misconduct. The panel also finds that your dishonesty caused considerable distress to Patient A's family. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that you have made admissions to some of the charges and you have demonstrated an understanding of how your actions put Resident A at a risk of harm. Further, you demonstrated an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. You apologised to Resident A's family for your misconduct and explained how you would

handle the situation differently in the future. The panel determined that you have shown developing insight, but it was not satisfied that you have understood and shown understanding of the full impact of the events on the family. To date, the family are still uncertain regarding the exact nature of the events that led to Resident A's fall or the subsequent timeline leading up to her admission to hospital.

The panel also noted that there were late additions to some elements of your evidence, notably in relation to the changing of Resident A's clothing and in terms of the timeline of events, that called into question the accuracy of your recollection.

The panel carefully considered the evidence before it in determining whether or not you have taken sufficient steps to strengthen your practice. The panel noted your evidence that you have worked as a senior Health Care Assistant at Kings Lodge with significant supervision and that you have been reinstated in your role as a registered nurse at Kings Lodge. However, the panel determined that this is insufficient to show that you have strengthened your practice. In the absence of any recent and current supervision records, an up-to-date report from your line manager, and any further evidence of your time in these roles, the panel was unable to conclude that you had fully remediated the concerns about your practice.

The panel took into account the training certificates you have provided:

- Venepuncture dated 23 November 2021
- Wound Care Management dated 28 August 2021
- Fire Awareness in Care dated 14 November 2021
- Fluids and Nutrition dated 19 January 2022
- End of Life Care dated 23 November 2021
- Pressure Ulcer Prevention dated 10 March 2022
- Display Screen Equipment dated 27 November 2022
- Dignity and Respect dated 8 November 2022
- Oral Health dated 9 November 2022

- Future Care Advanced Medication Training dated 4 April 2022
- Future Care Equality and Diversity dated 14 March 2022
- Future Care Mandatory Fire Training dated 4 March 2022
- Future Care Practical Moving and Handling dated 28 March 2022
- Future Care Practical Moving and Handline dated 20 February 2021
- Food Safety Level 2 dated 28 November 2021
- Falls Prevention dated 16 January 2023
- Basic Life Support dated 14 November 2022
- Learning Disabilities dated 19 January 2022
- Dysphagia dated 10 September 2021

The panel considered these training certificates and found it concerning that the Falls Prevention training was only dated as being completed on the current date. It accepted however that you have made efforts to keep up to date with key aspects of training.

The panel is of the view that there is a risk of repetition as it cannot be satisfied that you would not act dishonestly again if you were put in a similarly stressful situation where you had made an error or mistake. It took into account your description of your treatment of a resident following a fall in December 2022 but considered that this did not demonstrate how you might act if you made a clinical error and did not address concerns about your honesty. 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds 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.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

The panel also bore in mind Dr Joshi's submission to impose a striking off order. Dr Joshi submitted that you were dishonest on two separate occasions at Kings Lodge. He asked the panel to consider the background to these two incidents. He accepted that the dishonesty regarding Resident A was not long standing, however he submitted that until this recording of a 999 call was put to you, you did not admit your dishonesty.

Dr Joshi informed the panel that there have been no interim restrictions on your practice and so you have had an opportunity to practice as a registered nurse, however he referred the panel to the Home Manager reports provided by you, specifically the report dated 26 November 2022. He submitted that as of recently there are still concerns from Kings Lodge about your practice as a nurse.

Ms Mattin referred the panel to her written submissions on sanction.

Ms Mattin submitted that the appropriate and proportionate sanction is that of a short suspension. She submitted that this would adequately protect the public, maintain public confidence in the profession and to maintain oversight of you. She submitted that a suspension would have a significant impact on you and would send a clear message to you.

Ms Mattin reminded the panel that you were demoted over four years ago to a senior Health Care Assistant with regular supervision and you were reinstated as a registered nurse at Kings Lodge over two years ago. She submitted that imposition a striking off order would be inappropriate and disproportionate as your employer and the NMC has allowed you to practice as a registered nurse since these incidents occurred.

Ms Mattin referred the panel to the Home Manager reports provided by you. She explained to the panel that these reports do not show significant concerns but identify small areas of improvement. Ms Mattin submitted that there has been no repetition or clinical concern since the incident with Resident A and there has been significant evidence of you improving your practice. She therefore submitted that a striking off order would be wholly inappropriate, disproportionate and draconian.

Decision and reasons on 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:

- Prolonged dishonesty in that you only admitted to your dishonesty after three weeks when played the recording of the 999 call and you had no other option
- Serious dishonesty in falsifying records
- Serious dishonesty in misrepresenting the events surrounding Resident A's fall to both your colleagues, managers and Resident A's family
- Direct harm to Resident A
- Direct harm to the family of Resident A by your dishonesty
- A breach of your duty of candour

The panel also took into account the following mitigating features:

- Engagement with the NMC throughout including making a number of admissions prior and during this hearing
- Your developing level of insight
- Your genuine heartfelt remorse
- Your apology to Resident A's family
- Your personal circumstances
- Your continued practice as a nurse without further concern
- Your commitment to working in a care home through COVID-19
- Evidence of relevant training

The panel determined that the aggravating features outweigh the mitigating features in this case. The panel noted that your dishonesty was repeated and prolonged. It also took account of the direct harm caused to Resident A and the distress caused to her family.

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 seriousness of the case. 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 of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The dishonesty identified in this case is not something that can be addressed through retraining or any conditions. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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:

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

The panel considered that this was not a single instance of misconduct and it noted that there were two separate incidences of dishonesty in 2016 and 2018. The panel

determined that your dishonesty in the falsification of documentation of Resident A's fall, the impact of your dishonesty on the family of Resident A and the time between this incident occurring and your admission of dishonesty were reflective of an underlying attitudinal problem. The panel is concerned that if you were placed in a similarly stressful situation, it could not be satisfied that you would not be dishonest and attempt to cover up your actions if you believed you had done something wrong. Whilst the panel acknowledged that you have practised as a nurse after these incidents without any further concerns being raised, it determined that there is a risk of repetition of your dishonesty due to the attitudinal concerns identified. The panel took into account your positive developing insight, however as previously noted, the panel did not find this to amount to full insight into your dishonesty. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that the prolonged nature of your deceit surrounding the fall of Resident A called into question your professionalism. It noted that a duty of candour is at the heart of safe nursing practice and your serious breach in this respect undermines public confidence in the nursing profession.

The panel determined that your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate

that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct yourself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to you in writing.

Interim order

As the striking-off 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 your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Dr Joshi. He invited the panel to impose an interim suspension order for 18 months in order to cover the appeal period and any appeal hearing if this is requested.

Ms Mattin did not oppose the application.

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 due to adequately protect the public over the appeal period.

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

That concludes this determination