Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 11 April 2023 – Thursday 20 April 2023,
Wednesday, 13 September 2023 – Friday, 15 September 2023,
Thursday 12 October 2023 (panel drafting day),
Friday 13 October 2023, Monday 16 October 2023 – Thursday 19 October 2023

Virtual Hearing

Name of Registrant:	**Nanette Combatir Florida**
NMC PIN	02H1104O
Part(s) of the register:	RN1: Registered Nurse – (sub part 1) Adult – Level 1 – August 2002
Relevant Location:	Bury
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Frances Clarke (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Daisy Sims (11 - 20 April & 13 - 15 September & 12 - 13 October & 16 - 18 October 2023) Sherica Dosunmu (19 October 2023)
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Florida:	Not present and represented by Megan Fletcher-Smith, (Royal College of Nursing) – Tuesday 11 April – Wednesday 19 April 2023 Present and represented by Megan Fletcher-Smith (Royal College of Nursing) – 19 April, 13-15 September, 13 October & 16 - 18 October 2023)
No case to answer:	1(a), 1(b)(i), 1(b)(iii), 2, 3 (in relation to charge 1(b)(i) and (iii)), 4(a), 5, 7(c) & 9(e)
Facts proved by admission:	4(b), 6, 7(a), 7(d), 7(e), 8, 9(b), 9(c), 9(e) & 10

Facts proved:	7(f)
Facts not proved:	1(b)(ii), 3, 7(b), 9(a), 9(d)(i), 9(d)(ii) & 9(d)(iii)
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months) – with review**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to exclude hearsay evidence

The panel heard an application made by Ms Fletcher-Smith, on your behalf, under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules), to exclude the hearsay evidence of Ms 1, Ms 2, Ms 3, Ms 4 (and therefore the evidence provided by Patients D and E) and the handwritten minutes of the disciplinary hearing (save for the evidence given by you in that hearing).

Ms Fletcher-Smith provided the panel with written submissions on this application.

Ms Fletcher-Smith took the panel through the guidance around hearsay outlined in the case of *Thorneycroft v NMC* [2014] *EWHC 1565 (Admin)*:

(i) Whether the statements are the sole or decisive evidence in support of the charges

(ii) The nature and extent of the challenge to the contents of the statements

(iii) Whether there was any suggestion that the witnesses had reasons to fabricate their allegations

(iv) The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career

(v) Whether there is a good reason for the non-attendance of the witness

(vi) Whether the NMC have taken reasonable steps to secure attendance

(vii) Whether the Registrant had prior knowledge that the witness statements were to be read'.

Ms Fletcher-Smith submitted that all of the hearsay evidence in this application is relevant as it goes to the charges against you. However, she made submissions to the effect that in respect of all of the hearsay evidence relating to this application, limbs (ii), (iv), (v), (vi) and (vii) are engaged. She submitted that a number of the charges relate to dishonesty and so are serious and, if found proved, could have an adverse impact on your career, that there is no good reason for the non-attendance of all of the witnesses as there is no evidence from the Nursing and Midwifery Council (NMC) of any steps taken to secure their attendance. Whilst you had prior knowledge of this

evidence within the exhibit bundle, the NMC had not produced it in an admissible format for these proceedings.

Ms Fletcher-Smith then took the panel through the reasons for the inadmissibility of the evidence of the above individually. She submitted that the evidence of Ms 1 is inadmissible as it is unfair hearsay evidence. She explained that this evidence takes the form of a handwritten statement dated 19 August 2017 and does not include a statement of truth. She stated that no patient had been directly identified but that it can be assumed that this evidence relates to charges 1-6. Ms Fletcher-Smith submitted that it is not clear in this statement whether Ms 1 had first-hand knowledge of the information she provided or whether she had been a witness to any of the incidents. She reminded the panel that there is no NMC written statement from Ms 1 nor is there any evidence that this handwritten statement was tested during a local investigation. Ms Fletcher-Smith submitted that Ms 1 may have had reason to fabricate the contents of this written statement as if patients had not been checked on her shift it would be convenient for her to blame those on the shift prior to hers. She submitted that Ms 1 is a registered nurse and so it is concerning and highly unacceptable that there is no evidence from the NMC of the steps taken to secure her attendance at this hearing. She invited the panel to query why the NMC had neglected their investigatory duty. She submitted that the contents of this written statement contain multiple hearsay. She referred to the fact that Ms 1 stated that 4 patients had capacity, however Ms 2 stated that 2 patients had capacity. Further she stated that Ms 1's evidence was of such a prejudicial nature including the fact that she was unable to cross examine Ms 1 and therefore she submitted that this evidence should not be admitted.

Regarding the handwritten statement dated 19 August 2017 of Ms 2, Ms Fletcher-Smith submitted that this evidence is inadmissible as it is unfair to you. She stated this statement refers to a shift that started on 18 August 2017 and so it is unclear whether this evidence relates directly to the charges and that there is no statement of truth. She submitted that as the contents relate to comments and gestures allegedly made by patients, it amounts to multiple hearsay. She submitted that there is no evidence that Ms 2 was trained in conducting investigatory interviews. She also stated that this statement refers to another member of staff that was working with Ms 2, however there

is no statement from this other member of staff or evidence of steps taken to identify them. Ms Fletcher-Smith submitted that this absent and unidentified witness adds to the unfairness against you as there is no evidence to suggest that they would corroborate the contents of Ms 2's written statement. The contents of Ms 2's statement have not been tested at a local level.

Ms Fletcher-Smith moved on to the written evidence of Ms 3 and Ms 4 of their alleged interviews with Patient D and Patient E. She stated that this document is not signed by the patients in question and is not signed by either Ms 3 or Ms 4. She submitted that there is no evidence to suggest that Ms 3 or Ms 4 were trained in conducting investigatory interviews. She submitted that it is not clear why Ms 3 and Ms 4 were asked to conduct these interviews. Ms Fletcher-Smith submitted that there is a lack of evidence regarding the circumstances in which these interviews took place, in that it is not clear whether the patients were asked questions within earshot of each other; it is not clear whether the documents were written individually or collectively by Ms 3 and Ms 4; or whether this document was created at the time of the interview as it is an undated document. She submitted that this evidence and the evidence of Patient D and Patient E cannot be tested and so it is both prejudicial and unfair for this evidence to be admitted. She also stated that it was unknown whether these patients had capacity. Ms Fletcher-Smith stated that Ms 3 and Ms 4 were senior personnel and questioned why the NMC had not obtained witness statements from them.

Ms Fletcher-Smith moved on to the handwritten minutes from the disciplinary hearing. She submitted that, save for the evidence provided by you in this document, it is inadmissible as it is unfair. She submitted that this document is unclear and disjointed in that multiple persons are named by their first names with no further information and that it is not possible to decipher who is speaking at points in this document. She submitted that it was unclear whether pages were missing from this document as there were no page numbers and she questioned whether this evidence was complete. She submitted that those mentioned by their first names in this document do not have a local statement or an NMC statement in evidence and so it is unclear of their roles or involvement. She submitted that as there is evidence that is not clearly attributed to any witness it is clearly unfair to admit this into evidence.

Mr Radley, on behalf of the NMC, informed the panel that he would not address each document individually, but collectively. He opposed Ms Fletcher-Smith's application in its entirety. He submitted that there is a difference in obtaining evidence and presenting cases in regulatory hearings in contrast to civil and criminal proceedings. He referred the panel to the case of *White v Nursing and Midwifery Council [2014] EWHC 520* and noted that there was no '*expectation'* that a registrant should be allowed to cross examine a witness.

Mr Radley referred to the submission of Ms Fletcher-Smith that those carrying out investigations may not have been qualified to do so. He submitted that these are not criminal proceedings and so the requirement is lower. Those mentioned are professional people and are competent to conduct simple questioning to determine whether an incident took place. He submitted that this is not a reason for the panel not to rely on this evidence.

Mr Radley informed the panel that the NMC had decided that '*no further statements would be taken'* and so it is not a situation where any potential witness has refused to give a statement to the NMC.

He submitted that it is arguable that the NMC would suffer almost as much as you by the non-attendance of these witnesses. He submitted that you have the opportunity to provide evidence to the panel under oath/affirmation and you can challenge the evidence that is being presented by the NMC. He submitted that this is not a case where you would suffer due to the admission of this evidence. He further submitted that the representations made by Ms Fletcher-Smith can be dealt with during the course of the hearing if the panel admits the evidence in question.

Ms Fletcher-Smith further submitted that it is not of relevance whether a witness has refused to provide a statement to the NMC as there are no local statements in evidence either. She further submitted that weak evidence is not an argument to admit evidence. Given all the context, she submitted that these witnesses give multiple hearsay and the fact that you cannot challenge this evidence means that it should not

be admissible. She submitted that the suggestion that this evidence may also be unfair to the NMC and the suggestion that it could be possible for the panel to deal with this documentation during the course of the hearing is not a relevant consideration for this panel.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. The legal assessor advised that pursuant to Rule 31, the admission of hearsay evidence is subject to the requirements of relevance and fairness. She drew the panel's attention to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin); *NMC v Ogbonna* [2010] EWCA Civ 1216; and *El Karout v NMC* [2020] EWHC 3079, and advised that the relevant principles articulated by the above cases are as follows:

- The decision to admit hearsay evidence is not to be regarded as a routine matter.
- The panel must specifically consider the issue of relevance; and if relevant, then whether it is fair to admit the evidence;
- Considerations of what weight can be attributed to the evidence once it has been admitted are not relevant to the question of whether it would be fair for the evidence to be admitted in the first place.

The panel adopted the seven-part list of considerations outlined in the case of Thorneycroft when considering the fairness of each part of the hearsay evidence.

The panel determined that limbs (i), (ii), (iv), (v), (vi) and (vii) are the same for all of the evidence in this application. It determined that the evidence, individually, is not the sole or decisive evidence in support of any of the charges. The panel bore in mind the NMC Guidance that dishonesty charges are serious and so determined that the charges in question are serious. The panel heard that the NMC had made the decision not to call potential witnesses, some of whom were senior and on the NMC register, which the panel determined was unacceptable. It further determined that you did have prior knowledge of this evidence, but accepted Ms Fletcher-Smith's submission that this was not in the admissible format for these proceedings.

The panel determined that the evidence of Ms 1 is relevant to the charges. The panel determined that the content of the evidence of Ms 1 in relation to limb (ii) is challenged. It noted the submissions of Ms Fletcher-Smith who stated that there is no statement of truth, and this evidence has not been challenged at a local level and is not able to be challenged at this hearing. The panel determined that there is no opportunity to challenge this evidence as the witness is not going to attend this hearing. The panel also determined in relation to limb (iii) that there is no evidence before the panel to suggest that Ms 1 has a reason to fabricate her evidence, however, there is a suggestion from Ms Fletcher-Smith that this evidence could have been fabricated for personal protection. The panel determined that the evidence of Ms 1 is unfair. Whilst it is not the sole and decisive evidence in this case, it relates to serious charges. The content of the evidence and the circumstances in which it was obtained cannot be tested as the witness is not appearing in front of this panel. No cogent reason was given for their non-appearance. This would, in the panel's view, be more prejudicial than probative and risks causing unfairness to you. The panel therefore determined that her evidence should be excluded.

The panel considered the evidence of Ms 2. It noted that Ms 2's evidence is a handwritten statement with no statement of truth and is dated 18 August 2017. It determined that this evidence contains multiple hearsay as it contains comments made by Patient D and Patient E. The panel noted that the date of this statement does not directly correlate to the charges against you. However, the panel determined that as the statement refers to the case of Patient D and Patient E, that it is relevant in the broad sense. The panel determined, similarly to the evidence of Ms 1, that the contents of this evidence would be open to challenge from you in respect of the procedure used in gathering it. The panel determined that the evidence of Ms 2 is unfair. Whilst it is not the sole and decisive evidence in this case, it relates to serious charges. The content of the evidence and the circumstances in which it was obtained cannot be tested as the witness is not appearing in front of this panel. No cogent reason was given for their non-appearance. This would, in the panel's view, be more prejudicial than probative and risks causing unfairness to you. The panel therefore determined that her evidence should be excluded.

The panel then considered the evidence of Ms 3 and Ms 4 who made notes on an interview with Patient D and Patient E. The panel noted that this document is unsigned and contains multiple hearsay through comments from Patient D and Patient E. The panel determined that this evidence is relevant as it relates to the charges against you. The panel considered the challenge to the contents of this evidence from Ms Fletcher-Smith who stated that it is unclear who created this document and whether it was made by Ms 3 and Ms 4 collectively or individually. Ms Fletcher-Smith also stated that the content is challenged as there are no patient notes provided to corroborate this evidence and submitted that there is no information about the circumstances of the interview in that it is not clear whether Patient D and Patient E had the capacity to undertake the interview and it is unclear how this interview was conducted. The panel accepted this position and determined that this evidence is unfair. Whilst it is not the sole and decisive evidence in this case, it relates to serious charges. The content of the evidence and the circumstances in which it was obtained cannot be tested as the witnesses are not appearing in front of this panel. No cogent reason was given for their non-appearance. This would, in the panel's view, be more prejudicial than probative and risks causing unfairness to you. The panel therefore determined that their evidence should be excluded.

The panel then considered the handwritten minutes from the disciplinary hearing. It determined that the minutes are disjointed and unclear. The panel determined that whilst the notes are confusing, unsigned, undated and the author of the minutes is not clear, there appears to be aspects of the minutes which may be relevant to the charges as they refer to Patient D and Patient E. The panel therefore determined that these minutes may have some relevance to the charges. The panel then went onto consider the fairness of the minutes remaining in evidence. The panel bore in mind the submissions of Ms Fletcher-Smith who submitted that the contents are challenged as it is difficult to interpret the contents of these minutes. The panel determined that as it is unaware of the author of these minutes, they are unsigned, undated, disjointed and incoherent and are therefore unfair to you. The panel determined that the handwritten minutes from the disciplinary hearing is unfair. Whilst it is not the sole and decisive evidence in this case, it relates to serious charges. The content and provenance of the evidence cannot be tested. It is unclear who is the author of this evidence and no

witnesses have been produced by the NMC regarding ownership of these minutes. As a number of possible witnesses mentioned within these minutes are not in front of the panel and no cogent reason was given for their non-appearance, the authenticity of these minutes cannot be examined. This would, in the panel's view, be more prejudicial than probative and risks causing unfairness to you. The panel therefore determined that this evidence should be excluded.

The panel further determined that the disciplinary minutes are excluded from evidence, the evidence of those named within the minutes, that has not already been identified and is only referred to in these minutes, is also excluded from evidence on the basis of this evidence being unfair and prejudicial.

In these circumstances the panel accepted the application from Ms Fletcher-Smith in its entirety. It determined that the evidence of Ms 1, Ms 2, Ms 3, Ms 4 (and therefore the evidence provided by Patients D and E) and the handwritten minutes of the disciplinary hearing (save for the evidence given by you in that hearing) be excluded.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Radley to amend the wording of charge 2, charge 3 and charge 9(a).

One of the proposed amendments was to amend typographical errors in charges 2 and 3.

Mr Radley proposed that the wording of charge 9(a) should be amended from '*checks every 4 hours*' to '*checks every 2 hours'*. He submitted that the policy documentation before the panel states that these checks were to be conducted every two hours and so he submitted that there has been an error in this charge.

The proposed amendments are as follows:

'That you, a registered nurse, whilst employed at Fairfield General Hospital;

1) […]

*2) Your actions in charges 1 a) above were dishonest as you knew Patient D had not been repositioned every two hours, but you sough**t** to represent that they had.*

*3) Your actions in one or more of charges 1 b) i), 1 b) ii) & 1 b iii) were dishonest as you knew Patient D had not declined skin care check**s**, but you sought to represent that they had.*

4) […]

5) […]

6) […]

7) […]

8) […]

9) On or around 27 July 2018;
*a) Did not conduct Patient B's skin care checks every **4 2** hours as required.*
b) […].

10) […].'

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

The panel heard from submissions from Ms Fletcher-Smith who stated that she had no comments to make on the typographical errors. She submitted that the proposed amendment to charge 9(a), whilst it does not create a particular prejudice to you, it

does potentially make the charge more serious in that it would make the alleged failure more frequent.

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

The panel was of the view that such amendments, as applied for, was in the interest of justice. Whilst the panel noted that the amendment to charge 9(a) does make it more serious, it determined that this does not alter the nature of the charge. 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.

On day 4 of this hearing, the panel, of its own volition, stated that the timings in charge 9(e) are not clear as to whether they relate to a 24-hour clock or not.

Mr Radley agreed with the panel and made an application to amend the wording of charge 9(e) to reflect a 24-hour clock as outlined in all other charges.

Ms Fletcher-Smith supported the application.

The panel accepted this application.

Details of charge (as amended)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

1) On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that;
    a) Patient D had been repositioned every 2 hours
    b) Patient D had declined skin care checks at;
        (i) 02:00
        (ii) 04:00
        (iii) 06:00

2) Your actions in charges 1 a) above were dishonest as you knew Patient D had not been repositioned every two hours, but you sought to represent that they had.

3) Your actions in one or more of charges 1 b) i), 1 b) ii) & 1 b iii) were dishonest as you knew Patient D had not declined skin care checks, but you sought to represent that they had.

4) On or around 16 August 2017, inaccurately recorded Patient E's intentional rounding log to indicate that;
    a) Patient E had been repositioned every 2 hours
    b) Patient E had declined skin care checks

5) Your actions in charge 4 a) were dishonest, as you knew patient E had not been repositioned every 2 hours, but you sought to represent that they had

6) Your actions in charge 4 b) were dishonest, as you knew Patient E had not declined skin care checks, but you sought to represent that they had.

7) On or around 26 July 2018;
    a) Did not wear Personal Protective Equipment, namely an apron when administering IV Omeprazole to Patient A.
    b) Did not clean the access device of Patient A's cannula with a Sani-Cloth CHG/wipe and allow it to air dry for 30 seconds.
    c) Did not flush the cannula with 0.9 % Saline 10ml following the administration of IV Omeprazole to Patient A.
    d) Incorrectly flushed the cannula with 0.9 % Saline 50ml following the administration of IV Omeprazole to Patient A.
    e) Did not record that you had incorrectly flushed the peripheral cannula with Saline 50 ml in Patient A's notes.
    f) Did not document/monitor Patient A's fluid intake and urine output on an hourly basis.

8) On or around 27 July 2018, incorrectly recorded Patient A's NEWS score as green.

9) On or around 27 July 2018;
    a) Did not conduct Patient B's skin care checks every 2 hours as required.
    b) Failed to offer Patient B a skin care check at 14:00
    c) Inaccurately signed Patient B's rounding log to indicate that he had declined a skin care check at 14:00.
    d) Made inappropriate comments to Patient B in that you stated/used words to the effect;
        (i) "You don't do anything for yourself"
        (ii) "You need to lose weight"
        (iii) That Patient B was costing the NHS £5,000 a week.
    e) Between 03:00 & 05:00 did not change Patient B's leg dressings.

10) Your actions in charge 9 c) above were dishonest as you knew Patient B had not declined a skin care check at 14:00, but you sought to represent that they had.

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

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

On Wednesday 13 September 2023, whilst Mr Radley and Ms Fletcher-Smith were making submissions on a short adjournment application to gain further information regarding Patient B's inability to attend the hearing, [PRIVATE]. The legal assessor reminded the panel that there had not previously been an application pursuant to Rule 19. The legal assessor stated that it would be wholly appropriate that [PRIVATE].

Mr Radley and Ms Fletcher-Smith agreed with the legal assessor's proposition.

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 to go into private session as and when [PRIVATE] is raised.

Background

You entered the NMC register on 19 August 2002. The NMC received a referral by the Pennine Acute NHS Trust (the Trust) as concerns were raised during your employment at Fairfield General Hospital (the Hospital). The concerns relate to poor patient care in areas of medication administration, skin care checks and associated dishonesty in terms of falsifying records.

It is alleged that on or around 16 August 2017 you inaccurately recorded Patient D's intentional rounding log to indicate that Patient D had declined skin care checks. It is further alleged that on or around 16 August 2017 you inaccurately recorded Patient E's intentional round log to indicate that Patient E had declined skin care checks.

Person C, a relative of Patient A, wrote a letter of complaint to the Trust dated 18 August 2018 about the care afforded to Patient A whilst they were receiving care at the Hospital. You were one of the nurses caring for Patient A whilst they were receiving care at the Hospital on or around 26 July 2018. Person C, in their complaint letter and subsequent written statement to the NMC, alleged that you did not follow the correct procedure while administering medication to Patient A by not following Aseptic Non-Touch Technique (ANTT), including not wearing the appropriate Personal Protective Equipment (PPE) and not cleaning the cannula port/access device properly and not flushing and not recording the incorrect flush of Patient A's cannula appropriately. It is further alleged you did not document Patient A's fluid intake and urine output on an hourly basis.

Around 27 July 2018, Patient B was a patient in your care at the Hospital. Patient B raised a complaint to the Hospital about the care provided to them including that skin

care checks were not carried out when required, that you made inappropriate comments to Patient B in that you used words to the effect of '*you don't do anything for yourself', 'you need to lose weight'* and that Patient B was costing the NHS £5,000 a week. It is further alleged that on or around 27 July 2018 you inaccurately signed Patient B's rounding log to indicate that they declined a skin care check at 14:00 which was dishonest on your part, and that between 03:00 and 05:00 you did not change Patient B's leg dressings.

Admissions to charges

At the outset of the hearing, the panel heard from Ms Fletcher-Smith who informed the panel that you made admissions to charges 4(b), 6, 7(a), 7(d), 7(e), 8, 9 (b), 9(c), 9(e) (although misconduct was not admitted) and 10.

The panel therefore found charges 4(b), 6, 7(a), 7(d), 7(e), 8, 9(b). 9(c) 9(e) (noting that misconduct is not admitted) and 10 proved in their entirety, by way of your admissions.

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

- Person C: Granddaughter of Patient A;
- Patient B: Patient B
- Witness 1: Assistant Director of Nursing for Urgent Care at the Hospital
- Witness 2: Assistant Director of Nursing for Specialist Medicine at the Hospital at the time

Submissions on application of no case to answer

Following the close of the NMC's case, the panel considered an application from Ms Fletcher-Smith that there is no case to answer in respect of charges 1(a), 1(b)(i), 1(b)(iii), 2, 3, 4(a), 5, 7(b), 7(c), 7(f), 9(a), 9(d)(i), 9(d)(ii), 9(d)(iii) and 9(e). This application was made under Rule 24(7) and Rule 24(8).

Ms Fletcher-Smith provided the panel with written submissions on this application:

'[…]

Submissions

Charge 1(a)

On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that Patient D had been repositioned every 2 hours.
8. [Witness 1] *gave evidence that the intentional rounding log does not show that the patient was repositioned every two hours.*

9. Exhibit Bundle, page 27 & 26.
22:00- Patient D on their right side
00:00- Patient D on their left side
02:00- Patient D on their left side
04:00- Patient D on their left side
06:00- Patient D on their back

10. There is therefore no evidence upon which this panel can rely to find the charge proved.

Charge 2

Your actions in charge 1(a) above were dishonest as you knew Patient D had not been repositioned every two hours but you sought to represent that they had.

11. Charge 2 requires that charge 1(a) be proved. As such, the NMC have adduced no evidence upon which this panel can find charge 2 proved.

Charge 1(b)(i) & (iii)

On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that Patient D had declined skin care checks at 02:00 & 06:00.

12. There is no evidence from Patient D before this panel. There are no other witnesses to these allegations.

13. The registrant's responses to questions in the investigation interview were as follows: (Exhibit Bundle, page 42)

We checked him when he arrived to Ward 21 but he refused all night to check.

We came to wake him to check him. Explained but patient refused to check, we tried to explained but he refused any don't want to be check.

(page 43)
Yes, this man was snappy, he did refuse, I remember him, he rude to us, not to be disturbed and checked so I put refused on rounding log.

After 10 o'clock he refused everything, he said to us he don't be disturbed and rude to us.

14. The registrant's responses to questions in the disciplinary hearing were as follows: (Exhibit Bundle, page 72)

Patient D difficult. Rude to her and […]. 2am 4am refused. Wake- not happy. Wanted to sleep. Explained. Refused. Cannot force. Signed rounding log herself. Should have added […]. HCA's also checked refused.

15. The registrant's statement, dated 27 September 2017, provides as follows: (Exhibit Bundle, page 46)

To be honest, I did checked the patients mentioned on investigation with 1 staff as well, 2 of us we checked but I wrote myself on the rounding log.

16. The NMC have adduced no evidence whatsoever to undermine any of the above statements made by the Registrant.

17. As such, there is insufficient evidence to find these charges proved.

Charge 3

Your actions in charges 1(b)(i) and 1(b)(iii) were dishonest as you knew Patient D had not declined skin care checks but you sought to represent that they had.

18. It is open to the panel to find that the parts of this charge relating to 1(b)(i) and 1(b)(iii) only, are not proved; leaving Charge 3 in relation to 1(b)(ii) only to be considered at the conclusion of the facts stage.

Charge 4(a)

On or around 16 August 2017, inaccurately recorded Patient E's intentional rounding log to indicate that Patient E had been repositioned every 2 hours.

19. There is insufficient evidence that the records show that Patient E had been repositioned every 2 hours (inaccurately or otherwise). Louise Palmer gave evidence to this effect.

20. Exhibit Bundle, page 30
22:00- Patient E is on their back
00:00- Patient E is on their back
02:00- Patient E is on their back
04:00- Patient E is on their back
06:00- Patient E is on their back

21. As such, there is no evidence upon which this panel can rely to find this charge proved.

Charge 5

Your actions in charge 4(a) were dishonest, as you knew Patient E had not been repositioned, but you sought to represent that he had.

22. Charge 5 required a positive finding in relation to charge 4(a). In the absence of that positive finding, it is submitted that there is no evidence upon which the panel can find this charge proved.

Charge 7(b)

On or around 26 July 2018, did not clean the access device of Patient A's cannula with a Sani- Cloth CHG/ wipe and allow it to air dry for 30 seconds.

23. Person C confirmed that she no independent recollection of the reason for her complaint as regards the lack of compliance with antiseptic non touch technique (ANTT).

24. Both [Witness 1] *and Patient C accepted that not wearing an apron would be a breach of ANTT. The Registrant has accepted breach of ANTT by not wearing an apron.*

25. Person C did not witness the Registrant failing to comply with ANTT by not cleaning the access device with a Sani cloth CHG/ wipe and allowing it to airdry for 30 seconds.

26. There is no other witness or documentary evidence which supports this charge.

27. As such, there is no evidence upon which this panel can rely, to find this charge proved.

Charge 7(c)

On or around 26 July 2018, did not flush the cannula with 0.9% Saline 10ml following the administration of IV Omeprazole to Patient A.

28. The Registrant has admitted incorrectly flushing the cannula with 50ml following the administration of IV Omeprazole to Patient A, as set out in charge 7(d). It is therefore unclear how the NMC allege that, in so doing, the Registrant did not flush with 10ml.

29. In order to flush with 50ml, the Registrant, as a mater of common sense, must have flushed with 10ml.

30. The panel, having found charge 7(d) proved, cannot find that there is also sufficient evidence to find charge 7(c) proved, as this would not be compatible with their previous finding.

Charge 7(f)

On or around 26 July 2018, did not document/ monitor Patient A's urine input/output on an hourly basis.

31. There is no evidence that it is ever necessary to record a patient's urine input. Rather, that it is necessary to record fluid intake.

32. The NMC provided no documentary evidence to back up this assertion, instead relying solely upon the evidence of Patient C. On the contrary, the Registrant provided Patient A's relevant fluid balance charts and urinary catheter monitoring chart.

33. Exhibit Bundle, page 145

Roster shows that on 26 July 2018, the Registrant was on a long day shift. The evidence is that a long day shift lasts from approximately 07:30am to 08:30pm.

34. Registrant's Bundle, page 2 (PDF page 3):

Catheter inserted sometime between afternoon an evening on 26 July 2018.

35. Registrant's Bundle, page 1 (PDF page 2):

08:00- IV intake 100.
09:00- IV intake 100. Incontinent.
10:00- IV intake 100.

11:00- IV off.
12:00- IV off.
13:00- IV off.
14:00- IV intake 100. Incontinent of urine.
15:00- 50ml oral intake. IV intake 100.
16:00- IV intake 100.
17:00- IV intake 100.
18:00- IV intake 100.
19:00- 100ml oral intake. IV intake 100.
20:00- IV off. Urine output 300- catheter emptied. (first reference to catheter).
21:00- IV intake 100. Urine output 100.

36. It is clear from the above that Patient A's fluid intake and urine output was recorded on an hourly basis, thereby undermining and contradicting the evidence of Person C. [Witness 1] *gave evidence to the effect that fluid intake and urine output were recorded hourly from 26 July 2018.*

37. The evidence of [Witness 1]*, and contained in the response letter to Patient C, was that there were no scales on the ward for the purpose of weighing incontinence pads. The Registrant should not be held responsible for a lack of proper provision of equipment on the ward.*

38. Further, the allegation is not one of sufficiency. There is a record that the patient was incontinent of urine on two occasions before the catheter was placed, which, according to [Witness 1]*, amounts to a record of urine output.*

39. As such, there is insufficient evidence upon which the panel can rely to find this charge proved.

Charge 9(a)

On or around 27 July 2018, did not conduct Patient B's skin care checks every 2 hours as required.

40. There is no evidence as to how often Patient B was due to have skin care checks. The panel have not been provided with a SKINN bundle or care plan relating to Patient B.

41. Nevertheless, [Witness 1]*'s evidence was that Patient B needed a skin check every 4 hours; although under cross-examination, she was unable to state why that would be.*

42. None of the policies provide a guide as to the frequency of skin checks, particularly for patients who are mobile. Both [Witness 1] *and Patient B confirmed, with reference to documentary evidence, that Patient B was mobile.* [Witness 1] *confirmed that mobile patients should have skin checks once or twice a day.*

43. In the absence of a SKINN bundle, [Witness 1] *was unable to provide evidence as to the frequency of skin checks required for Patient B.*

44. As such, there is insufficient evidence for the panel to find this charge proved.

Charge 9(d)(i), (ii), & (iii)

On or around 27 July 2018, made inappropriate comments to Patient D to the effect:

(i) 'You don't do anything for yourself'
(ii) 'You need to lose weight'
(iii) 'That patient B was costing the NHS £5,000 a week

45. It is submitted that the evidence in relation to this is confused and contradictory. When taken at its highest, the evidence of Patient B is internally inconsistent and is inconsistent with other evidence. It could not properly result in a fact being found proved against the nurse.

46. Patient B gave evidence that:

(i) 27 July 2018 was the first time Ms Florida had nursed Patient B;

(ii) By 5am on 27 July 2018, Ms Florida had made these comments to Patient B Patient B knows this because he called someone at 5am on 27 July 2018, screaming for them to come and reassure him;

(iii) Either he, or his family, informed [Witness 2] *that these inappropriate comments had been made to him by Ms Florida.*

47. [Witness 2] *gives evidence that she was not informed that any such inappropriate comments were made, and that, had she been made aware, she would have included that in her statement.*

48. [Witness 1] *gave evidence as to the approximate start and end times of shifts. The roster is in evidence before the panel (Exhibit bundle page 145).*

49. The evidence is that Ms Florida was not on shift at or before 5am on 27 July 2018.

50. As such, there is insufficient evidence before this panel, to find this charge proved.

Charge 9(e)

On or around 27 July 2018, between 3:00 and 5:00am did not change Patient B's leg dressings.

51. The Registrant admits the facts of this charge. This submission is made under Rule 24(8), in that there is insufficient evidence to find the Registrant's practice impaired as a result of this admission.

52. Exhibit Bundle, page 145. The Registrant was on a long day shift on 26 July 2018 (approximately 7:30 to 8:30) and an early shift on 27 July 2018 (starting at approximately 07:30).

53. The evidence is therefore that the Registrant was not on shift between 03:00 and 05:00am.

54. Not changing a patient's dressings when not on shift cannot amount to misconduct and there is therefore insufficient evidence that the Registrant's practice could be impaired in relation to this charge.'

Ms Fletcher-Smith provided the panel with further oral submissions on this application.

Mr Radley also provided the panel with written submissions on this application:

*'**Response to submission***

1. *The NMC rely upon the evidence before the panel together with the Matrix presented at the commencement of the case.*

2. *Charge 1(a) – The NMC refer the panel to the statement of* [Witness 1] *at para's 7/8 and the evidence matrix.*
    - *However, Page 26 Transcript refers to this questioning and the evidence of the witness.*
    - *The Registrants representations are not challenged here*

3. *Charge 2 – This follows from the above matter and the NMC make no representations*
4. *Charge 1 (b)(i) & (iii) – It is noted that charge 1 (b) ii is not challenged*
    - *The panel are reminded that at this stage the requirement is to establish if there is some evidence that could be relied upon not to find the charges proven (Registrants skeleton 17, Page 5).*

- *There appears to be no questioning about charges 1(b) I – iii in the transcript*
- *The Matrix identifies the statement of* [Witness 1] *paragraphs 6 -8 as providing evidence here.*
- *The NMC say there can be a case to answer on the above evidence.*
- *The Registrant stated that she had other staff checked but she wrote herself. This is not an accurate reflection of the skin care and should be carefully considered by the panel.*

5. *Charge 3 – Charge 3 can stand for 1(b) (ii) as there are no representations. The NMC assert that this is a matter better considered at the end of the facts stage for all counts.*

6. *Charge 4 (a) -*
    - *Exhibit bundle Page 43 – point 26 to 29 refers to this patient (E)*
    - *Paragraphs 6 – 8* [Witness 1] *apply to this charge.*
    - *The sufficiency of the evidence here is for the panel to consider if it meets the Galbraith test.*

7. *Charge 5 – The NMC make no representations here beyond the above*

8. *Charge 7(b) – The evidence here was from person C Paragraph 6*

    - *There is evidence from the statement (Person C) confirmed on oath what she witnessed that charge 7(b) could amount to a case to answer.*
    - *Questioning from Registrant is found on page 15 onwards of the transcript confirming that although not in the original complaint she stood by her account.*

9. *Charge 7(C) – The NMC make no comment here*

10. *Charge 7 (f) – This is strictly a matter for the panel and it is a factual decision. At this stage based on the test in Galbraith.*

- *Person C gave evidence about how this could be measured (weighing)*
- *We assert that the reasonable efforts of staff are not unreasonable to ask for scales to be delivered or collected if this is the method used by them.*
- *This is a factual matter for the panel.*

11. *Charge 9 (a) – The evidence in this regard is provided by* [Witness 1] *and* [Witness 2]
    - *The Registrant asserts that certain evidence is not provided, Skin bundle or care plan. It is not for a panel to speculate on what is not provided.*
    - *The NMC make no further submissions here.*

12. *Charges 9 (d) (i), (ii) & (iii) – This is a matter of fact for the panel having heard the evidence.*
    - *The panel will need to assess if the accuracy of the timing is crucial. If it is and it is established that the nurse is not at work at the time of the charge this could be fatal.*
    - *The charge is framed 'On or around' and is not time specific.*
    - *Other charges are admitted against this patient so the NMC assert that issues had arisen between them and may support the assertion that comments were made here, simply the timing is wrong*

13. *Charge 9 (e) – The charge is framed 'on or around' and is not date specific.*
    - *The charge is admitted by the Registrant*
    - *As the charge is accepted the appropriate time to consider this matter is with other charges admitted and not in Isolation.*
    - *This is evidence of inappropriate behavior by the Registrant within a single setting over a period of time. It is therefore submitted, that it is most inappropriate to make this decision now.'*

Decision and reasons on application of no case to answer

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

The panel considered the application carefully in respect of each of the charges. The panel had regard to all the evidence adduced by the NMC both written and oral, and the submissions of Ms Fletcher-Smith and Mr Radley. The panel was mindful of the test in considering such applications, as set out in the judgment of Lord Lane LCJ in *R v Galbraith [1981] 1WLR 1039* and of the NMC guidance on no case to answer (DMA-5).

The legal assessor referred the panel to the two-limbed test laid down in *Galbraith*. In relation to these proceedings the test can be put as follows:

1. If there is no evidence against the registrant to support a particular charge, then the case must be stopped in respect of that particular charge.
2. If there is tenuous evidence in that it is inherently weak or vague or inconsistent with other evidence and if the panel considers taking the NMC evidence at its highest that it could not properly find the particular charge to be proved on the balance of probabilities, then the case must be stopped as far as that particular charge is concerned. However, where the NMC's evidence is such that its strength or weakness depends on the view to be taken on a witness's reliability, or other matters which are generally speaking within the province of the panel, as judges of the facts, where on one possible view of the facts there is evidence on which the panel could properly come to the conclusion that a particular charge is proved, then the case should proceed.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could (not would) find the relevant facts proved and whether you had a case to answer.

Charge 1(a)

'On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that Patient D had been repositioned every 2 hours.'

The panel determined that there is NOT a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and noted that Mr Radley did not challenge the application on this charge. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel noted the Intentional Rounding Log of Patient D dated 16 August 2017 which shows that Patient D was not repositioned every 2 hours during the night as follows:

'22:00- Patient D on their right side
00:00- Patient D on their left side
02:00- Patient D on their left side
04:00- Patient D on their left side
06:00- Patient D on their back'

The panel then noted the transcript of the previous dates of this hearing in which Witness 1 was asked, and answered, the following question by Ms Fletcher-Smith:

'Q: And so would you agree with me that this intentional rounding log does not show that Patient D was repositioned every two hours?
A. That's correct'.

The panel considered this is direct evidence that Patient D was not repositioned every two hours and determined that this evidence does not support this charge. The panel also considered that the NMC had not provided the panel with any evidence that any signature on that page belongs to you.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1(a) proved in line with limb 1 of the Galbraith test.

Charge 1(b)(i)&(iii)

'On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that:

(b) Patient D had declined skin care checks at

(i)02:00

(iii)06:00.'

The panel determined that there is NOT a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. It noted that Mr Radley did not challenge the application on this charge. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel noted that there was no evidence provided by Patient D or other direct witnesses to any skin care checks of Patient D. The panel then considered the Intentional Rounding Logs of Patient D dated 16 August 2017 and 17 August 2017 which show that the patient refused checks at 02:00 and 06:00 on both dates. The panel also considered the notes from the Disciplinary Investigation Meeting held on 21 September 2017 in which you stated *'We came to wake him to check him and explained but patient refused check, we tried to explain but he refused and don't want to be check […] Yes, this man was snappy, he did refuse, I remember him … not be disturbed and checked so I put refused on rounding log … after 10 o'clock he refused everything, he said to us he don't be disturbed …'.*

Your responses to questions asked of you in the disciplinary hearing are recorded as follows:

'Patient D difficult. Rude to her and […]. 2am 4am refused. Wake- not happy. Wanted to sleep. Explained. Refused. Cannot force. Signed rounding log herself. Should have added […]. HCA's also checked refused.'

The panel further noted that the entry at 06:00 was recorded by an HCA, not you.

The NMC has adduced no evidence to undermine any of the above statements made by you. The only direct evidence is that provided by you, that Patient D declined skin care checks.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1(b)(i)&(iii) proved in line with limb 1 of the Galbraith test.

Charge 2

'Your actions in charge 1(a) above were dishonest as you knew Patient D had not been repositioned every two hours but you sought to represent that they had.'

The panel determined that there is NOT a case to answer.

As the panel has determined that there is no case to answer on charge 1(a), this charge falls away.

Charge 3

'Your actions in charges 1(b)(i) and 1(b)(iii) were dishonest as you knew Patient D had not declined skin care checks but you sought to represent that they had.'

The panel determined that there is NOT a case to answer in respect of charge 1(b)(i) and 1(b)(iii).

As the panel has found no case to answer on charge 1(b)(i) and 1(b)(iii) the charge of dishonesty falls away in relation to charge 1(b)(i) and 1(b)(iii). Charge 3 in relation to sub-charge 1(b)(ii) will be considered by the panel at the conclusion of the facts stage.

Charge 4(a)

'On or around 16 August 2017, inaccurately recorded Patient E's intentional rounding log to indicate that

(a) Patient E had been repositioned every 2 hours.'

The panel determined that there is NOT a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel considered the Intentional Rounding Logs of Patient E dated 16 August 2017 and 17 August 2017. The documents show that Patient E was on his back between 22:00 and 06:00.

The panel also considered the oral evidence of Witness 1 within the transcript bundle where they were asked, and answered, the following question:

'So would you agree with that this rounding log does not suggest that this patient has been repositioned every two hours? A. That appears so, yes.'

The panel determined that there is no evidence either that Patient E had been repositioned every 2 hours or that you had inaccurately recorded such.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 4(a) proved in line with limb 1 of the Galbraith test.

Charge 5

'Your actions in charge 4(a) were dishonest, as you knew Patient E had not been repositioned, but you sought to represent that he had.'

The panel determined that there is NOT a case to answer.

As the panel has determined that there is no case to answer on charge 4(a), this charge falls away.

Charge 7(b)

'On or around 26 July 2018, did not clean the access device of Patient A's cannula with a Sani- Cloth CHG/ wipe and allow it to air dry for 30 seconds.'

The panel determined that there is a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel considered the evidence provided to it by Person C who was regularly present with Patient A whilst they were receiving care and treatment. It particularly noted Person C's NMC witness statement:

'I believe the Registrant did not use Aseptic Non Touch Technique ("ANTT") correctly when accessing Patient A's canula. ANTT requires the use of a Sani-Cloth CHG or the trust equivalent wipe to clean the access device correctly and allow it to air-dry for 30 seconds. In my opinion the Registrant failed to follow these steps correctly when accessing Patient A cannula, I know this because it is documented in my formal complaint to the hospital […]'.

The panel further considered Person C's complaint letter to the Trust dated 18 August 2018 in which they state:

'I witnessed the nurse (SN Florida) attach IV medications without using correct ANTT [Aseptic non touch technique]*.'*

In respect of limb 1 of the Galbraith test, the panel determined that there is some evidence against you to support this particular charge such that the panel could (not would) find the charge proved in due course The panel then considered limb 2 of the Galbraith test. It determined that there is evidence which is not so tenuous that it is inherently weak or vague or inconsistent with other evidence.

The panel determined, in line with limb 2 of the Galbraith test, that there is a case to answer on this charge and the panel will consider what weight to give to the evidence produced at the conclusion of the factual stage of proceedings.

Charge 7(c)

'On or around 26 July 2018, did not flush the cannula with 0.9% Saline 10ml following the administration of IV Omeprazole to Patient A.'

The panel determined that there is NOT a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. It noted that Mr Radley made no representations on this charge. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel considered that you have admitted to charge 7(d) in that you incorrectly flushed the cannula with 50ml following the administration of IV Omeprazole to Patient A.

The panel determined it is clearly logical that as you have admitted to flushing the cannula with 50ml of IV Omeprazole you must have flushed the cannula with 10ml of IV Omeprazole. The panel agreed with the submission of Ms Fletcher-Smith that:

> *'The panel, having found charge 7(d) proved, cannot find that there is also sufficient evidence to find charge 7(c) proved, as this would not be compatible with their previous finding'.*

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 7(c) proved in line with limb 1 of the Galbraith test.

Charge 7(f)

> *'On or around 26 July 2018, did not document/ monitor Patient A's urine input/output on an hourly basis.'*

The panel determined that there is a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel determined that there is evidence in respect of this charge namely Patient A's fluid balance charts and urinary catheter monitoring chart provided by you, Person C's written and oral evidence to the panel regarding Patient A's fluid intake and urine output and Witness 1's evidence in this respect including how this could be measured by weighing incontinence pads. In respect of limb 1 of the Galbraith test, the panel determined that there is some evidence to support this particular charge.

The panel determined, that there is a case to answer on this charge and the panel will determine what weight to give to the evidence at the conclusion of the factual stage of proceedings.

Charge 9(a)

On or around 27 July 2018, did not conduct Patient B's skin care checks every 2 hours as required.

The panel determined that there is a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel noted the evidence of Witness 1, Witness 2 and Patient B that skin care checks could have been required every two hours.

The panel therefore determined that there is evidence before it to support this charge. It determined that whether skin care checks were required and/or conducted is a factual matter and the panel will determine what weight to give to the evidence at the conclusion of the factual stage of proceedings.

Charge 9(d)(i), (ii) and (iii)

On or around 27 July 2018, made inappropriate comments to Patient D to the effect:

(i) 'You don't do anything for yourself'

(ii) 'You need to lose weight'

(iii) That patient B was costing the NHS £5,000 a week

The panel determined that there is a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. The panel first considered limb 1 of the *Galbraith* test namely whether there is any evidence before it to support this charge.

The panel considered the written statement together with the oral evidence provided by Patient B. Patient B stated that you did make these comments.

The panel determined that there is evidence before it to support this charge. It determined that the weight to attribute to this evidence is a matter for the factual stage of proceedings.

Charge 9(e)

On or around 27 July 2018, between 03:00 and 05:00 did not change Patient B's leg dressings.

The panel determined that there is NOT a case to answer.

The panel bore in mind the submissions of Ms Fletcher-Smith and Mr Radley. It bore in mind that this submission was made under Rule 24(8) of the Rules, in that there is insufficient evidence to find that your practice is impaired as a result of the admission to this charge.

On looking at the charge, it is clear that this relates to between 03:00 and 05:00 on 27 July 2018. The panel did not accept Mr Radley's submission that the charge should be considered more widely '*on or around'* in light of the specific timeframe set out in the charge of 03:00 to 05:00. The evidence before the panel is that you were '*on a long day shift on 26 July 2018 (approximately 7:30 to 8:30) and an early shift on 27 July 2018 (starting at approximately 07:30)'.* In fact, you were not on any night shift that week as indicated from the Roster week 1. Although you have admitted this charge as a factual charge in that you did not change Patient B's leg dressings, the panel accepted your submission that not changing a patient's dressings when you were not on shift cannot amount to misconduct.

The panel was therefore satisfied that there is insufficient evidence that your practice could be impaired in relation to this charge. The panel therefore found no case to answer in relation to Rule 24(8).

Further amendment to the charges

On handing down its no case to answer decisions to the parties, the panel invited representations in relation to a proposed amendment to charge 7(f). The Chair explained to the parties that, as currently drafted the reference to '*urine input'* did not make sense. It was clear to the panel that the evidence provided to it during the hearing was in relation to '*fluid intake'* and '*urine output'* and, as such, the panels view was to amend the charge to read '*fluid intake'* and '*urine output'.*

Mr Radley supported this proposed amendment on behalf of the NMC.

Ms Fletcher-Smith accepted that this would not cause any prejudice to you but stated that charges should be drafted correctly at the outset.

The panel undertook a common sense approach and determined to make the amendment to charge 7(f) to better reflect the evidence presented to it.

The charge now reads:

'That you, a registered nurse, whilst employed at Fairfield General Hospital;

7) On or around 26 July 2018;

f) Did not document/monitor Patient A's ~~fluid intake and urine output~~ ***fluid input and urine output*** *on an hourly basis.'*

Decision and reasons on facts

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 Radley on behalf of the NMC and by Ms Fletcher-Smith.

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.

Charge 1b(ii)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

1) On or around 16 August 2017, inaccurately recorded Patient D's intentional rounding log to indicate that;

b) Patient D had declined skin care checks at;

ii) 04:00

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement, corresponding exhibits and oral evidence provided by Witness 1.

The panel first considered the Intentional Rounding Log of Patient D dated 16/08/2017 and 17/08/2017. It noted the column titled 04:00 on 16/08/2017 is filled in to show that Patient D was checked and on 17/08/2017 in the column titled 04:00 shows a symbol which indicates that '*patient refused inspection'.*

The panel then considered the contemporaneous minutes from the first disciplinary hearing exhibited by Witness 1 which states that Patient D was '*difficult, rude to her* [the registrant]*, 2 and 4am refused'.*

The panel determined that there is sufficient evidence before it to show that you did record Patient D's refusal for skin care check on their intentional rounding log on or around 16 August 2017. The panel did not hear any evidence from Patient D or any other witness to refute your position that Patient D had declined the skin care check at 04:00. It therefore determined that the evidence presented to it does not demonstrate that it is more likely than not that this record was '*inaccurate'*.

The panel determined that the NMC has not discharged its burden of proof in relation to this charge and found this charge not proved.

Charge 3

That you, a registered nurse, whilst employed at Fairfield General Hospital;

3) Your actions in 1 b) ii) were dishonest as you knew Patient D had not declined skin care checks, but you sought to represent that they had.

This charge is found NOT proved.

As the panel had found charge 1bii) not proved, this charge falls away and is no longer to be considered by the panel.

Charge 7b)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

7) On or around 26 July 2018;

b) Did not clean the access device of Patient A's cannula with a Sani-Cloth CHG/wipe and allow it to air dry for 30 seconds.

This charge is found NOT proved.

In reaching this decision, the panel considered the NMC written statement, corresponding exhibits and oral evidence provided by Person C.

The panel first considered Person C's written statement which states:

'*I believe the Registrant did not use Aseptic Non Touch Technique ("ANTT") correctly when accessing Patient A's cannula. ANTT requires the use of a Sani-Cloth CHG or the trust equivalent wipe to clean the access device correctly and allow it to air-dry for 30 seconds. In my opinion the Registrant failed to follow these steps correctly when accessing Patient A cannula, I know this because it is documented in my formal complaint to the hospital'.*

The panel also considered the following passage of Person C's written statement:

'Due to the amount of time that has passed since this incident happened in July 2018, I have reviewed the complaint that I provided to the Trust on 18 August 2018, which I attach at exhibit Person C/1, to assist me in providing the following account'.

Upon examination of the complaint forwarded to the Trust on 18 August 2018, the panel noted '*I witnessed the nurse (SN Florida) attach IV medications without using correct ANTT'.* The panel noted this complaint letter did not contain specifics in relation to the use or non-use of the Sani-Cloth.

The panel then considered the oral evidence provided by Person C who accepted that they had no clear recollection of this incident. Under cross examination Person C stated, as a registered nurse, if they had seen you putting a patient at risk by failing to clean the access device with a Sani-Cloth they would have stopped you/intervened and Person C did not recall doing this.

The panel considered what weight to attach to Person C's NMC statement and concluded that as Person C relied upon their complaint letter to the Trust which did not include any reference to improper use of a Sani-Cloth, that less weight can be attached to the evidence of Person C in this regard.

In considering all of the above, the panel determined that the NMC has not discharged its burden of proof in relation to this charge.

Charge 7f)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

7) On or around 26 July 2018;

f) Did not document/monitor Patient A's fluid intake and urine output on an hourly basis.

This charge is found proved.

In reaching its decision, the panel considered the NMC written statement and corresponding exhibits provided by Person C, together with the 24-Hour Fluid Balance

Chart of Patient A dated 26/7/2018, the Urinary Catheter Monitoring Chart of Patient A dated 26/7/2018 and the 24-Hour Fluid Balance Chart of Patient A dated 27/7/2018.

In the letter of complaint to the Trust from Person C dated 18 August 2018 it states; *'on arrival to the ward, his input and output were not documented hourly, correctly or if at all even though he had an IV infusion running 24 hours most days.'.*

The panel then considered the 24-Hour Fluid Balance chart of Patient A dated 26/7/18. At 08:00 under the column oral intake it states '*NBM'* which the panel inferred to mean '*nil by mouth'*, under the column IV Intake -1 at 08:00 it states 100 and in under the column 'hourly running total input' at 08:00 it states 100. The panel noted the gap in entries under the 'hourly running total input' column from 11:00 – 13:00. Whilst it noted that at 11:00 under the column IV intake -2 it states '*off*', it determined there is a lack of documentation of Patient A's hours running total input from 11:00 to 13:00.

The panel noted that on the 24-Hour Fluid Balance Chart of Patient A it states under '*urine output*' at 09:00 and at 14:00 '*incontinent'.* The panel considered the Urinary Catheter Monitoring Chart of Patient A which showed that at some stage in the late afternoon on 26/7/2018, Patient A was catheterised. It noted that on the 24-Hour Fluid Balance Chart of Patient A dated 26/7/18 at 20:00 under '*urine output*' it states, '*300 chamber emptied'*. The panel came to the view that Patient A was catheterised around this time and a urine output was able to be measured.

The panel then considered the 24-hour Fluid Balance Chart dated 27/7/18. The panel noted that under the column '*urine output'* there is no entry at 09:00, 12:00 and 15:00. The panel further noted your apparent admission during the investigation interview on 1 November 2018; '*I did hourly but only 3 hrs I didn't do due to shift busy, I did after my work completed'.*

The panel determined that there is a lack of hourly documentation in Patient A's fluid intake and urine output charts. It determined, that on the balance of probabilities, it is more

likely than not that on or around 26 July 2018 you did not document/monitor Patient A's fluid intake and urine output on an hourly basis.

Charge 9a)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

9) On or around 27 July 2018;

a) Did not conduct Patient B's skin care checks every 2 hours as required.

This charge is found NOT proved.

In reaching its decision, the panel considered the NMC written statements, corresponding exhibits and oral evidence provided by Witness 1, Witness 2 and Patient B.

The panel noted the oral evidence provided by Witness 1 and Witness 2 that Patient B was not entirely bed bound and was mobile to an extent.

The panel considered the Trust's Policy for Integrated Hospital and Community pressure ulcer prevention and management dated 16 February 2016. It noted that this policy states '*skin assessment must occur regularly for all individuals identified to be at risk of pressure ulcers and the frequency should be based on their vulnerability and condition. In the hospital setting, the frequency must be documented on the SKIN bundle'.* The panel noted there was no evidence of an up to date '*SKIN*' bundle and therefore it was not possible to ascertain at what frequency skin care checks should have been made for Patient B.

The panel had also had reference to Witness 2's oral evidence in which they confirmed that the documents which outlined the frequency of skin care checks are the SKIN bundle in combination with the care plan, but the panel were not provided with either of these documents for Patient B.

Whilst the panel noted the evidence of Witness 1 that Patient B should have been repositioned every 4 hours, it determined that the evidence provided does not go to prove the charge in respect of skin care checks being required every 2 hours. The NMC has not produced any evidence to the panel regarding the frequency required of skin care checks for this patient.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to this charge.

Charge 9di) ii) & iii)

That you, a registered nurse, whilst employed at Fairfield General Hospital;

9) On or around 27 July 2018;

d) Made inappropriate comments to Patient B in that you stated/used words to the effect;

i) "You don't do anything for yourself"

ii) "You need to lose weight"

iii) That Patient B was costing the NHS £5,000 a week.

This charge is found NOT proved.

In reaching its decision the panel considered the NMC written statement and oral evidence provided by Patient B and Witness 2.

Patient B stated in their oral evidence to the panel that they were distressed by these comments made by you and made a phone call to their partner at around 5am on 27 July 2018. It noted that Patient B stated that they told Witness 2 about these comments at around 13:30 when Witness 2 visited Patient B.

The panel noted the oral evidence of Witness 2 who stated that Patient B did not inform them of these alleged remarks by you when Patient B was complaining to Witness 2 about their care on Friday 27 July 2018. Witness 2 told the panel that had they done so they were confident that they would have included it in their local statement at the time.

The panel noted that Patient B, in their oral evidence, indicated that they did not have a clear recollection of the circumstances of this event and told the panel that it would be best to speak to their partner about this incident. During Patient B's evidence to the panel Patient B raised that there were further notes that could assist the panel. Patient B, during cross examination, was then provided time to collect these notes and make a new NMC witness statement, however Patient B did not provide these notes and did not appear at the hearing again to conclude their evidence and the panel was not able to question Patient B about this incident.

The panel considered the inconsistencies in the evidence provided to it in relation to this incident. It noted that you were not on shift at the time Patient B allegedly contacted his partner concerning the allegations. It noted that Witness 2 denied that Patient B informed them of these allegations later that afternoon. For these reasons the panel determined that the evidence provided by Patient B was less reliable and no supporting evidence, including any evidence from Patient B's partner, had been provided to the panel.

Taking all of the above into consideration, the panel determined that the NMC had not discharged its burden of proof in relation to this charge.

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's Guidance DMA-1, states '*The question that will help decide*

whether a professional's fitness to practise is impaired is: can the nurse, midwife, or nursing associate practise kindly, safely and professionally?'.

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.'*

Mr Radley provided the panel with written submissions:

1. *'The Panel have found facts against Ms Florida (NF) on the following Regulatory Charges 7f. NF has admitted charges 4b, 6, 7a, 7d, 7e, 8, 9b,9c, 10 The Panel will now be considering Misconduct [and] Impairment.*

2. *The Panel will be aware of the fitness to practice library FTP – 3 (a, b and c) and the sanctions for serious cases – NMC guidance.*

3. *The Panel will be aware that the professional standards of practice and behaviour for nurses, midwives and nursing associates sets the professional standards that patients and public tell the NMC what they expect.*

4. *The panel will be familiar with the leading case of **Roylance v GMC [1999] UKPC 16** where **Lord Clyde** provided guidance when considering what could amount to Misconduct.*

   '[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [Nurse] practitioner in the particular circumstances'.

5. *Further assistance may be found in the comments of **Jackson J** in **Calhaem v GMC [2007]EWHC 2606 (Admin) and Collins J in Nandi v GMC [2004] EWHC2317 (Admin);***

   '[Misconduct] connotes a serious breach which indicates that the [Nurse's] fitness to practice is impaired.

   And

   *'The adjective **'serious'** must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.*

6. *The NMC assert that here, NF's, acts or omissions, falls short of the standards set out in the Code**: Professional standards of practice and behaviour for nurses and Midwives (2015) ("The Code")***

7. *Due to NF's falling short of "the Code", what she did or failed to do amounts here, the NMC say, to **serious professional misconduct and this has resulted in her currently being impaired.***

8. *FTP – 3a, The actions reported and found proven are failings directly related to clinical practice with potential harm to vulnerable patients. This behaviour could be seen to demonstrate **serious concerns** which are more difficult to put right (FTP - 3a) For example, Dishonesty relating to record keeping covers up failings of the nurse such as charge 4b and 6.*

9. *Record keeping that is inaccurate could impact on the treatment given by future nurses caring for the patient. This may result in opportunities for care being lost or delayed.*

10. *Following a finding of dishonesty, the wider implications to the family of nurses, HCA's and health professionals mean that they could be mistrusted.*

11. *FTP – 3b, Upholding the reputation of the profession. When an act of Dishonesty takes place trust and confidence can be lost.*

12. *These acts or omissions are not simply breaches of a local disciplinary policy or minor concerns, they are matters at the heart of and fundamental to the professional's practice. It is a serious concern at the heart of a caring profession specialising in the vulnerable patients (Elderly, Bariatric etc).*

13. *This can be serious professional misconduct because these issues relate to the nurses role as a registered professional and the potential impact on her area of practice.*

14. *Therefore, the NMC say that the behaviour here amounts to 'Serious Misconduct'.*

15. *The panel will be aware that seriousness is an important concept which informs various stages of our regulatory processes. The public's trust and confidence were affected (see the evidence of Person C/ complaint) resulting in complaints being investigated.*

16. *When considering the seriousness of misconduct, you will consider evidence of any relevant contextual factors. NF was working under the Hospital Regulations, in a busy ward setting.*

17. *The Panel have already carried out a full review of the evidence and it is not necessary to recite **all** the facts proven here.*

18. *I therefore turn to **"the Code".***

"The Code" (2015)

19. *The NMC say that "The Code" has been breached. The following particular sections of the code being engaged are;*

20. *Section 1 - Treat people with dignity and uphold their dignity: 1.3 (failures in care to Patient B*

21. *Section 2. – Listen to people and respond to their concerns 2.1, 2.5,*

22. *Section 3 – Make sure people's physical, social and psychological needs are assessed and responded to: 3.1, Has the Registrant met changing social care needs here (Patient A)? 3.4, The nurse has not challenged poor practice in line with her duty.*

23. *Section 4 – Act in the best interests of people at all times: - Falsifying records*

24. *Section 8 - Working cooperatively: 8.2, 8.3, 8.4, 8.5, 8.6.*

25. *Section 9 – Sharing skill knowledge and experience*

26. *Section 10 – Keep clear and accurate records relevant to your practice. 10.2, 10.3,*

27. *Section 14 – Be open and Candid with all service users. 14.2,*

28. *Section 19 - Be aware of and reduce as far as possible any potential for harm associated with your practice: 19.1, 19.3, 19.4.*

29. *Section 20 - Uphold the reputation of the profession – 20.1, 20.2, 20.3, 20.5, 20.6, 20.7, 20.8.*

30. *The Panel may, be particularly concerned about;*

    i. *Dishonest*

    ii. *Failures in record keeping*

    iii. *The potential effects on patient care – Skin care checks*

iv. *Potential harm by cross infection to vulnerable people (failure to use PPE and cleaning cannulas*

v. *Failure to document fluid intake*

vi. *NEWS score failures*

vii. *Lack of duty of candour at the time. Will this change in a busy working environment.*

Representations on Impairment

1. *The Panel are now considering whether or not Ms Nanette Florida's fitness to practise 'is impaired' (Art 22(1)(a) of the Nursing and Midwifery Order 2001).*
2. *Impairment is not defined in the legislation.*
3. *There have been many legal cases which have developed the concept of impairment and the factors that should be considered when deciding whether a professional's fitness to practise is impaired. The question that will help decide whether a professional's fitness to practise is impaired is:*

"Can the nurse, midwife or nursing associate practise
Kindly, safely and professionally?"

4. *Consideration has been given to the nature of the concern by looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;*

"Do our findings of fact in respect of the [nurse'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 professions 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 professions; and/or*
d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

5. *The NMC represent that this question is answered positively. The NMC represent that the professional's fitness to practise is impaired.*
6. *The Panel will be aware that a decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. Additionally, the NMC do not aim to punish the Registrant for the charges proven/admitted. Impairment is a current state of affairs. However, we submit that this position is difficult to argue when the Registrant faces two charges of Dishonest actions.*
7. *It is dependent on the individual circumstances surrounding each concern.*
8. *As stated above these events took place in the Hospital setting with vulnerable patients (Patient B Bariatric)*
9. *The panel will no doubt ask themselves if any part of the CODE was breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors the panel feel is important. Here the NMC refer the panel to the earlier concerns on the breaches of the CODE.*
10. *The NMC say that the breaches of the Code involves breaching a fundamental tenet of the profession, the Panel would be entitled to conclude that a finding of impairment is required in Ms Florida's case.*
11. *The finding of impairment, the NMC assert, is required to mark the unacceptability of the behaviour, emphasise the importance of the fundamental*

*tenet breached, and to reaffirm proper standards or behaviour (**Yeong v GMC [2009] EWHC 1923 (Admin) Hamer para 36.07).***

12. *It cannot be said that this was a one-off incident, especially when there has been an internal investigation for a similar matter (incident in the hospital 2017).*
13. *The Fitness to Practise Panel will consider the context in which things have happened. Here the panel will be asked to consider;*

    - *The professional's working environment within a busy ward.*
    - *The behaviour was witnessed by a Nurse visitor.*

14. *The NMC say this does adversely affect the professional's ability to practice professionally and as a consequence the professional will not be able to demonstrate that they are currently able to practise kindly, safely and professionally.*

15. *The third area of context is the learning, insight and steps the professional has taken to strengthen their practice. Ms Fletcher Smith will report for this area and we are told that the Registrant may give evidence.*

16. *Whether it is likely that the conduct will be repeated is also a concern for the NMC. This will impact on the professional's ability to practise kindly, safely and professionally, resulting in the NMC suggesting a finding of impairment to be appropriate.*

17. *The consequences of the professional's conduct affected patient care and could have been very serious, potential infections. Expectations of behaviour and professionalism are high for all regulated professionals and Dishonesty has no place in a caring profession.*

18. *For these reasons the NMC say that Ms Nanette Florida's practice is impaired.'*

Ms Fletcher-Smith also provided the panel with written submissions on misconduct and impairment:

'Remaining Charges

1. *The facts of the following charges were admitted by the Registrant:*

   4(b), 6, 7(a), 7(d), 7(e), 7(f), 8, 9(b), 9(c), 10

1. *The facts of the following charges were found proved by the Panel:*

   7(f)

Misconduct

The Legal Test

1. *Falling short of the NMC Code does not necessarily mean that the act or omission amounts to serious professional misconduct.*

2. *Roylance v GMC (No 2) [2000] 1 AC, Lord Clyde defined misconduct as:*

   'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances.'

3. *Meadow v General Medical Council [2007] 1 All ER 1, Auld LJ referred to the case of Roylance as regards seriousness.*

   'As Lord Clyde might have encapsulated in his discussion of the matter in Roylance v General Medical Council, it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute.'

4. *Nandi v General Medical Council [2004] EWHC 2317 (Admin), Collins J rightly emphasised at [31] the need to give the term 'misconduct' proper weight, observing that in other contexts it has been referred to as:*

   'conduct which would be regarded as deplorable by fellow practitioners.'

SUBMISSIONS

5. *The Registrant accepts that the charges admitted and found proved amount to misconduct.*

Impairment

The Law

6. *Alongside the formulation set out by Dame Janet Smith in her fifth Shipman report, the panel should also have regard to the case of Yusuff v General Medical Council [2018] EWHC 13 Admin, in which it is stated at paragraph 20.5:*

   'Admitting the misconduct is not a condition precedent to establishing that the registrant understood the gravity of the offending and is unlikely to repeat it.'

7. *Ronald Jack Cohen v. General Medical Council [2008] EWHC 581 Admin: The panel is obliged to consider all relevant factors known to the panel at the impairment stage. This includes the opinion of experts, the practitioner's record and whether the conduct was 'easily remediable'.*

Submissions

8. *It is submitted that the Registrant's fitness to practise is not currently impaired. The panel are invited to undertake a forward-looking assessment.*

9. *The Registrant has demonstrated significant insight, as established in her reflective account. She made immediate admissions to the most serious charges of dishonesty in her disciplinary investigations. The Registrant has also made*

very significant admissions before the panel. Although she has provided context for her failings, she has not sought to excuse her behaviour.

10. *The Registrant has demonstrated appropriate remorse and reasoning.*

11. *The last charge is from July 2018, more than 5 years ago. It has taken an inordinate amount of time to bring this hearing before the NMC. In that time, there have been no further complaints against the Registrant. The Registrant has been working for the same agency since 2019 and there have been no concerns as to her clinical capabilities, record keeping or honesty.*

12. *It is accepted that dishonesty is more difficult to remediate. However, the Registrant's continued practice with no further such concerns is demonstrable of a fully remediated practice.*

13. *The Registrant has strengthened her practise and has taken steps to address her shortcomings. She is a highly experienced nurse. She has developed and implemented robust checking mechanisms for ensuring errors are prevented. The Registrant has reflected fully, and adjusted the way in which she is working. She has not tried to deflect blame or make excuses and has demonstrated a willingness to learn and improve. The Registrant has been practising safely during these 5 years.*

14. *If there were, at the time, attitudinal issues, it is submitted that these have been fully remediated. The risk of repetition in her case is low.*

15. *The lengthy and careful process of this hearing and the fact that it took several years to get to this point is, it is submitted, sufficient to demonstrate to the public that the standards of conduct are being properly upheld. The Registrant is not liable in the future to put patients at unwarranted risk of harm, and has amended her practise to ensure that this is the case.*

16. *The Registrant has been open and honest about her shortcomings, admitting 9 out of the 10 charges proved. She has always accepted her misconduct and has worked hard to remediate her practise.*

17. *It is therefore submitted that the Registrant's fitness to practise is not currently impaired.'*

Decision and reasons on misconduct

The panel ensured that you had sight of and had read the NMC's submissions on misconduct and impairment.

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

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 breaches of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.2** make sure you deliver the fundamentals of care effectively*

***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving

care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

> ***10.1*** *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> ***10.2*** *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
>
> ***10.3*** *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

> ***19.1*** *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection.*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20 Uphold the reputation of your profession at all times

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

To achieve this, you must:

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

20.2 *act with honesty and integrity at all times, […]'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the failures in this case relate to fundamental aspects of nursing care and dishonesty. It determined that individually and collectively these are a serious departure of the standards expected of a registered nurse.

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 patients were put at risk and could have been caused physical and emotional harm as a result of your misconduct. Your misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel also found that you had acted dishonestly. The panel found all four limbs of the *Grant* test are engaged in relation to your past conduct.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered:

- Whether the concerns identified in your nursing practice were capable of remediation;
- Whether they have been remedied and;
- Whether there was a risk of repetition of a similar kind at some point in the future.

In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you had provided evidence of insight and remorse.

The panel was mindful that there are two distinct types of concerns in this case; clinical concerns and dishonesty concerns. The panel considered the three limbs set out in *Cohen* individually for the clinical concerns and dishonesty charges.

Regarding the clinical concerns identified in your practice, the panel determined that these are capable of remediation. It determined that whilst you have provided some evidence of training these were not specific to the areas identified within the charges and therefore of limited value in demonstrating a strengthening of your practice. It noted that there are

more relevant and appropriate courses that could have been completed to adequately address the clinical concerns in this case. The panel noted that you made admissions to some of the clinical concerns at the time of the incidents. However, it also noted that you sought to blame this on work pressures and your personal circumstances rather than take ownership of your failings. The panel therefore determined that whilst you have shown some remediation, the clinical concerns have not been fully remedied and so there is a risk of repetition at some point in the future.

The panel then considered the dishonesty concerns in this case. It determined that dishonesty concerns are serious, and the panel had regard to the NMC Guidance DMA-1 and DMA-7 with regards to dishonesty. The panel noted that the dishonesty charges in this case relate to an incident which occurred in August 2017 and another in July 2018, 11 months apart. The panel noted that whilst dishonesty concerns are difficult to remediate, they are capable of remediation. The panel noted that there is no evidence of any repetition of such dishonest conduct of this nature since 2018. However, the panel determined that despite the fact that you have shown remorse, your insight into the seriousness and implications of your dishonesty is limited.

Whilst it recognised your early admissions when challenged during the Trust investigation, the panel determined that you have not taken ownership of the dishonesty concerns, nor have you shown how your actions would have affected patients, fellow colleagues, or the wider public. In light of this, the panel determined that the dishonesty concerns have not been remediated and, mindful that you repeated this behaviour previously, it could not be satisfied that you are highly unlikely to repeat conduct of a similar nature at some point in the future. The panel therefore found all four limbs of *Grant* are engaged with regard to your future behaviour.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

The panel considered the concerns together and determined that there is a risk of repetition of both clinical and dishonesty concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

In relation to the public interest, this includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds 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 suspension order for a period of six months with review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley provided the panel with written submissions on sanctions, Ms Fletcher-Smith confirmed that she had read these submissions to you:

'The following matters will be considered by the Panel at this stage of the case.

Proportionality

1. ***The Panel will be seeking to find a fair balance between Ms Florida, the nurses rights, and our <u>overarching objective of public protection</u> (Huang v Secretary of State for the Home Department [2007] UKHL 11)***
2. *The NMC's case is that The FTP committee can Justifiably restrict the Nurses right to practice in this case. The NMC say that only 'Strike off' can be sufficient to reflect this.*
3. *The panel will consider whether the sanction with the least impact on the Nurses practise would be enough to achieve public protection and in the wider Public Interest looking at the reasons why the nurse, isn't currently fit to practise and any aggravating or mitigating features.*
4. *The Panel can conclude that the Nurse is not fit to practice currently because.*

The NMC note the Panel finding of the Statutory grounds of

a. *It is necessary for protection of the public; AND*
b. *In the wider public interest*

Aggravating features

The representations on aggravating factors are;

1. *Serious concern, with the potential for patient harm and to undermine trust and confidence in the profession.*
2. *This conduct was not isolated 11 months apart.*
3. *The conduct was a calculated Dishonesty linked to record keeping directly relating to the patient.*
4. *The conduct appears to be linked to an earlier event (2017) The lack of information is noted from defence Counsel*
5. *The Registrant shifted blame by suggesting the ward was understaffed etc.*
6. *There is a lack of clear ownership of the Dishonesty concerns (panel page 65)*

Mitigating features

The mitigating features are;

1. *No previous regulatory (NMC) referrals*
2. *Accepted part, of the regulatory concerns*
3. *Engaging with the Regulator in the process*

Proposed sanction

1. *Striking off*
    - *These are serious Regulatory concerns, particularly dishonesty*
    - *The actions were repeated 11 months apart and on two occasions here (additionally the 2017 matters)*
    - *Serious concerns by covering up Nursing failings (record keeping)*
    - *This is the only sanction that would protect patients, members of the public and maintain professional standards.*
    - *In terms of Public interest, the bar is set high – (Bawa-Gaba v GMC [1 WLR 942] para 13. 'The views of an informed and reasonable member of the public appraised of all the circumstances of the case'.*

2. *Considering all of the factors in this case the sanction bid here is for a 'Strike off'.'*

Ms Fletcher-Smith provided oral submissions.

Ms Fletcher-Smith referred the panel to NMC guidance on '*cases involving dishonesty*'. She highlighted that the guidance stated that cases which involve dishonesty will always be serious and a nurse who has acted dishonestly will always be at some risk of being removed from the register. She reminded the panel that not all forms of dishonesty are of the same severity and highlighted that the records you completed did not seek to suggest that skin checks had been done when they had not, as it was clear to anyone reading the documentation that you had not performed skin checks for the patients concerned. She stated that the records for both Patient E and Patient B indicated that the skin checks had been refused and therefore you were only dishonest about the reason why the checks were not undertaken. She submitted that you have always accepted, since the Trust's

internal investigation that you have acted dishonestly and breached the duty of candour. She invited the panel to take this into account when considering the seriousness of the dishonesty in this case.

Ms Fletcher-Smith submitted that according to the NMC guidance, the dishonesty in this case is of a less serious nature, as:

- The incidents in this case can be considered one-off incidents against a background of 15 years honest conduct; and
- They were both opportunistic and spontaneous conduct, with no direct personal gain related to the dishonesty.

Ms Fletcher-Smith submitted that you have demonstrated some insight into your failings, which the panel has found to be limited. She submitted that you have described yourself as ashamed and detailed the importance of nurses acting honestly in your statement provided to the panel at the misconduct and impairment stage. She stated that although you can and should take full ownership of your misconduct, both in relation to clinical failings and dishonesty, it is not the case that you have placed blame elsewhere and not looked inwardly at your own misconduct at all. She submitted that dishonesty does have the potential to be remediated and there has been no evidence of patient harm as a result of your misconduct.

Ms Fletcher-Smith submitted that the incidents occurred 11 months apart from each other, but there is no evidence to support any assertion that there have been any concerns about your 15 years of practice as a nurse prior to this period. In addition, she submitted that since the NMC referral, you have practised as a nurse for five years unrestricted with no further concerns.

Ms Fletcher-Smith submitted that in relation to the mitigating features of this case, the panel has found that there is some level of insight and understanding of the problems and some attempts to address it, including early admission of the facts. She submitted that you

have also put forward personal mitigation [PRIVATE]. She stated that you have no previous regulatory findings and a total period of 20 years of practice as a nurse with no concerns. She stated that of the ten charges found proved, you have admitted nine of them from the very beginning, at the Trust's internal investigation.

Ms Fletcher-Smith submitted that conduct in this case is not so serious that it is fundamentally incompatible with continuing to be a registered professional. She submitted that since the NMC referral you have been working without restriction with no interim order, as this was never applied for. She submitted that a member of the public appraised with the information that you have been working without restriction for the past five years, would not be concerned if you are not removed from the register, but would be glad if you are given the opportunity with structure to take full ownership of your misconduct. She submitted that in this respect, the most appropriate sanction would the conditions of practice order to include undertaking of specific training and the preparation, and completion of a practice development program. She submitted that this would provide you with the structure you need to take full ownership of your misconduct and remediate the concerns.

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:

- Conduct both in relation to clinical concerns and dishonesty which put patients at risk of suffering harm;

- Two separate incidents of dishonesty within an 11-month period; and
- Lack of ownership into failings, including the impact of your actions on patients, fellow colleagues, and the wider public.

The panel also took into account the following mitigating features:

- Early admissions and apologies.

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 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. It noted that there were clinical concerns in this case that could be addressed through retraining. However, the panel had regard to the fact that the concerns in this matter also related to dishonesty and you have demonstrated limited insight into your dishonest conduct. The panel was therefore of the view that there are no practical or workable conditions that could be formulated, given your failure to address the dishonesty elements of this case. The panel concluded that the

placing of conditions on your registration would not adequately protect the public and meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where 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 found that the concerns in this case included two instances of misconduct due to dishonesty, although these were some time apart and not continuous. There was no evidence of deep-seated personality or attitudinal problems. It took into account that you have demonstrated limited insight into your failings and there is a consequent risk of repetition. However, the panel noted that you have practised as a nurse for five years since the incidents with no repetition and therefore determined that there was no evidence of a significant risk of repetition.

The panel also had regard to the NMC's guidance on '*seriousness*' and '*cases involving dishonesty*' (Reference: SAN-2). The panel noted that not all dishonesty was equally serious, and the more serious type of dishonesty will call into question whether a nurse should be allowed to remain on the register. In respect of the guidance, the panel was of the view that the following were applicable to this case in respect of dishonesty:

- '…

- *…*
- *vulnerable victims*
- *…*
- *direct risk to patients*
- *…*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain'.*

The panel took into account that you did not complete the records for Patient E and Patient B to indicate that you had completed skin checks when you had not, but your dishonesty related to the reason why the checks were not undertaken. It also noted that each incident occurred in isolation although they were 11 months apart. In this regard, whilst the panel acknowledged that there was some risk of harm to patients, it considered that this was reduced by the fact that your colleagues would have been aware that these checks were not completed. The panel considered that there was no direct personal gain to you and considered that your conduct was not premeditated. Having regard to the above, the panel did not consider your dishonesty as the most serious category.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of six months with a review was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- A reflective statement using a recognised model of reflection addressing the panel's findings on misconduct, including both clinical failings and dishonesty;
- Evidence of any completed training and associated assessments that relate to and address the regulatory concerns in this case;
- Comprehensive character references or testimonials; and
- Attendance and engagement at a future hearing.

This will be confirmed to you in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that an interim order should be made on the grounds that it is necessary the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in the panel's findings.

The panel also took into account the submissions of Mrs Fletcher-Smith. She reminded the panel that you have been working for five years without restriction and without any application from the NMC for any such restriction. She invited the panel to bear this in mind when making its decision on an interim order.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the suspension order takes effect.

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 and the reasons set out 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 consistent or appropriate in this case, for 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 to allow for any possible appeal.

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

That concludes this determination.