Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 7 March - Friday, 8 March 2024

Virtual Meeting

Name of Registrant:	**Sheena Patricia Mordue**
NMC PIN	05D0155E
Part(s) of the register:	Registered Nurse - Sub Part 1 RNA: Adult Nurse, Level 1 (15 November 2005)
Relevant Location:	North Yorkshire
Type of case:	Lack of competence
Panel members:	Bryan Hume (Chair, Lay member) Lorraine Wilkinson (Lay member) Beth Maryon (Registrant member)
Legal Assessor:	Ashraf Khan
Hearings Coordinator:	Margia Patwary
Facts proved:	Charges 1, 2, 3, 4a, 4b, 4c, 4d, 5, 6, 7, 8, 9, 10, 11a, 11b, and 11c
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Mordue's registered email on 26 January 2024.

The panel accepted the advice of the legal assessor.

In exercising its due diligence, the panel took into account that the Notice of Meeting provided details of the allegation, information on when the meeting would take place (on or after 1 March 2024) and the fact that this meeting was to be heard virtually.

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

Details of charge (as amended)

That you failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

1) On 31 December 2019 failed to administer the required insulin to Patient A when their blood sugar was greater than 25. [**FOUND PROVED]**

2) On 24 February 2020 Failed to safely insert a subcutaneous line into Patient C. [**FOUND PROVED]**

3) On 31 December 2019 Failed to document Patient A's Hyperglycaemic episode. [**FOUND PROVED]**

4) On 24 February 2020 Failed to document the following for a new patient admission: [**FOUND PROVED]**
   a) nursing risk assessments.
   b) MUST assessments.
   c) Nutritional assessments.
   d) Waterlow assessments.

5) On 20 May 2020 for an unknown patient did not complete: [**FOUND PROVED]**
   a) assessment documentation Trusted A & B;
   b) the falls risk assessment.

6) On 2 November 2019 for a patient unknown failed to identify an urgent transfer to an acute hospital for potential sepsis, where the patient had a NEWS score of 6 and multiple comorbidities and an infection. [**FOUND PROVED]**

7) Failed to progress and communicate with colleagues to arrange a bed sensor and crash mat for Patient G. [**FOUND PROVED]**

8) On 24 September 2019 Failed to complete a 7am patient observations resulting in morning staff, colleagues having to complete this. [**FOUND PROVED]**

9) On 23 September 2019 Failed to complete initial risk assessments or admission documents for new patients resulting in colleagues having to complete these. [**FOUND PROVED]**

10) On 16 July 2020 failed to complete the morning medication round by 10am. [**FOUND PROVED]**

11) Persistently failed to: [**FOUND PROVED]**
    a) manage your time efficiently;
    b) complete tasks;
    c) provide effective care

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

Decision and reasons on application to amend charge 4d

The panel of its own volition decided to amend charge 4d. The amendment for charge 4d was to change the word ‘waterloo’ to ‘waterlow’. The panel noted this was a typographical error. The panel considered that this amendment would provide clarity and more accurately reflect the evidence.

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

The panel was of the view that such an amendment, was in the interests of justice.

The panel was satisfied that there would be no prejudice to Mrs Mordue and no injustice would be caused to either parties by the proposed amendment being allowed. It was therefore appropriate to allow the following amendment to ensure clarity and accuracy:

> **“**On 24 February 2020 Failed to document the following for a new patient admission:
>
> a) nursing risk assessments.
> b) MUST assessments.
> c) Nutritional assessments.
> d) ~~Waterloo~~ **Waterlow** assessments.”

Background

Mrs Mordue was referred to the NMC on 4 December 2020, Witness 1, Ward Manager at Whitby Hospital, Humber Teaching NHS Foundation Trust (the Trust).

Whilst Mrs Mordue was employed as a Band 5 Nurse by the Trust, she was initially placed on an informal capability plan in March 2020 due to multiple concerns. These concerns were regarding a number of incidents raised about Mrs Mordue's clinical skills, time management, prioritisation of workload, delegating workload, and poor record keeping.

Incidents took place between October 2019 and July 2020. Each incident was followed up with a supervision meeting with one of the Band 7 Nurses. Due to the impact of Covid-19, the informal capability plan was put on hold until July 2020.

At a review meeting on 29 July 2020, there was little progress made and Mrs Mordue was informed that the informal process would move to a formal process. Mrs Mordue then resigned from her role in September 2020.

Decision and reasons on facts

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

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

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

- Witness 1: Charge Nurse
- Witness 2: Band 6 Specialist Nurse and Deputy Manager
- Witness 3: Band 5 Nurse
- Witness 4: Healthcare Assistant

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

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

Charge 1

> "On 31 December 2019 failed to administer the required insulin to Patient A when their blood sugar was greater than 25."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1.

Witness 1 in her written statement stated:

> *"The patient had a blood glucose reading of 27.6 at 16.10 hours. This was reported to Sheena by the HCA. The patient was prescribed as required fast acting insulin to be administered if their blood glucose was greater than 25. Sheena didn't administer this insulin as it was prescribed but waited until the night staff came on duty at 20.30 hours and handed it over to the staff nurse.*

Further, the panel noted that Mrs Mordue made local admissions to this allegation to which Witness 1 stated in her written statement:

> *"Sheena greed that this was a serious event. However, she was unable to clearly account for why she didn't administer the as required insulin as per the prescription chart.*
>
> *Sheena did admit she may have failed to read and take in the administration notes which clearly stated 'to administer if blood glucose is greater than 25'. Sheena also said she felt awful about the incident afterwards and worried about the patient all night. Sheena stated she'd done a written reflection following this incident and noted her colleague, SB, was very helpful in his explanation of what action she should have taken earlier and why."*

The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to administer insulin to Patient A.

The panel determined on the balance of probabilities that Mrs Mordue failed to administer the required insulin to Patient A and therefore, the panel finds charge 1 proved.

Charge 2

"On 24 February 2020 Failed to safely insert a subcutaneous line into Patient C."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 3, Witness 3's local statement and the Supervision Record dated 4 September 2019.

In relation to cannula issues, the panel noted Witness 3 in her written statement stated:

> *"I talked through the procedure with Sheena and she was happy to proceed. Once you insert the line, you have to pull the guide out after insertion. However, when Sheena did this, the plastic cannula bent and the wire had damaged cannula.*
>
> *Again, Sheena didn't hold on to the cannula properly and I could see it was bent when the guide wire came out*
>
> *I told Sheena we'd have to do it again but she tried to push the cannula back in and administer a flush through the line.*
>
> *Patient C never said anything but he was being stabbed multiple times with the needle so it must of caused discomfort. You could also see he was visibly annoyed.*
>
> *CC and I then put the subcutaneous cannula in together. Sheena wasn't in the room with us. After we inserted the line, patient C said "do not let her administer medication to me as she is incompetent". I don't remember if either of us responded to this comment. To clarify, he was referring to Sheena."*

The panel also had sight of the Supervision Record which demonstrates that Mrs Mordue was supervised on 4 September 2019. The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to safely insert a subcutaneous line into Patient C.

The panel determined on the balance of probabilities that Mrs Mordue failed to safely insert a subcutaneous line into Patient C and therefore, the panel finds charge 2 proved.

Charge 3

"On 31 December 2019 Failed to document Patient A's Hyperglycaemic episode."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1 and the Supervision Record dated 31 December 2019.

Witness 1 in her written statement stated:

> *"With this same patient, Sheena had failed to document the patient's hyperglycaemic episode as part of her review of their condition in the care plan. This demonstrated a lack of defensible documentation.*
>
> *I made it clear to Sheena and discussed that on every shift she must ensure demonstration of defensible documentation in the following way. An entry must be made on the System One electronic tab journal regarding each patients clinical condition on that shift. It must include a brief assessment, including the NEWS observation score, and where appropriate blood glucose readings, a review of the patient's care plan, an amendment to that care plan with an explanation and justification using professional rational when necessary."*

The panel also had sight of the Supervision Record which demonstrates that Mrs Mordue was supervised on 31 December 2019. The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to document Patient A's Hyperglycaemic episode.

The panel determined on the balance of probabilities that Mrs Mordue failed to document Patient A's Hyperglycaemic episode and therefore, the panel finds charge 3 proved.

Charge 4

“On 24 February 2020 Failed to document the following for a new patient admission:

a) nursing risk assessments.
b) MUST assessments.
c) Nutritional assessments.
d) Water low assessments.”

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1, the Informal Action Plan and the screenshots from System One (patient record entries).

Witness 1 in her written statement stated:

> *“On 24 February 2020, Sheena was allocated as a team leader responsible for a group of 11 patients. There was a new patient admission at 14.00 hours. Sheena had failed to document any nursing risk assessments, MUST, nutritional, or Waterlow assessment on the patients. She also failed to document any care plans to meet the patient's needs. There was no entry made by Sheina at all on this patient's record during this whole shift.*
>
> *In the informal action plan, an action was put in place to address this concern. The action for Sheena was that all new patients were to be clinically assessed and existing patient care needs under her responsibility to have documentation completed in a timely manner on the System One care record. An entry regarding every patient's condition and the alterations in their plan of care should also be made on System One for every patient she's responsible for on every shift including the NEWS observation score. This could be a brief entry but on 24 February 2020, there were no entries from Sheena at all.”*

The panel had sight of the screenshots from System One which indicates that someone

else completed the assessments. The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse, responsible for the newly admitted patients to document information for new patient admissions sufficiently.

The panel determined on the balance of probabilities that Mrs Mordue failed to document nursing risk assessments, MUST assessments, nutritional assessments and waterlow assessments for a new patient admission. Therefore, the panel finds charge 4 proved.

Charge 5

"On 20 May 2020 for an unknown patient did not complete

a) assessment documentation Trusted A & B;
b) the falls risk assessment."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1.

Witness 1 in her written statement stated:

> *"On 20 May 2020 Sheena was working a shift from 07.30 - 20.30 hrs and wars allocated as team leader for a group of 4 patients on West wing. Sheena was asked to complete the assessment documentation Trusted A and B and the falls risk assessment for a patient. Sheena did not complete any of this documentation during her 12 hour shift."*

The panel determined on the balance of probabilities that Mrs Mordue for an unknown patient did not complete assessment documentation Trusted A & B and the falls risk assessment. Therefore, the panel finds charge 5 proved.

Charge 6

"On 2 November 2019 for a patient unknown failed to identify an urgent transfer to an acute hospital for potential sepsis, where the patient had a NEWS score of 6 and multiple comorbidities and an infection."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1, Witness 2 and the Supervision Record dated 2 November 2019

Witness 1 in her written statement stated:

"On the morning of 2 November 2019, the patient had 1 red flag present on their sepsis screening due to their oxygen saturation being less than 91 per cent. The NEWS score had been total of 6 which needed to be escalated. This was rechecked and it was still scoring the same. The patient also had multiple comorbidities and an infection where they had been nursed in isolation. Sepsis was a distinct possibility.

This patient had requested she was for resuscitation in the event of a cardiac arrest and for an escalation and transfer to acute hospital where she wanted whatever treatment deemed appropriate.

In this scenario, the appropriate course of action by any nurse would be to dial 999 and arrange an urgent transfer to the acute hospital by saying it's a possible sepsis."

This also corroborated Witness 2's written statement which stated:

"…another supervision session took place in regards to a patient having a red flag with sepsis. As far as I can recall, she didn't make the decision to raise the red flag as she said she did not know how to or had the confidence to do this as far as I can recall. The patient was transferred to the acute hospital for assessment of sepsis"

The panel noted that it was Mrs Mordue's duty to raise concerns to as a Band 5 Registered Nurse to identify urgent transfers. It noted that she had a duty to raise concerns regarding sepsis even if she had been unsure to the correct procedure at the hospital at the time.

The panel determined on the balance of probabilities that Mrs Mordue failed to identify urgent transfers for potential sepsis and therefore, the panel finds charge 6 proved.

Charge 7

> "Failed to progress and communicate with colleagues to arrange a bed sensor and crash mat for Patient G."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 4.

Witness 4 in her written statement stated:

> *"Prior to this incident, the other HCA and I discussed with Sheena that Patient G was getting distressed and hallucinating. To ensure patient safety, we asked Sheena if we could put a sensor on the bed and crash mats in place. I can't recall what Sheena said exactly but she didn't really give us a response.*
>
> *…*
>
> *Sheena didn't respond so we spoke to another nurse on the ward, Paul Butler (PB). PB gave us the confirmation to put a bed sensor on Patient G and change 4 hourly rounds to 1 hour to make sure they were ok…*
>
> *I discussed with Sheena whether we could put a bed sensor in the situ and the crash mats. I asked her how she wanted us to proceed with Patient G.*

Sheena did not respond and had ignored us. I'm not sure if she got in contact DS as they weren't on duty that day."

The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to communicate with colleagues and raise concerns when needed to. The panel found that other nurses had to provide support when it was Mrs Mordue's responsibility to provide guidance on this issue.

The panel determined on the balance of probabilities that Mrs Mordue failed to progress and communicate with colleagues to arrange a bed sensor and crash mat for Patient G and therefore, the panel finds charge 7 proved.

Charge 8

"On 24 September 2019 Failed to complete a 7am patient observations resulting in morning staff, colleagues having to complete this."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1, the Supervision Records dated 3 October 2019 and 2 December 2019.

Witness 1 in her written statement stated:

"Sheena had failed to do the 7 o clock observations and had handed over to the morning staff. Giving our learning from the previous incident, this was not satisfactory. The only time 7 o'clock observations can be handed over to the morning staff if there is a clinical emergency on the ward. On this occasion, there wasn't a clinical emergency.

<u>On 2 December 2019</u>
I had a supervision discussion with Sheena in regards to time management and prioritisation of workload. I discussed with Sheena that these concerns had been discussed with her in previous supervision meetings and now colleagues are

starting to feel placed under undue pressure when working with her. It appeared to them Sheena wasn't completing her fair share of a registered nurses workload."

The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to adequately complete patient observations.

The panel determined on the balance of probabilities that Mrs Mordue failed to complete a 7am patient observations which resulted to colleagues having to complete and therefore, the panel finds charge 8 proved.

Charge 9

"On 23 September 2019 Failed to complete initial risk assessments or admission documents for new patients resulting in colleagues having to complete these."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 1.

Witness 1 in her written statement stated:

"Also, during our discussion on 3 October 2019, we talked about time management, which is linked with the two previous concerns mentioned. Further to this, on the late shift on 23 September 2019, 3 new patients had been admitted to the ward. Sheena had responsibility as team leader for that group of patients. She hadn't reviewed or completed any of those patients initial risk assessments or admission documents at all. This not only impacted on the patients as a safety risk but also on the team colleagues who had to pick up this workload the following morning. I also discussed with Sheena that this could have resulted and adverse clinical impact on the patients."

The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to complete initial risk assessments or admission documents for new patients adequately.

The panel determined on the balance of probabilities that Mrs Mordue failed to complete initial risk assessments for new patients which resulted in her colleagues having to complete. Therefore, the panel finds charge 9 proved.

Charge 10

> "On 16 July 2020 failed to complete the morning medication round by 10am."

This charge is found proved.

In reaching this decision, the panel took account of the written witness statement of Witness 4.

Witness 4 in her written statement stated:

> *"Also, on this day, there would have been 3 medication rounds and for each of them, Sheena took a long time.*
>
> *The morning medication was still going on when we were giving out lunches. This should've been completed by 10am. Pain medication was running behind."*

The panel noted that it was Mrs Mordue's duty as a Band 5 Registered Nurse to complete medication rounds in a timely manner.

The panel determined on the balance of probabilities that Mrs Mordue failed to complete the morning medication round by 10am and therefore, the panel finds charge 10 proved.

Charge 11

> "Persistently failed to
> a) manage your time efficiently;
> b) complete tasks;
> c) provide effective care"

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, 2, 3 and 4's written witness statements and supervisions at which these issues were regularly addressed. The panel was satisfied that these issues arose sufficiently frequently as to be described as persistent.

Witness 1 in her written statement stated:

> *"Clinical duties*
> *Sheena was a very pleasant and personable individual but she spent an inappropriate amount of time in social conversations with patients unrelated to their care, when there were other clinical duties she needed to complete. This impacted on the colleagues working with Sheena as they were having to pick up the clinical duties that were her responsibility. After a while this would cause some friction within the team.*
>
> *Sheena would also spend time with patients who weren't her responsibility. Of course we're all there for all patients but that group of patients would have their own registered nurse team leader. She should have concentrated on her own patients she's responsible as it could undermine the other registered nurse's role and responsibility which can cause frustration, friction and avoidable stress.*
>
> *Patient in pain*
> *Also, with this same patient, one of the HCA's expressed their concerns that they reported to Sheena the patient was in pain but she failed to act upon their concerns. Sheena had prioritised something which held much less priority over seeing this patient. The team were all made aware that he was admitted with uncontrolled palliative end of life symptoms, pain being one of them. For any registered nurse, any patient in pain, particularly if their end of life, they would be a priority. Only a cardiac arrest would supersede this as a priority. When someone else attended to this patient later, he was in significant pain.*
>
> *Colleagues having to complete work*

In our session, Sheena indicated she hadn't recorded the patient's routine observations at around 7 o'clock. We spoke about the importance of this. Sheena had been working the night duty and it was her responsibility to conduct the morning observations. This is so any deteriorating patient can be identified and escalated without delay and the nurse in charge of the morning shift at 7.30 am will be aware of any deteriorating patients."

In relation to not managing workload/not completing tasks, Witness 2 in her written statement stated:

"I explained to Sheena she needed to help with the observations. I can't recall the exact time, but this would have been between 6 and 8pm. 30 minuets later, Sheena came to me and asked if the HCA could finish off the observations. I asked her why she could not complete them herself and she said she needed to complete some documentation. I told Sheena it's her responsibility to prioritise her workload and delegate what she can't complete."

In relation to time management issues, Witness 3 in her written statement stated:

"Overall, I required to observe Sheena with patients to make sure she was delivering care in a timely manner. She had issues with time management and would talk quite a lot to patients, and others appearing to delay delivering timely care to her patients as far as I can recall."

In relation to time management and relying on staff to complete tasks, Witness 4 in her written statement stated:

"Overall, Sheena is a caring individual but it's her time management and relying on other members of staff to complete tasks or point her in the direction of what to do next."

The panel determined that it was Mrs Mordue's duty to manage her time efficiently, complete tasks and provide effective care for patients as a Band 5 Registered Nurse and therefore, the panel finds charge 11 proved.

Fitness to practise

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

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

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

Representations on lack of competence and impairment

The panel took into account NMC's written representations on impairment, which states:

'We consider the following provisions of the Code have been breached in this case;

- ***1.2** make sure you deliver the fundamentals of care effectively.*
- ***1.4** make sure that any treatment, assistance, or care for which you are responsible is delivered without undue delay.*
- ***2.1** work in partnership with people to make sure you deliver care effectively.*
- ***6.2** maintain the knowledge and skills you need for safe and effective practice.*
- ***8.2** maintain effective communication with colleagues.*
- ***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff.*
- ***9.2** gather and reflect on feedback from a variety of sources, using it to improve*

your practice and performance.

- ***10** Keep clear and accurate records relevant to your practice.*
- ***10.1** complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.*
- ***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
- ***10.3** complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.*
- ***10.4** attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*
- ***10.5** take all steps to make sure that records are kept securely.*
- ***10.6** collect, treat and store all data and research findings appropriately.*

Recognise and work within the limits of your competence.

- ***13.1** accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.*
- ***13.2** make a timely referral to another practitioner when any action, care or treatment is required.*
- ***13.3** ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.*

It is submitted that the breaches of the Code amount to a lack of competence and are serious because a lack of competence in any area of nursing practice puts patients at risk, whether that be by poor record keeping which might mean other professionals do not have an accurate picture of care given or poor medication practice which might mean patients do not receive the correct medication, resulting in a deterioration of their condition or unnecessary pain and suffering.

We consider that concerns regarding Mrs Mordue's ability to delegate or manage her workload puts patients at risk by there being the possibility raised that her 7duties are

being delegated inappropriately to untrained members of staff who do not have the requisite skills to do the tasks of a registered nurse. In allegedly not managing her workload adequately, patients are placed at risk by Mrs Mordue's inability to recognise and prioritise the most critical tasks and attend to those first.

…[PRIVATE]…

Mrs Mordue has not provided any in depth information as to how this context affected her alleged lack of competence and therefore, in our view, it does not adequately explain the concerns raised regarding Mrs Mordue's practice.

Impairment

Impairment needs to be considered as of today's date. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. 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?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

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

2. *has Mrs Mordue in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
3. *has Mrs Mordue in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
4. *has Mrs Mordue in the past acted dishonestly and/or is liable to act dishonestly in the future.*

It is the submission of the NMC that point a, 1, 2 and 3 can be answered in the affirmative in this case.

i. *Mrs Mordue's actions placed Patients at harm. Mrs Mordue's actions left patients who were already vulnerable in a n even more vulnerable positions. Similar failings in the future could lead to a risk of harm and distress if not addressed.*
ii. *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. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Mrs Mordue's failings relate to basic and fundamental nursing duties. Mrs Mordue further failed to carry out a basic nursing task to properly complete and record a health assessment for either Patient C. As such her lack of competence is liable to bring the profession into disrepute.*
iii. *Mrs Mordue has breached the fundamental tenet of providing safe and effective care for patients. 9 20.Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin)

by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

We consider the registrant has displayed no insight. We take this view because Mrs Mordue has not provided us with any evidence of training that she has carried out following the concerns being raised or demonstrated any insight into the impact of those concerns on the patients. Mrs Mordue has not shown any understanding of why the concerns are so serious or how she might act differently in the future.
We note that Mrs Mordue has undertaken some employment as a nurse since leaving the Trust but further concerns regarding her practice have been raised by that employer. This gives us cause for concern that Mrs Mordue continues to repeat errors of a similar kind despite a change in environment.

Mrs Mordue has submitted to the NMC that she no longer wishes to work as a nurse, and does not intend to seek any further employment where she will be required to use her registration.

We consider there is a continuing risk to the public due to the registrant's lack of full insight and failure to undertake relevant training. She has not been able to demonstrate strengthened practice through work in a relevant area.

Taking all of this information into account we are not satisfied that the risk of repetition is low, and therefore we conclude that Mrs Mordue remains a risk to the health, safety and wellbeing of the public.

Public interest
In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

"In determining whether a practitioner's fitness to practise is impaired by reason of lack of competence, 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."

.Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior [SIC]. The registrant's conduct engages the public interest because Mrs Mordue has not undertaken any further treating and continued to make errors in a new 11 employment. The public rightly expect nurses to perform their duties safely and professionally, and as such, the absence of a finding of impairment risks undermining public confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

***6.2** maintain the knowledge and skills you need for safe and effective practice.*

8 Work co-operatively

To achieve this, you must:

***8.2** maintain effective communication with colleagues.*

***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff.*

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

***9.2** gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

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 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*

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.*

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

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.*

The panel bore in mind, when reaching its decision, that Mrs Mordue should be judged by the standards of the reasonable average Band 5 Registered Nurse and not by any higher or more demanding standard.

In the panel's judgement, Mrs Mordue's actions in each of the individual charges found proved did fall seriously short of the conduct and standards expected of a nurse and amounted to a lack of competence.

Mrs Mordue's failures had the potential to cause significant harm to patients and undermined public confidence in the profession. The panel determined that the numerous errors in medication administrations were basic fundamental nursing skills. Although, Mrs Mordue was made aware of the numerous errors in her medication administration and received support, she then repeated the errors.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mrs Mordue's practice was below the standard that one would expect of the average registered nurse acting in her role.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mrs Mordue's 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. 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.

The panel bore in mind this was a lack of competence case, nevertheless the panel had regard to 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/their fitness to practise is impaired in the sense that S/He/They:*

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*

The panel finds that patients were put at risk and there was a potential for physical and emotional harm as a result of Mrs Mordue's lack of competence. The panel determined that Mrs Mordue's lack of competence has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel went on to consider whether Mrs Mordue remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Regarding insight, the panel considered Mrs Mordue's provided no evidence that she had developing insight. The panel has not been able to ascertain her current level of insight and therefore it was unable, with confidence to accept that Mrs Mordue had demonstrated anything other than limited insight into her lack of competence or that she had considered the impact on patients, colleagues, the reputation on the profession and the wider public interest.

In its consideration of whether Mrs Mordue has taken steps to strengthen her practice, the panel had no information from her since the incidents and her dismissal to demonstrate any steps Mrs Mordue may have taken. In light of this, the panel is of the view that there is a risk of repetition as there is no evidence to demonstrate any strengthening of her practice or any training Mrs Mordue may have undertaken. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

Having regard to all of the above, the panel was satisfied that Mrs Mordue's fitness to practise is currently impaired on the grounds of both public protection and public interest.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Mordue's registration has been suspended.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 26 January 2024, the NMC had advised Mrs Mordue that it would seek the imposition of a 12-month suspension order with review if it found Mrs Mordue's fitness to practise currently impaired.

The panel took into account NMC's written representations on sanction, which states:

> ***'Sanction***
> *We consider the following sanction is proportionate:*
>
> *12-month suspension order with review The aggravating factors in this case are the medication errors and timeliness of medications rounds continued into the new job. In mitigation Mrs Mordue has had no previous referrals.*
>
> *With regard to our sanctions guidance the following aspects have led us to this conclusion:*
>
> ***No Action:*** *This sanction would not be appropriate as there are no exceptional circumstances that would warrant taking no action if found currently impaired.*
>
> ***Caution Order:*** *Considering the seriousness this is not appropriate. Caution orders are suitable where the concerns are at the lower end of the spectrum of impaired fitness to practise.*

Conditions of Practice Order: *This sanction may be appropriate where, as here, there is an identifiable area of a nurse's practice which can be addressed through retraining or assessment. However, our guidance says that conditions of practice may not be suitable unless the nurse has shown potential and willingness to respond positively to retraining. In the present case, Mrs Mordue has not practised since 2021 and has reached retirement age. Mrs Mordue has indicated clearly that she does not intend to work as a nurse again, therefore there are no workable conditions likely to address the lack of competence. In addition, there is a 12 risk to patient safety if she were allowed to continue to practise even with conditions.*

Suspension: *The NMC guidance on suspension orders states that this sanction may be appropriate where there is no evidence of a deep seated and/or harmful attitudinal issue. It is submitted that this would be the most appropriate sanction to impose in this case to manage the risk to the public. A 12-month suspension will mark the seriousness of the conduct in the public interest.*

Strike Off: *This sanction would be excessive as the incident is not so serious to be fundamentally incompatible with being on the register. This sanction is not available for cases of lack of competence.'*

Decision and reasons on sanction

Having found Mrs Mordue's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Medication errors and timeliness of medications rounds continued into the new job
- Conduct which put vulnerable patients at risk of serious harm
- Numerous incidents which continued over several months

The panel found no mitigating features in Mrs Mordue's case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would 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 Mrs Mordue's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Mordue's lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on Mrs Mordue's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the

seriousness of the facts found proved and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel also took into account that the Mrs Mordue has not engaged with the NMC thus it would not be able to formulate conditions of practice that would adequately address the concerns relating to her lack of competence without her involvement.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the lack of competence was not fundamentally incompatible with remaining on the register.

Balancing all of these factors the panel determined that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest given the seriousness of the competency issues in this case.

Accordingly, the panel determined to impose a suspension order for the period of 12 months which would provide Mrs Mordue with an opportunity to engage with the NMC, provide evidence that she has taken steps to address the concerns regarding her lack of competence. It considered this to be the most appropriate and proportionate sanction available.

The panel noted that a striking off order was not an available sanction as this case involved a lack of competence and not misconduct.

The panel noted the hardship such an order will inevitably cause Mrs Mordue. However this is outweighed by the public protection and the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the lack of competence.

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:

- Mrs Mordue's engagement with the NMC;
- Evidence of work in the healthcare sector;
- Any evidence of courses or training undertaken to maintain or improve Mrs Mordue's nursing knowledge and skills;
- A reflective piece demonstrating Mrs Mordue's insight into the concerns raised; and
- A Statement detailing Mrs Mordue's future intentions about practising as a registered nurse or otherwise.

This will be confirmed to Mrs Mordue in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Mordue's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC which stated:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's

determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

That concludes this determination.