Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

8 July 2019 – 11 July 2019

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

Name of registrant:	Funmilola Sijuwola Haastrup
NMC PIN:	02K0022O
Part(s) of the register:	Nursing, Sub part 1 RN1, Registered Nurse – Adult (1 November 2002)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Noreen Kent (Chair, Registrant member) Kathryn Smith (Registrant member) Jane McLeod (Lay member)
Legal Assessor:	Robin Hay
Panel Secretary:	Edmund Wylde
Funmilola Sijuwola Haastrup:	Not present and not represented
Nursing and Midwifery Council:	Represented by Katie Mustard, Case Presenter
Facts proved:	1, 2 (in their entirety)
Fitness to practise:	Impaired
Sanction:	Striking-Off Order
Interim Order:	Interim Suspension Order (18 months)

Details of charge:

That you a registered nurse,

1. *Whilst working the night shift of the 7/8 December 2017,*

    1.1 Were asleep whilst on duty; **[PROVED]**

    1.2 Did not ensure that Patient A was checked regularly; **[PROVED]**

    1.3 Did not ensure that Patient B was checked regularly; **[PROVED]**

    1.4 Allowed other staff members to sleep whilst on duty; **[PROVED]**

    1.5 Pre-signed MAR sheets for the morning round of medication. **[PROVED]**

2. *Your actions at charge 1.5 was dishonest in that the entries made were false in that you signed the MAR sheets prior to the morning round of medication taking place.* **[PROVED]**

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

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Haastrup was not in attendance and that written notice of this hearing had been sent to her registered address and also to her representative by recorded delivery and by first class post on 7 June 2019. Notice of this hearing was delivered to Mrs Haastrup's registered address on 10 June 2019.

The notice letter gave details of the allegations, the time, dates and venue of the hearing and also information about Mrs Haastrup's right to attend, to be represented and to call evidence. It referred also to the panel's power to proceed in her absence.

The panel accepted the advice of the legal assessor.

In the light of the information available, the panel was satisfied that Mrs Haastrup has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed despite the absence of Mrs Haastrup.

The panel had regard to Rule 21 (2).

Ms Mustard submitted that the hearing should proceed in the absence of Mrs Haastrup as she had voluntarily absented herself. She submitted that, as the notice of hearing was signed for with the name “Haastrup”, Mrs Haastrup is well aware of the hearing and of the documents to be placed before this panel. Ms Mustard said that Mrs Haastrup’s representative has been in regular and recent contact with the NMC with regard to this hearing. Further that Mrs Haastrup has made it clear that she has had no intention of attending. Mrs Haastrup has provided a written response to the charges, and has indicated that she wishes this to be considered by the panel. Ms Mustard submitted that this amounted to an acceptance and willingness for the hearing to proceed in her absence.

In this context, Ms Mustard referred to an email from Mrs Haastrup’s representative, dated 4 July 2019, which states:

> *Mrs Haastrup says she will not be attending but would rely entirely on her submission the content of which is in your possession… In consequence we consent to the hearing proceeding in our absence believing in the panel’s sense of justice and fairness.*

Ms Mustard submitted that, in the light of Mrs Haastrup’s written submissions and documents, there would be little prejudice to Mrs Haastrup. Further, as Mrs Haastrup, despite being in regular contact with the NMC has not requested an adjournment, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Ms Mustard said that the NMC is ready to proceed and that a number

of witnesses have been warned. She further submitted that it is in the public interest that this matter should be dealt with expeditiously.

The panel accepted the advice of the legal assessor.

The panel was aware that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 should be exercised "*with the utmost care and caution*".

The panel has decided to proceed in the absence of Mrs Haastrup. It had regard to the overall interests of justice and fairness to all parties.

The panel reached its decisions in the light of the following matters:

- Mrs Haastrup has made it clear in her correspondence that she has no intention of attending a substantive hearing, and has provided written submissions for consideration;
- Mrs Haastrup's representative, in the email dated 4 July 2019, has confirmed that Mrs Haastrup will not attend and has consented to the hearing proceeding in her absence; no application for an adjournment has been made by Mrs Haastrup;
- there is no reason to suppose that adjourning would secure her attendance at some future date;
- two witnesses have attended today, and another is due to attend;
- not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, those who need their professional services;
- further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- there is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Haastrup. The panel will draw no adverse inference from Mrs Haastrup's absence.

Decision and reasons on application pursuant to Rule 31

Ms Mustard applied for the written statements of Ms 4 to be admitted in evidence. She submitted that Ms 4's evidence is relevant to a number of the charges, and that, in the circumstances of the case, it would be fair to admit it. The statements are dated 8 December 2017 (the local statement) and 6 November 2018 (the NMC statement) respectively.

Ms Mustard observed that the admissibility of any such evidence is a matter for the panel in the exercise of its professional judgement. She commented that the panel has had the benefit of hearing from three witnesses, whose evidence has been tested before the panel.

Ms Mustard said that Ms 4's evidence relates to the unannounced night inspection on 8 December 2017. She completed her local statement about the incident at 05:43 that day. Ms Mustard submitted that the statement is in effect a contemporaneous record of the incident. Furthermore, Ms 4 asserts that it is a true recollection of events.

Ms Mustard said that Ms 4's NMC witness statement is in proper form, and that in it Ms 4 says that she wishes to rely on her local statement as her evidence.

Ms Mustard submitted that Ms 4's evidence is not sole or decisive to any charge, but is simply corroborative of evidence given by the three witnesses called. She submitted that Ms 4's evidence adds nothing new to that already before the panel.

With regard to the nature and extent of Mrs Haastrup's challenge to the content of Ms 4's statement, Ms Mustard referred to the documents provided by Mrs Haastrup in which she sets out her case. The panel has also heard how other witnesses have responded to questions put to them in fairness to Mrs Haastrup. Ms Mustard submitted that questions put to Ms 4 could add nothing as her evidence is merely corroborative of that already before the panel. She said that, at one stage, Mrs Haastrup's

representative had indicated that all the witness statements were agreed and that the witnesses were not required to attend.

Ms Mustard submitted that Ms 4 had nothing to be gained by fabricating an account, and referred to the fact that on two occasions she states in writing that her account is true; furthermore, it is not suggested by Mrs Haastrup that Ms 4 has any reason to lie or fabricate her account. Ms Mustard submitted that Ms 4 clearly knew the purpose and seriousness for which her statements may have been used when making her NMC statement – particularly as she too is a registered nurse.

Ms Mustard observed that, although the charges are serious, there is no case law to suggest that merely because a charge is serious, hearsay evidence is inadmissible – it is only a factor to be considered.

With regard to Ms 4's reason for non-attendance and the steps taken by the NMC to secure her attendance, Ms Mustard referred to the handwritten words at the foot of Ms 4's NMC statement:

> *N.B I am currently working and getting time off work may be difficult. I hope my statement will be sufficient as I have nothing more to add.*

Ms Mustard said that a High Court Summons was obtained to secure Ms 4's attendance and served on her on 4 July 2019 and by email on 5 July 2019; there has been no response to this Summons.

Ms Mustard referred to the convoluted procedural history of this case, evidenced by the relevant documentation and correspondence from Mrs Haastrup's representative. At one stage, all witnesses in this case were de-warned and told that they need not attend. This changed only recently when Mrs Haastrup's representative indicated that he wished to make formal representations. It was made clear on 3 July 2019 that the witness statements were not agreed. It was only from that time that witnesses could be

re-warned. Ms Mustard submitted that the NMC have taken, not only all reasonable, but all possible steps to secure Ms 4's attendance.

The panel accepted the advice of the legal assessor.

The panel determined that Ms 4's evidence is clearly relevant to some charges. Further it is not, in regard to any charge, the sole or decisive evidence, but is merely corroborative of the evidence of other witnesses. Ms 4's local statement was written soon after the conclusion of the inspection, at 05:43 on 8 December 2017. It is a contemporaneously-made document and, as such, is a reliable representation of Ms 4's recollection of events.

The charges against Mrs Haastrup are serious, and it is therefore important to consider all available evidence. The panel bore in mind the reasons given for Ms 4's non-attendance, and the convoluted procedural history of this case. It determined that the NMC have made the best possible efforts to secure her attendance, including securing a High Court Summons. Furthermore, until recently, all parties were proceeding on the basis that witnesses would not be required to attend and that their statements would be read. Indeed, the correspondence with Mrs Haastrup's representative made clear that she was content to agree that the statement of Ms 4 could be read.

In these circumstances, the panel was satisfied that the evidence of Ms 4 was relevant to the issue and that there would be no unfairness to Mrs Haastrup if it were to be admitted.

Background

On 30 January 2018 Mrs Haastrup was referred to the NMC by the General Manager of Aspray House Nursing Home ("the Home"), where she had been employed since 2004 as a registered nurse working night shifts.

On the night of 7/8 December 2017, Mrs Haastrup was the nurse in charge of the Emerald Unit of the Home, a 20-bedded unit for vulnerable adults. At approximately 03:30 on 8 December 2017, there was an unplanned night inspection of the Home by a team led by the General Manager of the Home ("the Team").

Mrs Haastrup and a number of carers at the Home were allegedly found to be asleep whilst on duty. It is alleged that Mrs Haastrup was not only asleep, but that she allowed other staff to be asleep on duty; as a consequence, some vulnerable residents were allegedly neglected and not regularly checked. Patient A was allegedly left in a soiled bed for an unknown period of time, estimated by the Team to be between 2 – 3 hours. Patient B was allegedly found to be in a bed which had been soaked in urine for a significant period. It is further alleged that there was no indication to the Team that any of the residents in Emerald Unit had been checked on for at least an hour prior to the commencement of the inspection.

During the course of the inspection, the Team allegedly also found that Mrs Haastrup had pre-signed, as administered, for medication, due to be given to 13 of the residents on Emerald Ward at 07:00 on 8 December 2017; this medication had yet to be administered and was found in its blister packs at around 04:00. It is alleged that Mrs Haastrup, in signing out the medication before it was administered, acted dishonestly.

Following this incident, Mrs Haastrup was suspended from duty and a local investigation was undertaken; this resulted in a disciplinary hearing being scheduled for 21 December 2017. Mrs Haastrup did not attend that hearing and instead submitted her resignation on the same day – this was formally accepted on 3 January 2018.

Decision on the findings on facts and reasons

In reaching its decisions, the panel considered all the evidence before it, including a brief video recording of the scene when the inspection team arrived. It considered also the submissions made by Ms Mustard and the written submissions made by Mrs Haastrup.

The panel accepted the advice of the legal assessor.

The panel has drawn no adverse inference from the non-attendance of Mrs Haastrup.

The panel heard evidence from three witnesses called by the NMC:

Ms 1 – Senior Carer at the Home;
Mr 2 – General Manager of the Home
Mr 3 – Assistant General Manager at the Home;

The panel also considered the hearsay statement of Ms 4 (a Registered Nurse).

The panel first considered the witnesses' overall credibility and reliability.

Ms 1 was candid in her account. She was balanced and fair and did not embellish her evidence in any way. The panel found her to be a credible witness.

Mr 2 was a credible and straightforward witness, who was frank about procedures at the Home. He accepted that there were some details that he could not remember and he indicated where the passage of time had affected his recollection.

Mr 3 was candid and confident in his evidence. His recollection was clear and consistent, and he demonstrated good recall of detail – particularly in relation to Patient B. Mr 3 was clearly passionate about high standards of nursing and care, but did not

show any adverse motivation towards Mrs Haastrup. The panel found him to be a credible and reliable witness.

Mrs Haastrup had previously returned a Case Management Form in which she made admissions to the charges. However, in the light of the procedural history of the case and the written representations of Mrs Haastrup, the panel did not regard these to be formal admissions.

The panel considered each charge and made the following findings:

Charge 1:

1. *Whilst working on the night shift of the 7/8 December 2017,*

Sub-Charge 1.1:

1.1 Were asleep whilst on duty

This sub-charge is found proved.

The evidence of Mr 2 was that, when he approached the Home prior to the unannounced inspection, it was in darkness with the lights off, despite being a 24-hour facility. He said that, when he approached Mrs Haastrup (having entered the Emerald Unit), she was seated in a comfortable position with her shoes and socks off, her legs up, and her eyes closed; she did not stir or acknowledge him even though there was a noise from the door when it was opened. The mobile phone footage showed a person (identified by Mr 2 as Mrs Haastrup) in exactly that position; it further showed that she remained immobile and did not react while the Team moved around her.

In his evidence Mr 2 said that when Mrs Haastrup did stir she appeared to be confused. In her local interview, Mrs Haastrup appears to contradict herself on a number of

occasions; the panel found this to corroborate Mr 2's evidence that Mrs Haastrup was trying to justify and/or cover up her actions.

Mr 2's evidence was that Mrs Haastrup's comment, when he spoke with her later, that she believed Mr 2 and the Team to be members of a resident's family, indicated to him that she was disorientated as if awaking from sleep. He further said that he had used a master key to enter the Home and that at 03:30 it would be most unlikely for family members to be present.

In their evidence, Ms 1 and Mr 3 said that they believed Mrs Haastrup to be asleep. Ms 4's evidence was in similar terms. Mr 3 stated that, even when standing in front of Mrs Haastrup, she did not react.

Mrs Haastrup, in her written representations, said that she was, at the relevant time, on a break and was only in a seated position because of that. The panel, however, preferred the evidence of Ms 1, Mr 2, and Mr 3. It took into account the fact that, within the Home, all staff were aware that the night shift was a waking shift and they were not entitled to sleep. Indeed, there was a declaration, dated 11 May 2011, signed by Mrs Haastrup, and it was the evidence of Mr 2 that all staff had signed a similar document. Further the evidence of Mr 2 was that the nurse in charge remains accountable throughout the shift.

The panel found the evidence of Ms 1, Mr 2 and Mr 3 to be compelling. Furthermore, it had in mind Mrs Haastrup's observations in her returned Case Management Form.

Taking all the above into account, the panel found this charge to be proved.

Sub-Charge 1.2:

1.2 Did not ensure that Patient A was checked regularly

This sub-charge is found proved.

In reaching this decision, the panel referred to the relevant care log and other documentation, which do not demonstrate entries of a regular nature on the night in question.

The evidence was that there should have been hourly checks of each patient. Indeed, Mrs Haastrup, at the investigation interview, said that there should be checks every thirty minutes or at least hourly.

Further the evidence was that Mrs Haastrup, as the nurse in charge, had the overall responsibility and accountability for ensuring that the checks were done, albeit that this checking could be delegated to carers.

In their evidence, Ms 1, Mr 2, and Mr 3 described their shock at Patient A's condition; they described the strong smell outside the room and also that the faeces around Patient A were dry, which indicated that she had not been checked for a number of hours. Ms 1 in her evidence said that the smell of faeces from the room was so strong that it would have alerted staff to Patient A's condition, even between any checks that might have been done.

Taking all the above into account, the panel found this charge to be proved.

Sub-Charge 1.3:

1.3 Did not ensure that Patient B was checked regularly

This sub-charge is found proved.

In his evidence, Mr 3 gave a detailed description of the condition in which he found Patient B. The sheets had been stained by urine and were yellow/brown and dry at the

edges. Mr 3 stated that, in his long experience as a nurse, this would only occur after a significant period of time, and is not indicative of recent incontinence. Mr 3 concluded from this that Patient B had not been checked for some hours. He further said that although Patient B, because of his medical condition, could not tell him how long he had been in the soiled bed, he did express disgust.

In his local statement, made contemporaneously, Mr 3 said:

> *I checked on* [Patient B] *I asked him "What's up* [Patient B]*" and he replied "I am wet". I checked his bed and it was urine soaked and brown stained from his neck to his knee… There was no indication that any of the residents was checked in the last hour.*

Although Mr 2, in his evidence, could not specifically remember seeing Patient B, the panel was satisfied that, as his main focus of that evening as General Manager may have been dealing with staffing issues and cover for the Home in the light of any potential suspensions, his attention and priorities may have been elsewhere.

The panel accepted the evidence of Mr 3 in respect of this charge.

Taking all the above into account, the panel found this charge to be proved.

Sub-Charge 1.4:

1.4 Allowed other staff members to sleep whilst on duty

This sub-charge is found proved.

The panel was satisfied from Mr 2's evidence that staff had been made aware that the night shift was a waking shift and they were not entitled to sleep and that all staff had signed the declaration to that effect.

In his evidence, Mr 2 said that the Team found other carers throughout the Home to be asleep. He then dismissed some of these carers, including one from the Emerald Unit.

In her local interview, Mrs Haastrup stated:

> *I used to go round to check to tell them even if you want to sleep don't make a bed, don't use a sheet. Don't do something like that, if you want to relax you can sit down on the chair.*

In her written submissions for this panel, Mrs Haastrup stated:

> *The other part of his allegation is that I allowed staff to sleep. Again this cannot be said to be perfectly accurate as there are other Nurses in each floor responsible for the residents and care workers in their floors. If he had alleged that as the most senior staff on duty I should take much more responsibility, maybe, I would have considered admitted fault for "permitting unsafe staffing by allowing others to sleep".* [sic]

The panel was satisfied that Mrs Haastrup and at least one carer in the Emerald Unit were asleep at the time of inspection. It found that therefore Mrs Haastrup was allowing that carer to sleep whilst on duty.

Taking all the above into account, the panel found this charge to be proved.

Sub-Charge 1.5:

1.5 Pre-signed MAR sheets for the morning round of medication.

This sub-charge is found proved.

Mr 3's evidence was that he had seen the relevant charts during the unannounced night inspection, and that the signature and initials were those of Mrs Haastrup. The charts, which were before the panel, were found, completed, by Mr 3 in advance of 04:00 whereas the medication was not due to be given until 07:00. Mr 3 stated that he found the corresponding medication still in its blister packs and administered it himself at the correct time.

Mrs Haastrup has admitted this charge in the local investigation, and in her written representations to this panel she states:

> *The most grievous of these allegation as you have said is that of falsification of medical records. I admit that this allegation is weighty as it borders on my professional competence. I admit this action as wrong and a matter for which I deeply regret.* [sic]

Taking all the above into account, the panel found this charge to be proved.

Charge 2:

2. *Your actions at charge 1.5 was dishonest in that the entries made were false in that you signed the MAR sheets prior to the morning round of medication taking place*

This charge is found proved.

The panel has determined that Mrs Haastrup signed the MAR sheets prior to the morning round of medication taking place.

Mr 2 described Mrs Haastrup's actions as "falsification of records". The panel also bore in mind that the Home's policy is clear that signing for medication should be at the time of administration, in order to maintain accuracy. Furthermore this is a requirement which should be known to every nurse; indeed it is set out in the NMC's *Standards for*

medicines management. The panel found it to be most unlikely that Mrs Haastrup did not know that, by signing for medication well prior to its administration, she was writing something that was clearly false.

The panel took into account Mrs Haastrup's explanation for her actions, namely that she did so in order to save time. Mr 2's evidence was that it takes the same amount of time to complete a MAR sheet entry, regardless of the hour at which it is completed, and that to do so is a matter of a few seconds only.

The panel concluded that Mrs Haastrup actions amounted to effectively telling an untruth on a patient's medical record. It determined that ordinary and decent people would regard the falsification of a medical record by a registered nurse in a position of authority, significantly in advance of the potential administration of medication, as dishonest.

The panel therefore found this charge to be proved.

Determination on misconduct and impairment:

Having announced its finding on the facts, the panel then considered whether the facts found proved amount to misconduct and, if so, whether Mrs Haastrup'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.

Ms Mustard submitted that Mrs Haastrup's actions amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015 ("the Code"). She then directed the panel to specific paragraphs and identified where Mrs Haastrup's actions amounted to misconduct.

Ms Mustard referred the panel to the case of *Roylance v GMC (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.'*

In regard to impairment, Ms Mustard referred to the need to protect the public and the wider public interest, which includes the maintenance of public confidence in the profession and in the NMC as regulator, and the declaring and upholding of proper standards of conduct and of behaviour.

Ms Mustard submitted that:

- Mrs Haastrup's misconduct either directly or indirectly placed patients at risk of harm (predominantly through neglect but also by virtue of falsification of records relating to patient's medication);
- the effect of the failures – in conjunction with the fact that the failures related to high-risk, vulnerable patients - are so serious that they would bring the nursing profession into disrepute

- the failures relate to basic nursing care (e.g. patient care and record keeping) and in this regard can be said to be a breach of a fundamental tenet of the nursing profession; and
- Mrs Haastrup's pre-signing of the MAR sheets was dishonest.

In regard to insight, Ms Mustard referred to Mr 2's evidence that at no stage during his investigation did Mrs Haastrup admit or accept that she had been sleeping, but, in general, that she would make excuses to justify her actions. Ms Mustard commented that, whilst at one stage Mrs Haastrup admitted the charges, she has subsequently changed her position. She submitted that Mrs Haastrup has not accepted accountability for her actions, and therefore has not demonstrated insight.

Ms Mustard submitted that, although in March and April 2018 Mrs Haastrup completed online training courses in Safe Administration of Medicines and in Activities and Exercise, there is little to indicate any significant remedial action. Furthermore, areas of Mrs Haastrup's misconduct are attitudinal in nature and are difficult to remedy, even with further training. As a consequence of these matters, the panel could not be satisfied that there is no risk of future repetition of her misconduct.

Ms Mustard submitted that Mrs Haastrup's actions are so serious that a finding of current impairment is required in order to maintain public confidence in the profession and to uphold proper professional standards.

The panel bore in mind Mrs Haastrup's written representations and supporting documentation.

The panel accepted the advice of the legal assessor.

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Second, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mrs Haastrup’s fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) (the Code).

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel determined that Mrs Haastrup's actions amounted to a breach of the Code, specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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,

8 Work cooperatively

To achieve this, you must:

8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

11 Be accountable for your decisions to delegate tasks and duties to other people

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

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

20 Uphold the reputation of your profession at all times

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, treating people fairly and without discrimination, bullying or harassment

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

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

To achieve this, you must:

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

The panel also determined that Mrs Haastrup's actions amounted to a breach of the NMC's *Standards for medicines management*, specifically:

Standard 8: Administration

2 As a registrant, in exercising your professional accountability in the best interests of your patients:

2.10 you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

Although breaches of the Code do not automatically result in a finding of misconduct, the panel determined that, individually and cumulatively, the charges proved amount to serious misconduct. They relate to fundamental aspects of a nurse's responsibilities. The condition in which Patient A and Patient B were left (for a significant period of time) is totally unacceptable, as is sleeping whilst on duty, as is dishonest falsification of medication records. Mrs Haastrup's actions placed vulnerable patients at a risk of serious harm, while in full knowledge of the risks inherent in such actions. Mrs Haastrup's actions would be seen as "deplorable" by fellow professionals, as demonstrated by the reaction of the witnesses at the inspection and in their evidence; two of those witnesses are registered nurses and the other a senior care assistant.

In all the circumstances, the panel found that Mrs Haastrup's actions fell seriously short of the conduct and standards expected of a nurse, and amounted to misconduct.

Decision on impairment

The panel then considered whether, as a result of her misconduct, Mrs Haastrup'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 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 reaching its decision, the panel considered the judgment of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) where at 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.*

Mrs Justice Cox went on to say in Paragraph 76:

> *I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my*

view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> *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 all limbs of the *Grant* "test" above are engaged.

The panel found that Mrs Haastrup put patients at an unwarranted risk of harm, brought the nursing profession into disrepute, breached fundamental tenets of the nursing profession, and acted dishonestly.

The panel turned its attention to whether Mrs Haastrup was liable to repeat her misconduct.

Mrs Haastrup has demonstrated no real recognition of the serious nature of her misconduct. She has not accepted responsibility for her actions and her written submissions serve only to attempt to excuse her behaviour, rather than to acknowledge that her actions put patients at risk of harm.

Mrs Haastrup has, furthermore, demonstrated very limited insight into her misconduct. She has not provided any serious reflection on the events of December 2017, nor on her responsibilities as a nurse: she makes no reference in her written submissions to either Patient A or Patient B. There is no real evidence of remorse and Mrs Haastrup does not appear to have accepted her failures, save with regard to the falsification of the MAR sheets; however, in respect of this charge, she does not acknowledge patient risk, only that she did something which she was not supposed to do. Mrs Haastrup has also not demonstrated any insight into the impact of her actions on patients, their families, colleagues, and the wider public confidence in the nursing profession.

The panel concluded that elements of Mrs Haastrup's misconduct (for example, dishonesty) are attitudinal, and therefore may be difficult to remedy. There is no evidence that she has made significant attempts to do so. The training which Mrs Haastrup has undertaken has little relevance to her misconduct, and does not amount to adequate remediation.

The panel is aware that, on 1 July 2014, Mrs Haastrup was subject to local disciplinary action in regard to a previous episode of sleeping on duty.

The panel has determined that, in all the circumstances, there remains a risk of repetition of Mrs Haastrup's misconduct. 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. The panel was satisfied that a finding of impairment on public interest grounds was also required.

Having regard to all the above, the panel concluded that Mrs Haastrup's fitness to practise is currently impaired.

Determination on sanction:

The panel has decided to make a striking-off order. It directs the registrar to strike Mrs Haastrup's name from the register.

In reaching this decision, the panel had regard to all the evidence that has been adduced. It took into account the submissions of Ms Mustard and the written representations of Mrs Haastrup, and bore in mind the NMC Sanction Bid (Striking-Off Order); however it was not bound by this bid. The panel accepted the advice of the legal assessor. The panel bore 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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel found there to be the following aggravating factors:

- Mrs Haastrup's misconduct relates to particularly vulnerable patients, some of whom lacked capacity;
- the misconduct caused actual harm to Patient A and Patient B, in terms of either distress or discomfort;
- the misconduct also exposed a number of other patients to a serious risk of harm;
- Mrs Haastrup's failures relate to fundamental nursing practice and the minimum expectations of a professional nurse;
- Mrs Haastrup's failures were in breach of local policies;
- Mrs Haastrup has demonstrated a significant lack of insight, with no real recognition of the serious nature of her misconduct, risk to patients, and the impact of her actions on the reputation of the profession;
- Although Mrs Haastrup has worked at the Home for 14 years, a previous local disciplinary hearing in 2014 upheld allegations against her of a similar nature.

The panel had some difficulty in identifying mitigating factors. It did however take into account that, in her written representations and in her response to the Case Management Form, Mrs Haastrup made partial admissions to one of the charges.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct. It would be neither proportionate nor in the public interest to take no further action. To take no action would not adequately protect the public, nor address public interest concerns. The misconduct found proved demands a sanction.

The panel therefore considered a caution order. Mrs Haastrup's misconduct was not at the lower end of the spectrum and a caution order would be inappropriate in view of its serious nature. The panel decided that such a sanction would be neither proportionate nor in the public interest, nor would it be sufficient to protect the public.

The panel next considered a conditions of practice order. It determined that there are no practical or workable conditions that could be formulated to address the nature of the misconduct found proved. Mrs Haastrup's misconduct does not relate to clinical failings which could be remedied through retraining. Such an order would not address her attitudinal issues or lack of insight into her dishonesty and unprofessional actions. It would not adequately address the seriousness of the misconduct, nor would it be sufficient to protect the public.

The panel then considered a suspension order. Mrs Haastrup's actions, although occurring on a single occasion, engaged wide-ranging elements of misconduct. Sleeping on duty was clearly not spontaneous, but pre-planned. She had removed her socks and shoes, arranged two chairs on which to lie, and the lights were switched off. Furthermore, she had pre-signed the MAR sheets well in advance of the morning medication round at 07:00. In that regard, Mrs Haastrup acted dishonestly, within a clinical setting. Her conduct indicates a deep-seated attitudinal issue relating to the

fundamentals of nursing. Actual harm was caused to Patient A and Patient B, and other vulnerable residents were put at risk of serious harm. Furthermore Mrs Haastrup has demonstrated only very limited insight into her actions and no true remorse – there exists a real risk of repetition. In this context, the panel had in mind that, in 2014 at a disciplinary hearing held at the Home, Mrs Haastrup was found to have been sleeping whilst on duty.

The panel had no doubt that other professionals would consider Mrs Haastrup's conduct to be "deplorable". Although a suspension order would temporarily protect the public, it would not address the public interest in maintaining confidence in the profession and in the regulatory process, nor would it declare and uphold proper professional standards. Mrs Haastrup's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. Her misconduct was so serious that to allow her to continue practising would undermine public confidence in the profession and in the regulatory process.

Having regard to the matters it identified, in particular the effect of Mrs Haastrup's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel concluded that nothing short of a striking off order would be sufficient to protect patients and to address public interest concerns.

The panel has therefore determined that a striking off order is necessary for the protection of patients, and also to mark the importance of maintaining public confidence in the profession. It will send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Determination on Interim Order

The panel took into account Ms Mustard's submissions that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. It 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after Mrs Haastrup is sent the decision of this hearing in writing.

That concludes this determination.