Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

19 November 2019

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

Name of registrant:	Gillian Atkinson
NMC PIN:	93I2347E
Part(s) of the register:	Registered Nurse – Sub Part 1 – Adult nursing (6 October 1996)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Ilana Tessler (Chair lay panel member) Janine Ellul (Registrant panel member) Linda Redford (Lay panel member)
Legal Assessor:	David Marshall
Panel Secretary:	Roshani Wanigasinghe
Facts proved:	All
Facts proved by admission:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off Order
Interim Order:	Interim Suspension Order for 18 months

Details of charge:

That you, a registered nurse:

1. Whilst working as a Staff Nurse at The Sands Care Home:

    a) On 31 December 2017 said words to the effect of "*tell him to fuck off*" in relation to Resident C's son; **(the panel found this charge proved)**

    b) On 3 January 2018, after being asked to by Colleague A, did not review or promptly review: **(the panel found this charge proved)**
        i. Resident A
        ii. Resident B

    c) On 3 January 2018 wrote an entry in the notes of Resident A at 19:50 that was not correct and/or that did not correspond to what you had been told by Colleague A. **(the panel found this charge proved)**

    d) On 3 January 2018 wrote an entry in the notes of Resident B at 19:51 that was not correct and/or that did not correspond to what you had been told by Colleague A. **(the panel found this charge proved)**

2. Your actions at charges 1c and/or 1d were dishonest in that you intended to create the impression that you had provided care to the residents and/or that they were well. **(the panel found this charge proved)**

3. In a job application form dated 30 January 2018 and/or in a job interview on 2 February 2018 at Whitelow House Nursing Home stated that between July 2017 and January 2018 you were looking after a family member in Ireland when this was not the case. **(the panel found this charge proved)**

4. Your actions at charge 3 were dishonest in that you were intending to conceal that you had worked at The Sands Care Home. **(the panel found this charge proved)**

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

Decision on service of notice of Meeting:

The panel was informed that notice of this meeting was sent to Ms Atkinson's registered address on 14 October 2019. The panel noted the Royal Mail Track and Trace document which confirmed that the Notice of this meeting was collected on 18 October 2019 and signed for in the name of "ATKINSON".

The panel accepted the advice of the legal assessor.

Rules 11A and 34 of the *Nursing and Midwifery Council (Fitness to Practise) Rules 2004* ("the Rules") state:

> ***'11A.****(1) Where a meeting is to be held in accordance with rule 10(3), the Conduct and Competence Committee or the Health Committee shall send notice of the meeting to the registrant no later than 28 days before the date the meeting is to be held.*
>
> ***34.(3)*** *Any other notice or document to be served on a person under these Rules may be sent by—*
> *(a) ordinary post'*

The panel is satisfied that the notice was sent more than 28 days in advance of this meeting. The panel therefore finds that notice has been served in accordance with the Rules.

Background:

Ms Atkinson was referred by her former employer, The Sands Care Home ("the Home") in March 2018. She was employed as a registered nurse from 19 June 2017. Ms Atkinson was dismissed on 30 January 2018.

The Home had capacity for 96 beds. There were four floors, operated as separate units. Ms Atkinson was employed on Langdale Unit which provided nursing care for up to 25 residents. She would normally be the only registered nurse working on the unit, supported by five care assistants and a senior carer.

Following several incidents in late December 2017 and early January 2018, the Home conducted an investigation into allegations of gross misconduct. The concerns referred to the NMC were her failure or refusal to assess or attend to unwell residents, unprofessional/inappropriate language in the workplace, inaccurate record keeping, that there were underlying health concerns that impacted on her ability to practice safely and effectively and the failure to act with honesty and integrity by not disclosing her employment/dismissal to prospective employers.

Decision on the findings on facts and reasons:

In reaching its decisions on the facts, the panel took into account all of the documentary evidence in this case, which included witness statements, extracts from Resident A and B's records, documents from the Home's local investigation, Ms Atkinson's completed application form provided to another prospective employer and communications from Ms Atkinson.

The panel accepted the advice of the legal assessor.

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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

Within the "responses to charges" document dated 18 October 2019 Ms Atkinson admitted all of the allegations made against her.

The panel considered each charge and made the following findings:

Charge 1a

That you a registered nurse

1. Whilst working as a Staff Nurse at The Sands Care Home:

    a) On 31 December 2017 said words to the effect of "*tell him to fuck off*" in relation to Resident C's son

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague A dated 9 May 2019.

> "Gillian's tone was loud enough at the nurse's station (which is on the corridor toward all of the residents' bedrooms) that all the staff were able to hear her; I cannot recall specifically who heard Gillian on that occasion. I knew the son could hear her because I was on the phone with the son, and when Gillian said "tell him to fuck off" he made it a point to say to me "I can hear everything she's saying". At that point I gave the phone to Gillian and I heard Gillian tell the son that his mum was lying in vomit, which was not true as I knew for sure she'd been cleaned by that point. Gillian spoke to the son with quite an aggressive tone. I am not aware if the son ever raised a complaint about Gillian's use of language or tone of voice."

The panel noted that this evidence in respect of this charge is not challenged by Ms Atkinson. It further took into account Ms Atkinson's admission to this charge.

Taking into account all of the above, the panel was satisfied that Ms Atkinson on 31 December 2017 said words to the effect of "tell him to fuck off" in relation to Resident C's son.

Accordingly, charge 1a is found proved.

Charge 1b

1. Whilst working as a Staff Nurse at The Sands Care Home:

    b) On 3 January 2018, after being asked to by Colleague A, did not review or promptly review:
        i. Resident A

ii. Resident B

This charge is found proved

In reaching this decision, the panel took into account the witness statement of Colleague A dated 9 May 2019.

The panel noted the following in relation to Resident A:

> "I cannot recall exactly when, but there was another concerning incident regarding Gillian involving a resident called Resident A being unwell and Gillian refusing to check on him. During the shift, I was told by a carer that Resident A appeared to be unwell and so I asked Gillian if she would go have a look at him. I recall informing Gillian that I was concerned about Resident A's overall condition and in particular his temperature. Gillian's response was "I don't have time to look at him right now". I didn't think Gillian looked very busy as she was just in the dining room… I went to get keys from Gillian so I could do observations on Resident A, and discovered he had a high temperature… I then spoke to Gillian regarding Resident A, and her response was "What do you want me to do"… At no point do I think Gillian went to check on Resident A, as she seemed uninterested..."

The panel noted the following in relation to Resident B:

> "There was another similar incident that occurred during the same shift. This involved Gillian not attending to a resident called Resident B. Resident B was a resident on Langdale Suite [who] was receiving palliative care… A resident is certainly more vulnerable if they are receiving palliative care… I'd noticed Resident B's breathing was very shallow and his condition seemed to have deteriorated very quickly… As this was the first time I'd ever seen Resident B this way, my concern was to alert the nurse on shift and inform his family so that they

may come in - any resident receiving palliative care that has been identified as nearing end of life should always be made a priority with the wishes of their families being respected… After seeing Resident B, I immediately went to ask Gillian to check on him, but Gillian refused."

The panel noted that this evidence in respect of this charge is not challenged by Ms Atkinson. It further took into account Ms Atkinson's admission to this charge.

Taking into account all of the above, the panel was satisfied that it was more likely than not that Ms Atkinson on 3 January 2018, after being asked to by Colleague A, did not review or promptly review Resident A and Resident B.

Accordingly, charge 1b is found proved.

Charge 1c

1. Whilst working as a Staff Nurse at The Sands Care Home:

    c) On 3 January 2018 wrote an entry in the notes of Resident A at 19:50 that was not correct and/or that did not correspond to what you had been told by Colleague A.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague B dated 1 May 2019. It also relied on the document titled 'Observations recorded for Resident A.'

The panel had regard to Colleague B's witness statement where she writes that:

> “Colleague A wrote in her statement that she informed Gillian about the high temperature and Gillian replied “what do you want me to do about it” and did not attend to Resident A. On review of the CMS records, Gillian has documented a daily care note at 19.50 hours on 3 January 2018 that there were no complaints of pain or discomfort, settled and uncomplaining. This contrasted Colleague A’s account of Gillian not attending to Resident A.”

The panel had a copy of the daily care note within the ‘Observations recorded for Resident A’ in which it noted that on Wednesday 3 January 2018 at 19.50 a daily care note was logged in the name of Gillian Atkinson. The panel found this log to be wholly inconsistent with Resident A’s position at the time as stated by Colleague A.

Therefore, the panel was satisfied on the balance of probabilities that on 3 January 2018, Ms Atkinson wrote an entry in the notes of Resident A at 19:50 that was not correct and/or that did not correspond to what she had been told by Colleague A, or the resident’s condition.

Accordingly, charge 1c is found proved.

Charge 1d

1. Whilst working as a Staff Nurse at The Sands Care Home:

    d) On 3 January 2018 wrote an entry in the notes of Resident B at 19:51 that was not correct and/or that did not correspond to what you had been told by Colleague A.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague B dated 1 May 2019. It also relied on the document titled ‘Observations recorded for Resident B.’

The panel had regard to Colleague B’s witness statement where she writes that:

> “I do not believe that Gillian’s entry documented at 19.51 is accurate and am concerned this was a dishonest entry. This is because she has documented a further entry at 20.24 hours that Resident B “appears quite unresponsive, laboured breathing, unresponsive to voice. I have informed his NOK [Next of Kin] and asked them to attend the unit ASAP, all en-route.” Gillian has also entered vital signs at 20.27 hours, which she did not do at 19.51 hours. She has noted that the vitals were recorded at 18.30 but I do not believe this was the case as if so, she should have noted this in her entry at 19.51 hours.”

The panel had a copy of the daily care note within the ‘Observations recorded for Resident B’ in which it noted that on Wednesday, 3 January 2018 at 19.51, a daily care note was logged in the name of Gillian Atkinson. The panel found this log to be wholly inconsistent with Resident B’s condition at the time as stated by Colleague A. The panel was of the view that Ms Atkinson therefore recorded that she had observed him, although she accepts, through her admission that she did not.

Therefore, the panel was satisfied on the balance of probabilities that on 3 January 2018, Ms Atkinson wrote an entry in the notes of Resident B at 19:51 that was not correct and/or that did not correspond to what she had been told by Colleague A.

Accordingly, charge 1d is found proved.

Charge 2

2. Your actions at charges 1c and/or 1d were dishonest in that you intended to create the impression that you had provided care to the residents and/or that they were well.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague B dated 1 May 2019.

The panel had regard to a passage of the statement of Colleague B's which read:

> "The time between the two recorded entries is only 33 minutes and I do not think Resident B's condition would have changed this quickly. It is not impossible but Gillian's entry at 19.51 hours does not correspond with what the care staff and … said about Resident B's deterioration and I was informed by Colleague A that Gillian was very flustered and panicky when calling Resident B's family."

Having regard to the difference in the information given by Colleague A, Colleague B and Ms Atkinson's notes within the records, the panel considered that it is more likely than not that she intended to create the impression that she had provided care to the residents and/or that they were well when she knew this was not the case. The panel determined that such actions would be regarded as dishonest according to the standards of ordinary decent people.

Therefore, this charge is found proved.

Charge 3

3. In a job application form dated 30 January 2018 and/or in a job interview on 2 February 2018 at Whitelow House Nursing Home stated that between July 2017 and January 2018 you were looking after a family member in Ireland when this was not the case.

This charge is found proved.

In reaching this decision, the panel took into account the application for employment form dated 30 January 2018 to Whitlow House Nursing and Residential Home, and Mr 1's witness statement dated 7 January 2019.

The panel noted that Ms Atkinson's explanation in the form for the gap in employment between July 2017 and January 2018 was;

> "family member unwell back in Ireland. I returned to look after him + remained there for past 6 months. Returned home in Jan 18 with a view to retuning to full time employment"[sic].

The panel considered the evidence of Mr 1 in which he states that he learnt from a member of staff that a nurse answering Ms Atkinson's description had been employed at the Home, and had been dismissed. He said:

> "I know the manager of the Sands [the Home], Colleague C, I contacted her to clarify whether Gillian had previously worked there. Although we do not speak often, I've known Colleague C since 2006 which made It easy to contact her with my query… she informed me that Gillian had been employed at the Sands from July 2017 to January 2018 and there were concerns around her attending to residents and medication. Colleague C told me that Gillian had been dismissed as a result of these concerns, and that she had referred Gillian to the NMC. The

information provided by Colleague C contradicted what Gillian wrote on her application as well as what she'd said during the interview regarding her 6 months absence from work…

I called Gillian after learning about her dishonesty … I informed her that I had received Information indicating her application form was incorrect and untrue… My impression of Gillian's response was that the information given to me by Colleague C was true and Gillian had been caught in a lie. She was dishonest on her application form, and her lack of defending herself or attempting to provide insight to the situation confirmed my suspicion about her lack of candour".

The panel, upon reviewing the statements and the application form considered that it had enough evidence before it to conclude that on 30 January 2018 and/or in a job interview on 2 February 2018 at Whitelow House Nursing Home, Ms Atkinson stated that between July 2017 and January 2018 she was looking after a family member in Ireland when this was not the case.

Therefore, this charge is found proved.

Charge 4

4. Your actions at charge 3 were dishonest in that you were intending to conceal that you had worked at The Sands Care Home.

The panel found this charge proved.

In reaching this decision, the panel relied on the same evidence it did for charge 3.

It was of the view that Ms Atkinson had knowingly and dishonestly provided false information on her application form as well as her job interview in order to secure a

nursing role. Having regard to the information given by Ms Atkinson on the application form and in the interview, the panel considered that it is more likely than not that she intended to conceal that she had worked at the Home. The panel determined that such actions would be regarded as dishonest according to the standards of ordinary decent people.

Therefore, this charge is found proved.

Misconduct and impairment:

Having made its findings on the facts, the panel went on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Atkinson'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 accepted the advice of the legal assessor.

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 protection of the public and the wider public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Ms Atkinson's actions fell significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the Code. The panel considered that the following sections of the Code were engaged in this case:

1.1 treat people with kindness, respect and compassion

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

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

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

8.2 maintain effective communication with colleagues

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

The panel had regard to the facts of this case, noting that Ms Atkinson was involved in dishonest record keeping for Resident A and Resident B, and that she provided poor standards of care to residents under her care. The panel further noted that Ms Atkinson submitted false information on a number of occasions, purporting to be in Ireland taking care of a family member when she was not. The panel considered that Ms Atkinson sought to mislead the potential new employer, for her own benefit in seeking employment. Ms Atkinson's dishonesty in record keeping in relation to residents' records had the potential to impact on patient safety, as the incorrect patient records would have led other nursing colleagues to believe that the resident was not deteriorating when this was not the case. Her dishonesty in providing false information within the job application would have impacted on the new employer's ability to risk assess Ms Atkinson and her suitability for the role.

The panel considered that Ms Atkinson's' dishonest behaviour was serious and fell far below the standards expected of a registered nurse. The panel considered that fellow members of the nursing profession and members of the public would expect nurses to behave with honesty and integrity. The panel therefore determined that Ms Atkinson's actions amounted to serious misconduct.

Decision on impairment:

The panel next went on to decide if, as a result of this misconduct, Ms Atkinson'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. In this regard the panel considered the judgement 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) 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."

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 considered that all four limbs of Dame Janet Smith's test as set out in the Fifth Shipman Report were engaged by Ms Atkinson's past actions. Ms Atkinson put residents at potential risk of harm by making false entries on patient records when she knew she had not conducted such patient checks. The panel considered that honesty and integrity is a fundamental tenet of the profession, and that members of the public would expect nurses to behave openly and honestly. By acting dishonestly in providing false information within patient records, as well as by creating the impression that she had provided care to residents when she had not, and by giving false information to a potential new employer, the panel considered that Ms Atkinson had breached fundamental tenets of the profession and brought the profession into disrepute.

The panel noted that it had no information from Ms Atkinson, save for the fact that she had admitted all of the charges against her. There was nothing before the panel from Ms Atkinson to provide any form of explanation for her behaviour. The panel had no evidence of reflection, insight or remorse, nor had it any evidence of any remedial steps taken by Ms Atkinson. The panel noted that Ms Atkinson's admission showed some insight into her failings. However, due to the lack of any further information provided, the panel did not consider that Ms Atkinson had remedied her failings in this case. The panel could therefore not be satisfied that this behaviour would not be repeated. The panel considered that a risk of repetition remained, and therefore determined that a finding of impairment was 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 wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel had regard to the seriousness of Ms Atkinson's failings, which involved acting dishonestly by writing entries which were false within patient records to create the impression that she had provided care to residents when she had not and by providing false information in a job application reference. The panel considered that members of the public, expecting nurses to act honestly and with integrity, would find such behaviour unacceptable. The panel therefore determined that a finding of impairment was also necessary on public interest grounds, in order to maintain public confidence in the nursing profession and in the NMC as a regulator, and in order to declare and uphold proper standards of conduct and performance.

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

Determination on sanction:

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

In reaching this decision, the panel has had regard to all the documentary evidence in this case. 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 first considered what it deemed to be the aggravating and mitigating factors in this case and determined the following:

Aggravating factors:

- Ms Atkinson wrote inaccurate notes after stating she had provided care for residents when she had not;
- Ms Atkinson's actions involved premeditated dishonesty, in providing false information at a job application and at an interview stating that she was looking after a family member in Ireland when she was not;
- That panel had no evidence of reflection, insight or remorse before it.

The panel had no information before it from which it could identify any mitigating factors in this case.

The panel then assessed the dishonesty and misconduct in this case, and considered where it fell on the spectrum of seriousness. The panel noted that Ms Atkinson made a

number of false assertions within patient records in respect of 2 residents, and in 2 instances, on the job application and again at the job interview. The panel considered that these latter actions were done for Ms Atkinson's own personal and financial gain in trying to obtain employment with Whitelow House Nursing Home. The panel noted that such acts were premeditated. The panel therefore determined that Ms Atkinson's dishonesty fell at the higher end of the spectrum of seriousness.

The panel then went onto consider what action, if any, to take in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of Ms Atkinson's actions, which involved dishonesty, and in light of the risk of repetition identified. The panel determined that taking no further action would not protect the public and it would not satisfy the public interest.

The panel next considered whether a caution order would be appropriate in the circumstances. The panel took into account the SG, which 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 Fitness to Practise Committee wishes to mark that the behaviour was unacceptable and must not happen again."

The panel considered that Ms Atkinson's misconduct was not at the lower end of the spectrum, as it involved premeditated dishonesty. The panel considered that a caution order would be inappropriate in view of the seriousness of the case and in light of the risk of repetition identified. The panel determined that imposing a caution order would not protect the public and it would not satisfy the public interest.

The panel next considered whether to impose a conditions of practice order. The panel considered that it was not possible to formulate practicable and workable conditions

which would address the dishonesty involved in this case. The panel had no evidence to suggest that Ms Atkinson would be willing to comply with conditions of practice. The panel further noted that Ms Atkinson has indicated her intention not to continue with nursing practice. The panel determined that it was not possible to formulate conditions which would protect the public and satisfy the public interest.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG and the factors to consider when deciding whether this would be an appropriate sanction.

The panel noted that Ms Atkinson had not provided the panel with any information by way of an explanation for her behaviour, nor by way of reflection to demonstrate any remorse or insight. The panel could therefore not be satisfied that Ms Atkinson had insight and therefore would not go on to repeat this behaviour. Whilst a period of suspension might protect the public, the panel did not consider that it would be sufficient to maintain public confidence in the nursing profession and in the NMC as a regulator. Having regard to the lack of information the panel had before it save for indication by Ms Atkinson as to her intention to not practice as a nurse any longer, the panel was of the view that no useful purpose would be served by a period of suspension.

The panel determined that a suspension order would not be appropriate or proportionate in the circumstances of this case.

The panel then considered whether to impose a striking-off order.

The panel considered that members of the public would be rightly concerned if a registered nurse who had behaved dishonestly by providing a false information within patient records, refusing to assess and attend to residents, using inappropriate language in the workplace and detailing false information in a job application in order to provide a misleading impression of her employment were to be kept on the register. The panel considered that Ms Atkinson’s actions represented a significant departure from the standards expected of a registered nurse, and were fundamentally incompatible with

her remaining on the register. The panel was of the view that Ms Atkinson's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Ms Atkinson'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 has concluded that nothing short of this sanction would be sufficient in this case.

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

Determination on Interim Order:

Under Article 31 of the Nursing and Midwifery Order 2001 (“the Order”), the panel considered whether an interim order should be imposed in this case. A panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, and/or is otherwise in the public interest, and/or is in the registrant’s own interests.

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. 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. 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 Ms Atkinson is sent the decision of this hearing in writing.

That concludes this determination.