Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Wednesday 24 February – Friday 26 February 2021
Tuesday 1 June – Friday 4 June 2021

Virtual Meeting

Name of registrant:	Fatemeh Moghanlou
NMC PIN:	96F0067O
Part(s) of the register:	Registered Nurse Adult Nursing – June 1996
Area of registered address:	West Sussex
Type of case:	Lack of competence and misconduct
Panel members:	Darren Shenton (Chair, Lay member) Patience McNay (Registrant member) Sadia Zouq (Lay member)
Legal Assessor:	Sean Hammond
Panel Secretary:	Vicky Green (24-26 February 2021) Graeme King (1-3 June 2021) Caroline Pringle (4 June 2021)
Facts proved:	1, 2a, 2b, 2c, 2d, 3b, 4a, 4b, 4c, 5a, 5b, 6a, 6c, 6d, 6e, 6h, 6j, 7b, 7c, 8a, 8b, 9, 10a, 10b, 11a, 11b, 12, 13a, 13b, 13c, 14a, 14b, 15a, 15b, 16a, 17a, 17b
Facts not proved:	3a, 5c, 6b, 6f, 6g, 6i, 7a, 8c, 16b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Notice of Meeting

The legal assessor informed the panel that a Notice of Meeting had been sent to Ms Moghanlou's email address, as recorded on the Nursing and Midwifery Council (NMC) register, on 18 January 2021. The notice letter informed Ms Moghanlou that her case would be heard at a meeting on or after 22 February 2021. The Notice of Meeting also invited Ms Moghanlou to send any comments or submissions for the panel to consider by 12 February 2021 however no such submissions have been received.

The panel noted that the Notice of Meeting had been served on 18 January 2021, which was more than 28 days before this meeting. The panel was satisfied that there was good service and that it served in accordance with Rules 11A and 34 of the Fitness to Practise Rules 2004 (as amended) (the Rules).

The panel also noted that as this matter is being considered at a meeting, Ms Moghanlou would not be able to attend or send a representative. However, it noted that Ms Moghanlou had been sent all of the evidence relating to this matter, and was informed that this meeting will take place on or after 22 February 2021. Ms Moghanlou was also asked to provide comment and/or a response to the charges no later than 12 February 2021 by using the response form attached to the Notice of Meeting, however no such response has been provided.

The panel was satisfied that this case could be properly dealt with by way of a substantive meeting. It noted that there did not appear to be any engagement from Ms Moghanlou with these proceedings since 2019.

Therefore, the panel was of the view that referring this matter to a substantive hearing would not serve any useful purpose. It determined that it had all the information necessary before it to reach a decision on this matter, having regard to the documentary evidence.

Details of charges

That you, between 1 July 2018 and 19 July 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 registered nurse:

1. On or around 4 September 2018 were not competent in calculating Nano grams to micrograms. **Found proved**

2. On 18 September 2018 in relation to Patient A:
    a) Failed to set up the dialysis equipment/machine correctly, namely by connecting the venous line to the saline bag **Found proved**
    b) Failed to check the “wash back” procedure was returning blood to patient A **Found proved**
    c) Did not stop the “wash back” procedure to Patient A when requested by one or more colleague(s) to do so **Found proved**
    d) Did not take responsibility for connecting the venous line to the saline bag **Found proved**

3. On 2 October 2018:
    a) Was not able to “needle” patient F **Found not proved**
    b) Vacated the dialysis unit without informing a member of staff **Found proved**

4. On 7 November 2018 in relation to Patient C’s dialysis:
    a) Failed to set the dialysis machine correctly, in that you set the dialysis machine to remove 5,000 ml of fluid from Patient C instead of 500 ml **Found proved**
    b) Claimed the dialysis machine was faulty **Found proved**
    c) Did not escalate the setting of the dialysis machine and/or your judgement that the machine was faulty to another member of staff. **Found proved**

5. On 9 November 2018 in relation to Patient D:

a) Administered Colecalciferol/Calciferol medication to Patient D **Found proved**

b) Administered Colecalciferol/Calciferol in error, namely a dose which was not due to be administered until on or around 19 November 2018 **Found proved**

c) Purported that Patient D was responsible for the medication error set out in 5(b). **Found not proved**

6. On 10 November 2018 in relation to Patient B:

a) Failed to set up the dialysis equipment/machine correctly, namely by connecting the venous line to the saline bag **Found proved**

b) Failed to check the "wash back" procedure was returning blood to patient B **Found not proved**

c) In the alternative to 6(b), failed to take any or any adequate action relating to the "wash back error" **Found proved**

d) Did not recognise that there was blood in the saline bag **Found proved**

e) Did not take any or any adequate action when you became aware of the circumstances in 6(a) **Found proved**

f) Did not stop the "wash back" procedure to Patient B when requested by one or more colleague(s) to do so **Found not proved**

g) Did not assist and/or obstructed one or more colleague(s) taking action regarding blood in the saline bag **Found not proved**

h) Allowed air into the lines of the dialysis machine; **Found proved**

i) Did not take responsibility for the "wash back" error; **Found not proved**

j) After the Medical Emergency Team arrived said the words "why did you call them" or words to that effect **Found proved**

7. On 13 November:

a) Without supervision attempted or put patient G on a dialysis machine; **Found not proved**

b) Stated that you did not require supervision or words to that effect **Found proved**

c) Did not comply with a request from colleague "A" not to place a patient on a dialysis machine **Found proved**

8. In regard to the Performance improvement plan dated 20 November 2018 to 20 December 2018 you were not successful in completing:
    a) A safe level of technique **Found proved**
    b) Improved communication **Found proved**
    c) A reflection diary **Found not proved**

9. On 21 November 2018 refused to put patient J on a new dialysis machine **Found proved**

10. On or around 8 December 2018 in relation to an unknown patient:
    a) Did not weigh the patient correctly and/or **Found proved**
    b) Recorded the incorrect weight of the patient into the records **Found proved**

11. On 24 December in relation to Patient L and a dialysis machine:
    a) Did not put the clamps to the “on” position **Found proved**
    b) Did not seek assistance from a member of staff relating to taking Patient L off a dialysis machine **Found proved**

12. On 24 December in relation to dialysis Patient M was not able to “needle” the patient correctly **Found proved**

13. On 12 January 2019 in relation to Patient H:
    a) Made a record keeping error, namely by entering Patient H’s weight onto another patients records **Found proved**
    b) Stated patient H had written his weight down **Found proved**
    c) Stated that Patient H had made an entry in the records regarding his weight **Found proved**

14. On an unknown date did not achieve a pass mark in the Monthly Maths Paper for New Staff:
    a) On the first attempt **Found proved**

b) On the second attempt **Found proved**

Further to the above charges, that you, whilst employed as a registered nurse by Brighton and Sussex University Hospitals NHS Trust (the Trust):

15. On an unknown date said:
    a) To unknown patient “you stupid man you should have done as I told you” or words to that effect **Found proved**
    b) To another unknown patient “I’ve told him a thousand times, what the time is” or words to that effect **Found proved**

16. Your conduct in charge 5 was dishonest in that you:
    a) In regard to charge 5(a), claimed that you had not administered Colecalciferol/Calciferol medication to patient D when you had **Found proved**
    b) In regard to charge 5(c), purported that Patient D was responsible for the medication error which you knew was untrue **Found not proved**

17. Your conduct in regard to charge 13 was dishonest in that you:
    a) In regard to 13(b) stated patient H had written his weight down, which you knew was untrue **Found proved**
    b) In regard to 13(c) stated that Patient H had made an entry in the records regarding his weight, which you knew was untrue **Found proved**

AND, in light of the above, your fitness to practise is impaired by reason of your lack of competence in one or more of the charges from 1 to 14 (inclusive) (save for charges 5(a), 5(c), 13 (b) and 13(c)) and/or your fitness to practise is impaired by reason of your misconduct in one or more of the charges 5(a), 5(c), 13 (b),13(c)) and 15 to 17 (inclusive).

Background

The NMC received a referral from the Brighton and Sussex University Hospitals NHS Trust (the Trust) in relation to Ms Moghanlou's practice. Ms Moghanlou had been employed as a band 5 nurse in the Renal Unit at Worthing Hospital (the Hospital).

The referral concerns four clinical incidents that occurred between 18 September 2018 and 14 November 2018. It is alleged that Ms Moghanlou was negligent in treating patients which resulted in patient care being compromised on four separate clinical incidents with four different patients.

The clinical allegations relate to:

- Two wash - back incidents in which Ms Moghanlou had incorrectly connected a patient to the machine
- Setting the incorrect fluid removal on a machine
- Giving a patient a dose of medication that was not due until the following week

It is also alleged that Ms Moghanlou's professional conduct fell short of the professional standards set out in the NMC Code of Practice. It is further alleged that complaints were received by both patients and staff members in relation to Ms Moghanlou's practice.

In December 2018, Ms Moghanlou was provided with supervision, training and support. On 24 December 2018, Ms Moghanlou allegedly made a further error, namely whilst taking a patient off the dialysis machine she was hesitant and failed to operate the dialysis machinery correctly.

In February 2019, Ms Moghanlou commenced a two week placement at Brighton Hospital, which was later extended. Ms Moghanlou was found not to have made sufficient progress and her practice was formally reviewed under the Trust's Capability Policy on 14 March 2019.

On 3 May 2019, Ms Moghanlou was summarily dismissed by the Trust. Ms Moghanlou appealed against this decision. The appeal hearing was held on 19 July 2019 where the original decision to dismiss was upheld.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the responses from Ms Moghanlou to the allegation.

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, Lead Nurse at the Trust

Witness 2, Advanced Nurse Practitioner at the Trust

Witness 3, Senior Staff Nurse at the Hospital

Witness 4, Healthcare Assistant at the Hospital

Witness 5, Healthcare Assistant at the Hospital

Witness 6, Registered Nurse at the Hospital

Witness 7, Senior Staff Nurse at the Hospital

Witness 8, Healthcare Assistant at the Hospital

Witness 9, Clinical Lead Trainer for Nipro

Witness 10, Healthcare Assistant at the Hospital

Witness 11 (Patient D in the charges), Patient at the Hospital

Witness 12, Head of Nursing for the Specialist Division at the Trust

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

Prior to considering the charges, the panel noted that the date in charges 7, 11 and 12 do not show the year. The panel were of the view that it would have been better if the charges had included the year, however it considered that charges 7, 11 and 12 quite clearly relate to dates in 2018. The panel noted that all the documentary evidence pertaining to these charges relates to 2018 and that this matches the period during which Ms Moghanlou was employed by the Trust. Having heard the advice of the legal assessor, the panel determined that there was no unfairness or prejudice to Ms Moghanlou arising from the manner in which charges 7, 11 and 12 were drafted. All parties clearly understood that they related to events that occurred in 2018. The panel therefore proceeded on that basis. The panel then considered each of the charges and made the following findings.

Regrettably only three days had been allocated to the initial substantive meeting and the panel were unable to conclude its deliberations in relation to the fact finding stage, and the meeting was therefore adjourned part-heard.

RESUMED SUBSTANTIVE MEETING (Tuesday 1 June 2021)

Notice of Resuming Meeting

The meeting resumed on 1 June 2021.

The legal assessor informed the panel that notice of this resuming meeting had been sent to Ms Moghanlou's email address, as recorded on the Nursing and Midwifery Council (NMC) register, on 21 May 2021. The notice letter provided details of the resuming meeting and invited Ms Moghanlou to send any comments or submissions for the panel to consider by 28 May 2021. No such submissions have been received.

The panel was satisfied that there was good service and that it served in accordance with Rules 11A and 34 of the Fitness to Practise Rules 2004 (as amended) (the Rules).

Panel's decision

The panel resumed its decision making on the facts in this case. It was reminded of the legal advice it had heard at the initial meeting and was mindful to reflect on its deliberations at that initial meeting.

Charge 1

> *On or around 4 September 2018 were not competent in calculating Nano grams to micrograms.*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's written statement in which she stated:

> *'I had spent thirty minutes after my shift with the Registrant [Ms Moghanlou] explaining how to administer alfacalcidol and how to transfer it from nanograms to micrograms.'*

The panel also had regard to an email dated 4 September 2018 from Witness 6 to Witness 7 that stated:

'She [Ms Moghanlou] still cannot convert between nanogram and microgram.'

The panel therefore found charge 1 proved.

Charge 2a

On 18 September 2018 in relation to Patient A:

a) *Failed to set up the dialysis equipment/machine correctly, namely by connecting the venous line to the saline bag*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 2's statement to the NMC in which she stated:

'One side [of the dialysis machine] is red and the other side is blue. Normally you disconnect the red side and attach it to the bag of saline.

[…]

The Registrant [Ms Moghanlou] did not do this. She disconnected the blue side of the line and connected this blue line to the saline bag.'

The panel also had regard to Witness 10's statement in which she stated:

'To carry out the procedure correctly, the Registrant [Ms Moghanlou] should have connected the red line which is connected to the saline bag first.

[…]

Instead of connecting the red line to the saline bag, the Registrant had connected the blue line to the saline bag.'

The panel also had regard to a Datix form completed by Witness 10 on 19 September 2018 that detailed this incident. It considered this to be a contemporaneous record of events.

The panel also had regard to the Trust's Chronic Haemodialysis Policies and Procedures, dated December 2016 that details the correct procedure for this treatment.

The panel therefore found charge 2a proved.

Charge 2b

On 18 September 2018 in relation to Patient A:

b) Failed to check the "wash back" procedure was returning blood to patient A;

This charge is found proved.

In reaching this decision, the panel had regard to a Datix form dated 18 September completed by Witness 10. It noted that this form was completed the same day as the incident detailed in charge 2b, and therefore considered this to be a contemporaneous record of the incident. The panel noted that on the Datix form, Witness 10 stated that another nurse had '*stopped the pump and had to talk the nurse [Ms Moghanlou] through what to do and explain what she had done wrong.'*

The panel also had regard to Witness 10's statement to the NMC in which she stated:

'The Registrant would have known to use the correct lines for dialysis treatment through her training at the Unit. We always say when a new member of staff joins us on the Unit that when washing back the blood to the patient it is important to look at the saline bag and to make sure the blue and red lines are connected to the correct part of the machine.'

The panel therefore found charge 2b proved.

Charge 2c

On 18 September 2018 in relation to Patient A:

c) *Did not stop the "wash back" procedure to Patient A when requested by one or more colleague(s) to do so*

This charge is found proved.

In reaching this decision, the panel had regard to a Datix form dated 18 September completed by Witness 10. It noted that this form was completed the same day as the incident detailed in charge 2b, and therefore considered this to be contemporaneous evidence. The panel noted that in the Datix form, Witness 10 stated:

'…I noticed blood going back up into the saline bag. I called out to the nurse [Ms Moghanlou] who appeared not to hear me so I called out to another nurse who was close and she shouted at the nurse to stop the pump again did not appear to hear her so she ran over and stopped the pump…'

The panel also had regard to Witness 10's statement to the NMC in which she stated:

'I called over to the Registrant [Ms Moghanlou] and said 'stop your pump, you're washing back the wrong way'. She ignored what I said. I called over to [Colleague B], another nurse on the Unit who was stood close to the Registrant. [Colleague B]

then told the Registrant to stop the pump. The Registrant also ignored [Colleague B]. [Colleague B] pushed the Registrant out the way to quickly turn off the pump.'

The panel therefore found charge 2c proved.

Charge 2d

On 18 September 2018 in relation to Patient A:

d) *Did not take responsibility for connecting the venous line to the saline bag*

This charge is found proved.

In reaching this decision, the panel had regard to the Trust's Investigation Report that stated that Ms Moghanlou sought to blame a colleague for this incident and that a colleague *'had then swapped over the lines'*. The panel noted that the Trust's investigation found no evidence of this.

The panel also had regard to Witness 2's statement to the NMC in which she stated:

'She [Ms Moghanlou] said that there was an issue and that someone changed the lines on the patient without her noticing and the machinery was located in a dark corner.'

The panel also had regard to Witness 1's statement to the NMC in which she stated:

'At the time of the interview for the internal investigation, the Registrant [Ms Moghanlou] did not take responsibility for this mistake.'

The panel therefore found charge 2d proved.

Charge 3a

On 2 October 2018:

a) Was not able to "needle" patient F

This charge is found NOT proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] started needling the patient. [Another nurse] went to the Registrant to help her needle the patient as she was struggling. The Registrant did not want any help or guidance.'

The panel considered that '*struggling*' to needle a patient did not mean not being able to do something. It had no further evidence before it to suggest that Ms Moghanlou could not needle patients.

The panel therefore found charge 3a not proved.

Charge 3b

On 2 October 2018:

b) Vacated the dialysis unit without informing a member of staff

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] walked out of the Unit without telling anyone where she was going.

[…]

The Registrant returned to the Unit later that day. She did not tell anyone where she had been…'

The panel did not have sight of any explanation for Ms Moghanlou having left the Unit.

The panel therefore found charge 3b proved.

Charge 4a

On 7 November 2018 in relation to Patient C's dialysis:

a) Failed to set the dialysis machine correctly, in that you set the dialysis machine to remove 5,000 ml of fluid from Patient C instead of 500 ml

This charge is found proved.

In reaching this decision, the panel had regard to Witness 1's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] set up the machine to remove 5000ml of fluid from Patient C instead of the 500ml which should have been input into the machine. As a result of the extraction of too much fluid, Patient C's blood pressure dropped and he could have had a cardiac arrest.'

The panel also had regard to Witness 6's statement to the NMC in which she stated:

'I noticed that the Registrant had programmed the machine to remove 5000ml of fluid from Patient C instead of 500ml.

[…]

The Registrant should have input the correct numbers into the machine. The Registrant would have known to do this as she had training at the Unit on these specific machines.'

The panel also had regard to Witness 8's statement to the NMC in which she stated:

'On doing my observations I noticed the Ultra Filtration Volume on his [Patient C] machine was set to remove 5000ml of fluid from him.

[…]

The Registrant informed me that she had put Patient C onto the machine.'

The panel also had regard to the Trust's 'Hdx Supernumerary Working Programme' and 'Skill Assessment for initiation of haemodialysis therapy' documents, which lay out the duties and competencies that Ms Moghanlou should have been aware of.

The panel therefore found charge 4a proved.

Charge 4b

On 7 November 2018 in relation to Patient C's dialysis:

b) Claimed the dialysis machine was faulty

This charge is found proved.

In reaching this decision, the panel had regard to in which she stated:

> *'The Registrant [Ms Moghanlou] stated in an interview that she put in 500ml and the machine changed it to remove 5000ml. The Registrant argued that the machine was faulty. It was my understanding that this was human error.'*

The panel also had regard to Witness 8's statement to the NMC in which she stated:

> *'She [Ms Moghanlou] told me she tried several times to correct the UF volume but the machine did not allow her to change it.'*

The panel also had regard to the Trust's Investigation Report that stated:

> *'When asked how this error occurred FM [Ms Moghanlou] stated that she had entered the correct amount into the machine but the machine was faulty and it re-set itself to remove 5000ml of fluid instead.'*

The panel therefore found charge 4b proved.

Charge 4c

> *On 7 November 2018 in relation to Patient C's dialysis:*
>
> *c) Did not escalate the setting of the dialysis machine and/or your judgement that the machine was faulty to another member of staff.*

This charge is found proved.

In reaching this decision, the panel had regard to an Appeal Hearing Outcome letter dated 25 July 2019 from the Trust to Ms Moghanlou that stated:

‘We heard from management that there had been no reports of faulty machines and no indication that the particular machine was faulty and was therefore still in use.

We heard from management that as a registered nurse it is your responsibility to ensure you take steps to ensure safe and effective patient care is still delivered. There was no evidence that you had raised any concerns about the faulty machine, nor had you asked a colleague for assistance.’

The panel also had regard to the Trust’s Investigation Report that stated:

..the IO said that she had not been told that the machine was faulty either before or since the incident…’

The panel had regard to Ms Moghanlou’s response to the NMC in 2019 in which she stated:

‘I called [another nurse] for help while she was on the other side of the Units and put the patient on HD machine. [Colleague C] were busy as well and both them looked at me. I rushed to toilet and I knew they will do check my work. [sic]’

The panel did not consider that leaving to go to the toilet and assuming colleagues would check her work to constitute Ms Moghanlou as having appropriately escalated the issue.

The panel therefore found charge 4c proved.

Charge 5a

On 9 November 2018 in relation to Patient D:

a) Administered Colecalciferol/Calciferol medication to Patient D

This charge is found proved.

In reaching this decision, the panel had regard to Patient D's Medication Chart that shows he had been prescribed '*Colecalciferol'* on a frequency of *'every 2 weeks'.* The Medication Chart shows that Patient D received a dose of Colecalciferol on 5 November 2018 at 07:47, and then again on 9 November 2018 at 13:16. Ms Moghanlou's name is listed under 'Staff Name' on the 9 November entry.

The panel therefore found charge 5a proved.

Charge 5b

On 9 November 2018 in relation to Patient D:

b) *Administered Colecalciferol/Calciferol in error, namely a dose which was not due to be administered until on or around 19 November 2018*

This charge is found proved.

In reaching this decision, the panel had regard to Patient D's Medication Chart that shows he had been prescribed '*Colecalciferol'* on a frequency of *'every 2 weeks'.* The Medication Chart shows that Patient D received a dose of Colecalciferol on 5 November 2018 at 07:47, and then again on 9 November 2018 at 13:16. Ms Moghanlou's name is listed under 'Staff Name' on the 9 November entry.

The panel also had regard to Witness 2's statement to the NMC in which she stated:

'Patient D had been given this medication the week commencing 5 November 2018. The Registrant [Ms Moghanlou] gave him the medication on the wrong date. She gave him it a week earlier than he should have been given it.'

The panel also had regard to Witness 11's statement to the NMC in which he stated:

> *'I had previously been administered the medication on Monday 5 November 2018 and therefore it should have next been administered to me on Monday 19 November 2018 as it is prescribed to be taken once every two weeks. This meant the Registrant had wrongly administered the medication to me as I had just taken the medication four days before on 5 November 2018.'*

The panel therefore found charge 5b proved.

Charge 5c

On 9 November 2018 in relation to Patient D:

c) *Purported that Patient D was responsible for the medication error set out in 5(b).*

This charge is found NOT proved.

In reaching this decision, the panel did not have sight of any evidence to suggest that Ms Moghanlou attributed responsibility for the medication error to Patient D. It noted that in his statement to the NMC, Witness 11 mentioned being made aware that Ms Moghanlou told another nurse that '*it was my [Patient D) fault that I hadn't told her that I was not due to have my Calciferol medication'*. However, the panel considered this to be hearsay evidence that could not be corroborated by any other evidence.

The panel therefore found charge 5c not proved

Charge 6a

On 10 November 2018 in relation to Patient B:

a) *Failed to set up the dialysis equipment/machine correctly, namely by connecting the venous line to the saline bag*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

> *'…the Registrant [Ms Moghanlou] connected the veinous line to the saline back to the blood therefore filling into a bag.'*

The panel also had regard to Witness 2's statement to the NMC in which she stated:

> *'The Registrant [Ms Moghanlou] again connected the wrong line to the saline bag. She turned the blood pump on. The blood pumped into and around the machine and into the saline bag instead of the patient.'*

The panel also had regard to the Trust's Investigation report that stated:

> '*FM [Ms Moghanlou] said that when the incident occurred she realised she had made a mistake after a few seconds…'*

The panel also had regard to a Datix report dated 10 November 2018 that detailed the incident. The panel considered this to be a contemporaneous record of the incident.

The panel therefore found charge 6a proved

Charge 6b

> *On 10 November 2018 in relation to Patient B:*

b) *Failed to check the "wash back" procedure was returning blood to Patient B*

This charge is found NOT proved.

In reaching this decision, the panel had insufficient direct evidence to determine that it is more likely than not that Ms Moghanlou failed to check the 'wash back' procedure.

The panel therefore found charge 6b not proved

Charge 6c

On 10 November 2018 in relation to Patient B:

c) *In the alternative to 6(b), failed to take any or any adequate action relating to the "wash back error"*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 5's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] said to [another nurse] that she had it all under control, told her to go away and moved her away.'

The panel also had regard to Witness 1's statement to the NMC in which she stated:

'She [Ms Moghanlou] said her colleagues interfered when the incident had occurred and that she could deal with it.'

The panel therefore found charge 6c proved

Charge 6d

On 10 November 2018 in relation to Patient B:

d) Did not recognise that there was blood in the saline bag

This charge is found proved.

In reaching this decision, the panel had regard to an email from a colleague present at the incident to Witness 2 in which she stated:

'I can confirm she [Ms Moghanlou] was not aware of her mistake at the time, she was not aware of the mistake until other member of staff alert her of it.'

The panel therefore found charge 6d proved

Charge 6e

On 10 November 2018 in relation to Patient B:

e) Did not take any or any adequate action when you became aware of the circumstances in 6(a)

This charge is found proved.

In reaching this decision, the panel had regard to Witness 5's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] said to [another nurse] that she had it all under control, told her to go away and moved her away.'

The panel also had regard to Witness 1's statement to the NMC in which she stated:

'She [Ms Moghanlou] said her colleagues interfered when the incident had occurred and that she could deal with it.'

The panel therefore found charge 6e proved

Charge 6f

On 10 November 2018 in relation to Patient B:

f) Did not stop the "wash back" procedure to Patient B when requested by one or more colleague(s) to do so

This charge is found NOT proved.

In reaching this decision, the panel had regard to Witness 7's statement to the NMC in which she stated:

'I told the Registrant [Ms Moghanlou] to stop the washback procedure. She stopped and detached Patient B and closed her line.'

The panel therefore found charge 6f not proved.

Charge 6g

On 10 November 2018 in relation to Patient B:

g) Did not assist and/or obstructed one or more colleague(s) taking action regarding blood in the saline bag

This charge is found NOT proved.

In reaching this decision, the panel had regard to Witness 7's statement to the NMC in which she stated:

> *'I told the Registrant [Ms Moghanlou] to stop the washback procedure. She stopped and detached Patient B and closed her line.'*

The panel therefore found charge 6g not proved.

Charge 6h

> *On 10 November 2018 in relation to Patient B:*
>
> *h) Allowed air into the lines of the dialysis machine*

This charge is found proved.

In reaching this decision, the panel had regard to an email that Witness 6 sent to her manager on the day of the incident in which she stated:

> *'Blood was unable to give back due to air in the system.'*

The panel also had regard to an email that Witness 7 sent to her manager four days after the incident. In this email she stated:

> *'When I arrived she [Ms Moghanlou] was trying to give her [Patient B] blood back with air in the system…'*

The panel also had regard to a Datix report, completed two days after the incident, which stated:

…'air was introduced to the patient's line.'

The panel also had regard to an email that Witness 5 sent to her manager three days after the incident in which she stated:

'[Another nurse] was going to try and introduce the blood back but the lines were full of air…'

The panel therefore found charge 6h proved.

Charge 6i

On 10 November 2018 in relation to Patient B:

i) Did not take responsibility for the "wash back" error

This charge is found NOT proved.

In reaching this decision, the panel had insufficient direct evidence to determine that Ms Moghanlou did not take responsibility for the wash back error.

The panel therefore found charge 6i not proved

Charge 6j

On 10 November 2018 in relation to Patient B:

j) *After the Medical Emergency Team arrived said the words "why did you call them" or words to that effect*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 7's statement to the NMC in which she stated:

> *'I remember the registrant [Ms Moghanlou] saying to me 'why did you call them?' and said that Patient B didn't need this.'*

The panel also had regard to Witness 6's statement to the NMC in which she stated:

> *'She [Ms Moghanlou] also failed to understand why a MET call needed to be placed.'*

The panel therefore found charge 6j proved

Charge 7a

On 13 November:

a) *Without supervision attempted or put patient G on a dialysis machine*

This charge is found NOT proved.

In reaching this decision, the panel noted that Ms Moghanlou was at times subject to performance reviews. However, it had insufficient evidence to determine that Ms Moghanlou was subject to supervision at the time of putting Patient G on a dialysis machine. The panel also noted the Trust's Appeal Outcome Letter that stated:

'…you [Ms Moghanlou] were offered supervision between the incidents related to Patient A and Patient B however you had refused this support.'

It also noted that, even if Ms Moghanlou was subject to supervision at this time, the panel did not have sight of any official documentation from the Trust to Ms Moghanlou confirming this

The panel therefore found charge 7a not proved

Charge 7b

On 13 November:

b) Stated that you did not require supervision or words to that effect

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's email to her manager dated 13 November 2018 in which she stated:

'She [Ms Moghanlou] refused to work under supervising [sic], she refused my request…

[…]

'I went to supervise her, she send [sic] me away…'

It also had regard to Witness 6's statement to the NMC in which she stated:

'I approached the Registrant [Ms Moghanlou] and reminded her that she should not be doing this alone. She argued with me and said she did not need supervision.'

The panel therefore found charge 7b proved

Charge 7c

On 13 November:

c) *Did not comply with a request from colleague "A" not to place a patient on a dialysis machine*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

'I asked the Registrant [Ms Moghanlou] not to put the patient on. The Registrant ignored me.'

The panel therefore found charge 7c proved

Charge 8a

In regard to the Performance improvement plan dated 20 November 2018 to 20 December 2018 you were not successful in completing:

a) *A Safe level of technique*

This charge is found proved.

In reaching this decision, the panel had regard to an Exclusion Risk Assessment from the Trust dated 28 January 2019 that stated:

'Despite supervised practice during investigation Ferri [Ms Moghanlou] continues to make clinical errors that compromise patient safety...

[…]

Ferri's performance at work since October has worsened....'

The panel also had regard to a Capability Report from the Trust dated 29 January 2019 that stated:

'Cause for capability concern remains…

[…]

… reports are received by the external trainers that FM [Ms Moghanlou] ability to learn and deliver safe dialysis treatment failed to instil confidence due to a combination of inconsistency and failings in basic dialysis tasks.'

The panel also had regard to Witness 1's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] was not successful in this performance improvement plan. Mentors provided me with negative feedback and asked to be excluded from mentoring the Registrant.'

The panel therefore found charge 8a proved

Charge 8b

In regard to the Performance improvement plan dated 20 November 2018 to 20 December 2018 you were not successful in completing:

b) *Improved communication*

This charge is found proved.

In reaching this decision, the panel had regard to an Exclusion Risk Assessment from the Trust dated 28 January 2019 that stated:

> *'Regular review as per performance improvement plan is not showing sufficient improvement and the specific aim to improve team contribution has worsened.'*
>
> *[…]*
>
> *Ferri reacts with heightened defensiveness....'*

The panel also had regard to a Capability Report from the Trust dated 29 January 2019 that stated:

> *'No improvement in team work*
>
> *[…]*
>
> *The team work improvement goal worsened'*

The panel therefore found charge 8b proved

Charge 8c

> *In regard to the Performance improvement plan dated 20 November 2018 to 20 December 2018 you were not successful in completing:*

c) *A reflection diary*

This charge is found NOT proved.

In reaching this decision, the panel had regard to Ms Moghanlou's Performance Improvement Plan dated 20 November 2018 – 2 December 2018. It noted that this document required Ms Moghanlou '*to write 1-page reflection'.* However, the panel did not consider a '*1-page reflection'* to constitute a reflection diary, as per the wording of this charge. Further, the panel did not have sight of any evidence to suggest that Ms Moghanlou did not provide a reflective piece.

The panel therefore found charge 8c not proved

Charge 9

On 21 November 2018 refused to put patient J on a new dialysis machine

This charge is found proved.

In reaching this decision, the panel had regard to Witness 1's statement to the NMC in which she stated:

'…the Registrant [Ms Moghanlou] had refused to put Patient J on the new dialysis machines because she couldn't do it.'

The panel also had regard to an email from a colleague of Ms Moghanlou who was present at the time of this incident, to Witness 1 in which she stated:

'…she refused to do Patient J this moment on the new Machine Fresenius 5008 because she can't do it....'

The panel therefore found charge 9 proved

Charge 10a

On or around 8 December 2018 in relation to an unknown patient:

a) Did not weigh the patient correctly and/or

This charge is found proved.

In reaching this decision, the panel had regard to Witness 10's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] said this patient was under her target weight. I weighed her again and she weighed 10kg more than the Registrant had noted.'

The panel therefore found charge 10a proved

Charge 10b

On or around 8 December 2018 in relation to an unknown patient:

b) Recorded the incorrect weight of the patient into the records

This charge is found proved.

In reaching this decision, the panel had regard to Witness 10's statement to the NMC in which she stated:

'The Registrant [Ms Moghanlou] said this patient was under her target weight. I weighed her again and she weighed 10kg more than the Registrant had noted.'

The panel also had regard to Witness 10's email to her manager on the day of this incident which it considered to be a contemporaneous record of the incident, demonstrating that Ms Moghanlou had incorrectly logged the weight of a patient.

The panel therefore found charge 10b proved

Charge 11a

On 24 December in relation to Patient L and a dialysis machine:

a) Did not put the clamps to the "on" position

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

'I went to the patient and noticed that the Registrant [Ms Moghanlou] had done something wrong. I noticed she was hesitant and there was blood everywhere. The Registrant said she was not sure if the lines were okay. I noticed the clamps were off. I immediately put the clamps to the on position.'

The panel therefore found charge 11a proved

Charge 11b

On 24 December in relation to Patient L and a dialysis machine:

b) Did not seek assistance from a member of staff relating to taking Patient L off a dialysis machine.

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

> *'The Registrant [Ms Moghanlou] had not mentioned this to any member of staff. If I had not gone over and noticed the error there could have been an issue as the Registrant did not ask for help'*

The panel also had regard to Witness 6's email to her manager on 4 January 2019 in which she stated:

> *'If I don't ask, she [Ms Moghanlou] does not ask for help…'*

The panel therefore found charge 11b proved.

Charge 12

> *On 24 December in relation to dialysis Patient M was not able to "needle" the patient correctly.*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 6's statement to the NMC in which she stated:

> *'The Registrant [Ms Moghanlou] struggled to needle the patient.*
>
> *[…]*

I could see that the Registrant could not needle the patient. She said she would try again.'

The panel therefore found charge 12 proved.

Charge 13a

On 12 January 2019 in relation to Patient H

a) *Made a record keeping error, namely by entering Patient H's weight onto another patients records*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 5's statement to the NMC in which she stated:

'Patient H has a problem with his hand so he does not weigh himself and write his weight on the template. He was weighed by the Registrant [Ms Moghanlou].

[…]

When I looked at Patient H's records there was no information or data on the computer as to his weight prior to the treatment.

[…]

As the Registrant had put Patient H on the machine she would have had to write down his weight prior to the treatment. I was unable to see his weight prior to treatment on his records. When I told her [Ms Moghanlou] this she got a ruler to show me where she had written it. The weight of the patient was not written under

Patient H's template. She had written Patient H's weight under another patient's name.'

The panel also had regard to a Datix report dated 12 January 2019 regarding this incident. It considered this to be a contemporaneous record of the incident and that it demonstrated that Ms Moghanlou had entered Patient H's weight under another patient's name.

The panel therefore found charge 13a proved.

Charge 13b

On 12 January 2019 in relation to Patient H

b) Stated that Patient H had written his weight down

This charge is found proved.

In reaching this decision, the panel had regard to Witness 5's statement to the NMC in which she stated:

'Patient H has a problem with his hand so he does not weigh himself and write his weight on the template. He was weighed by the Registrant [Ms Moghanlou].

[…]

The Registrant then said that it was Patient H who had written his weight down.'

The panel therefore found charge 13b proved.

Charge 13c

On 12 January 2019 in relation to Patient H

c) *Stated that Patient H had made an entry in the records regarding his weight.*

This charge is found proved.

In reaching this decision, the panel had regard to Witness 5's statement to the NMC in which she stated:

'I recognised her [Ms Moghanlou] handwriting and said to her that it was her handwriting. Her response to this was that Patient H had told her to write it there.'

The panel therefore found charge 13c proved.

Charge 14a

On an unknown date did not achieve a pass mark in the Monthly Maths Paper for New Staff

a) *On the first attempt*

This charge is found proved.

In reaching this decision, the panel had regard to a Monthly Maths Paper for New Staff from the Trust. This document is annotated '*1st Take (Attempt)*' and states that those taking the test '*are required to get 100%*'. The score given on this paper is 18/31.

The panel therefore found charge 14a proved.

Charge 14b

On an unknown date did not achieve a pass mark in the Monthly Maths Paper for New Staff

b) On the second attempt

This charge is found proved.

In reaching this decision, the panel had regard to a Monthly Maths Paper for New Staff from the Trust. This document is annotated '*2nd Take (Attempt)*' and states that those taking the test '*are required to get 100%*'. The score given on this paper is 19/31.

The panel therefore found charge 14b proved.

Charge 15a

On an unknown date said:

a) To unknown patient "you stupid man you should have done as I told you" or words to that effect;

This charge is found proved.

In reaching this decision, the panel had regard to Witness 10's statement to the NMC in which she stated:

'[…] a patient had not stopped bleeding after his treatment. He was told by the Registrant [Ms Moghanlou] to stay still. The patient got up to go to the toilet and for a cigarette and leant on the chair with his arm making it bleed more. The Registrant said 'you stupid man you should have done as I told you.

[…]

The Patient was upset with what the Registrant had said…'

The panel therefore found charge 15a proved.

Charge 15b

On an unknown date said:

b) To another unknown patient "I've told him a thousand times, what the time is" or words to that effect.

This charge is found proved.

In reaching this decision, the panel had regard to Witness 10's statement to the NMC in which she stated:

'We also had a patient who came to the Unit for treatment who had dementia. […] he asked me what the time was. He also asked the Registrant [Ms Moghanlou] what time it was. The Registrant turned round to me and said 'I've told him a thousand times, what the time is'.

The panel therefore found charge 15b proved.

Prior to the panel considering Ms Moghanlou's alleged dishonesty in charges 16 and 17, the legal assessor drew its attention to the case of *Ivey v Genting Casinos* [2017] UKSC 67. He advised the panel that it should adopt a two stage test. It should first ascertain (subjectively) Ms Moghanlou's knowledge or belief as to the facts. It should then consider whether Ms Moghanlou's actions would be considered dishonest by the standards of '*an ordinary, reasonable individual (having the same knowledge as [Ms Moghanlou])*'. The

legal assessor further advised the panel that the case of *Ivey* provides that whether or not Ms Moghanlou viewed her actions as dishonest by those standards is irrelevant.

Charge 16a

Your conduct in charge 5 was dishonest in that you:

a) *In regard to charge 5(a), claimed that you had not administered Colecalciferol/Calciferol medication to patient D when you had*

This charge is found proved.

In reaching this decision, the panel had regard to the evidence relied on in charge 5a to confirm that Ms Moghanlou had administered medication to Patient D.

The panel also had regard to the Trust's Investigation Report that stated:

'When asked to explain what happened FM [Ms Moghanlou] said that whilst the patients record says that she gave him the medication he was not due to have, she had not actually given him the dose that she had recorded on the electronic prescription system.

[…]

…at both meetings with the IO on 11.12.18 and 25.1.19, FM did not acknowledge or accept responsibility for this error.'

The panel also had regard to a written statement provided to the Trust from Ms Moghanlou in which she stated:

'Later on signed and documented on the computer for oral tablets Co-Calciferous as a given errors (I understand Patient D has got every two weeks Calciferous oral tablets) and I am sorry.'

The panel found in charge 5a that it is more likely than not that Ms Moghanlou administered Calciferol to Patient D. It subsequently considered there to be corroborative evidence that she claimed not to have done so.

The panel therefore found charge 16a proved.

Charge 16b

Your conduct in charge 5 was dishonest in that you:

b) *In regard to charge 5(c), purported that Patient D was responsible for the medication error which you knew was untrue.*

This charge is found NOT proved.

As the panel had found charge 5c not proved, it therefore followed that charge 16b was not proved.

Charge 17a

Your conduct in regard to charge 13 was dishonest in that you:

a) *In regard to 13(b) stated patient H had written his weight down, which you knew was untrue*

This charge is found proved.

In reaching this decision, the panel first had regard to its finding in charge 13. The panel next applied the test set out in the case of *Ivey.* In relation to the first part of the test, the panel was satisfied that Patient H had not written his weight down and Ms Moghanlou knew this to be untrue when she stated that he had.

Applying the second part of the test in *Ivey*, the panel was satisfied that Ms Moghanlou's actions would be viewed as dishonest by an '*ordinary, reasonable individual'* in that she deliberately sought to mislead her colleague.

The panel therefore found charge 17a proved.

Charge 17b

Your conduct in regard to charge 13 was dishonest in that you:

b) In regard to 13(c) stated that Patient H had made an entry in the records regarding his weight, which you knew was untrue.

This charge is found proved.

In reaching this decision, the panel first had regard to its finding in charge 13 and noted that charge 13b and 13c arise from the same incident involving Patient H. As such, the panel found charge 17b proved for the same reasons as 17a.

The panel therefore found charge 17b proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to lack of competence in charges 1 to 14 (inclusive) (save for charges 5(a), 5(c), 13 (b) and 13(c)) and/or misconduct in relation to

one or more of the charges 5(a), 5(c), 13 (b), 13(c)) and 15 to 17 (inclusive) and, if so, whether Ms Moghanlou'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 lack of competence and/or misconduct. Secondly, only if the facts found proved amount to lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, Ms Moghanlou's fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Representations on lack of competence, misconduct and impairment

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

The NMC submitted that the charges proved show a sustained pattern which demonstrate a lack of competence in the areas of patient care including 'wash back' errors, incorrect setup of a dialysis machine, a medication error, the knowledge and skills for safe and effective practice, not working within the limits of competence and not working cooperatively with colleagues.

The NMC further submitted that this is not a case of a registered nurse making an isolated mistake. Rather, the concerns referred to in the charges persisted, notwithstanding the

supervision which was put in place to support Ms Moghanlou to practise safely and competently. The concerns were wide-ranging and occurred on more than one date which, in itself, is indicative of a pattern demonstrating a lack of competence in the areas of patient care including 'wash back' errors, incorrect setup of a dialysis machine, a medication error, the knowledge and skills for safe and effective practice, not working within the limits of competence and not working cooperatively with colleagues.

The NMC also submitted that Ms Moghanlou's actions amount to serious misconduct and highlighted the relevant sections of the Code which it submitted that Ms Moghanlou had breached.

The NMC also invited the panel to find that dishonestly failing to record and report a medication error with the intention of concealing that error, in charges 16 and 17, amounts to behaviour that falls far short of what was expected. Further, the medication errors narrated in charge 5 fall far below what would be expected of a nurse.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel was referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC submitted that the Ms Moghanlou's fitness to practise is impaired by reason of her lack of competence and her misconduct because all four limbs in the case of *Grant* apply in this case. The registrant's actions will have undermined patient confidence as there have been a number of complaints from patients who have received substandard treatment from Ms Moghanlou. If repeated, such conduct would place patients at risk of unwarranted harm and undermine the public's confidence in the nursing profession.

The NMC submitted that by breaching the duty of candour, Ms Moghanlou has breached one of the fundamental tenets of the nursing profession and has brought the profession into disrepute. Further, by breaching several parts of the Code, Ms Moghanlou brought the

profession into disrepute and confidence in the regulator would be undermined if a finding of impairment was not made in the particular circumstances of this case.

The panel accepted the advice of the legal assessor which included reference to relevant case law.

Decision and reasons on lack of competence and misconduct

In coming to its decision the panel noted that the NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

The panel also had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 that defines misconduct as:

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

The standard of propriety in this case therefore may be found in the Code.

The panel went on to determine whether the charges found proved amounted to a lack of competence and/or misconduct. To achieve this the panel looked at each charge individually and cumulatively. In relation to the panel's findings of fact, the panel was of the view that Ms Moghanlou's actions did fall significantly short of the standards expected of a registered nurse and amounted to lack of competence (at charges 1, 2a, 2b, 2c, 2d, 3b, 4a, 4b, 4c, 5b, 6a, 6c, 6d, 6e, 6h, 6j, 7b, 7c, 8a, 8b, 9, 10a, 10b, 11a, 11b, 12, 13a, 14a and 14b) and misconduct (at charges 13b, 13c, 15a, 15b, 16a, 17a and 17b).

The panel noted that in assessing lack of competence, the standard to be applied was that applicable to the band 5 post that Ms Moghanlou had been appointed to and the clinical work expected of her. The panel further noted that the public is entitled to expect that the work of a registered nurse who performed in any specialty was at the standard applicable to that post and in that specialty. In considering lack of competence, the panel also had regard to the NMC's Standards of Proficiency for Nurses 2018.

The panel considered that, in not being able to calculate nanograms to micrograms as per charge 1, Ms Moghanlou did not meet the standards expected of a band 5 nurse. It considered that this lack of competence could pose a risk of harm to patients if Ms Moghanlou was not able to accurately calculate doses of medication.

The panel noted that charges 2a, 2b, 2c, 2d, 3a, 3b, 4a, 4b, 4c, 6a, 6c, 6d, 6e, 6h, 6j, 7b, 7c, 11a, 11b and 12 relate to issues around the use of dialysis machines/providing dialysis treatment, therefore the panel considered these charges as a group when assessing Ms Moghanlou's lack of competence. The panel had regard to Witness 1's statement in which she stated:

> *'The key factor raised by the Registrant's [Ms Moghanlou] team at the Worthing Unit was that she was unsafe.*
>
> *[…]*
>
> *…the Registrant's lack of acceptance and insight into her errors, being argumentative and the inconsistencies in her work.*
>
> *[…]*
>
> *The Registrant did not accept any form of feedback.*
>
> *[…]*

The Registrant was not successful in this performance improvement plan.

[…]

…despite the supervised practice, patient safety was compromised as the Registrant continued to make errors.

[…]

I informed the Registrant that not enough progress had been made and that there would be a formal review under the Capability Policy.'

The panel noted Witness 9's statement that confirmed that Ms Moghanlou was appropriately trained, however the trainer noted that Ms Moghanlou was *'stubborn and that she did not follow instructions'.* The panel considered that being unable to operate the dialysis machine despite having been trained constituted a lack of competence.

The panel further noted that action plans were put in place however Ms Moghanlou still failed to meet the competencies expected of a band 5 nurse and continued to make errors. The panel noted that Ms Moghanlou had received an extensive amount of support from the Trust, including a transfer to another hospital, to address the competency issues identified, however Ms Moghanlou continued to make clinical errors. The panel also noted that there were a number of repeated failings that occurred over a period of time, including like for like errors involving the use of dialysis machines. Further, Ms Moghanlou did not ask for help from her colleagues when necessary and expressly ignored their offers of help at the time. The panel was of the view that there is a pattern of failings and that they are wide ranging, serious and incorporate the basic, fundamental skills of a band 5 nurse engaged in dialysis treatment. The panel noted with some concern that the incident in charge 4 could have had fatal consequences and that the incident in charge 6 required a Medical Emergency Team to attend.

The panel considered charge 5b to demonstrate a basic medication administration error. It considered that the correct dosage frequency was clearly displayed on Patient D's medication chart, yet Ms Moghanlou did not notice/follow this instruction. While there was no actual patient harm in this instance, the panel considered that not following a medication chart constituted a lack of competence.

The panel considered that charges 8a and 8b demonstrate Ms Moghanlou not meeting the standards required of a band 5 nurse. It considered that Ms Moghanlou's failure to satisfactorily complete a Performance Improvement Plan, that was expressly designed to address her poor performance, amounted to a lack of competence.

The panel considered that charge 9 demonstrates Ms Moghanlou's lack of competence around dialysis machines/treatment. It considered that, had this been a standalone charge, it would be unlikely to warrant a finding of lack of competence. However, when viewed alongside Ms Moghanlou's other dialysis related failings, the panel considered this charge to contribute to a pattern of incompetence.

The panel considered that charges 10a and 10b demonstrated a lack of basic nursing skills. The panel noted that Ms Moghanlou's lack of competence in this charge could have had an impact on the patient if a colleague had not noticed the error. Similarly, the panel considered that Ms Moghanlou's actions in charge 13a to demonstrate a failing of basic nursing skills. While there was no potential for harm in this case, the panel noted that Ms Moghanlou attempted to conceal this error.

The panel considered charge 14a and 14b to demonstrate that, at the point of failing each maths test, Ms Moghanlou demonstrated a lack of competence as she was not meeting the standards expected of a band 5 nurse. The panel did note that Ms Moghanlou subsequently passed the maths test on the third attempt.

The panel then moved on to consider misconduct and determined that that Ms Moghanlou's conduct has fallen seriously short of the standards expected of a nurse and identified the areas of the Code which it determined that Ms Moghanlou had breached, 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

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 cooperatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

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

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

9.3 - deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times,

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

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

13 - Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 - make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

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

To achieve this, you must:

14.1 - act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 - explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers,

14.3 - document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

16 - Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 - raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

16.2 - raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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'

The panel considered that Ms Moghanlou's misconduct was serious, wide-ranging and was repeated on several occasions. The panel also considered that Ms Moghanlou's

misconduct put patients at a real risk of significant harm and in some instances only good fortune prevented a catastrophic outcome.

The panel considered that the medication error in charge 5a was an isolated incident and did not result in any patient harm, and therefore did not constitute misconduct of itself. However, the panel noted that its finding in relation to the facts of charge 5a was relevant to its finding of misconduct in relation to the dishonesty charge in 16a.

The panel considered that Ms Moghanlou's actions in charges 13b and 13c to demonstrate an attitudinal concern. It considered that Ms Moghanlou deliberately sought to misrepresent the nature of her error and stated something she knew to be untrue, as fact. Further, Ms Moghanlou attempted to blame a patient for the incorrect weight entry. The panel considered that Ms Moghanlou's actions amounted to serious misconduct.

The panel considered that Ms Moghanlou had not treated patients with dignity and respect in relation to charges 15a and 15b. It considered these to be blatant breaches of the Code, and therefore found misconduct in each charge.

The panel then considered the dishonesty found proved in charges 16a, 17a and 17b. The panel was satisfied that Ms Moghanlou deliberately sought to misrepresent her error and stated something she knew to be untrue, as fact. Further, Ms Moghanlou attempted to blame a patient for the medication administration error. The panel considered that Ms Moghanlou's dishonesty, which included the concealment of a clinical error, to be serious professional misconduct.

The panel considered that Ms Moghanlou has further breached fundamental tenets of the profession, including trust, professionalism, and integrity. These are qualities of the nursing profession that must be adhered to at all times. Her failure to adhere to these fundamental tenets could well result in members of the public losing faith with the profession and the NMC as its regulator. The panel considered that a well-informed member of the public, and members of the profession, would be extremely concerned about Ms Moghanlou's misconduct and dishonesty.

In summary, and in light of Ms Moghanlou's actions and the conduct displayed, the panel found that her actions did fall seriously short of the conduct and standards expected of a nurse and amounted to a lack of competence and misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence and misconduct, Ms Moghanlou'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, open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

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

The panel found that all four limbs are engaged in this case.

The panel considered that Ms Moghanlou's clinical failings put patients at unwarranted risk of harm. It considered that it was only colleague intervention that prevented Ms Moghanlou's patients potentially suffering harm as a result of her actions. The panel noted that concerns with Ms Moghanlou's practice spanned at least a three month period and were reported by various colleagues at two different hospitals. The panel had limited evidence of any insight from Ms Moghanlou and no evidence of any remorse or attempts Ms Moghanlou has taken to remediate or address the concerns identified. It had regard to Ms Moghanlou's response to the NMC in July 2019, however considered that this document does not address any of the regulatory concerns raised, rather it focuses on Ms Moghanlou's relationship with colleagues at the Trust. The panel also noted that Ms Moghanlou had indicated that she was bullied and/or discriminated against while working at the Trust but noted that the Trust's internal investigation found no evidence of this. The panel noted that Ms Moghanlou's response to the NMC indicated that she did not intend to

practice as a nurse anymore and therefore did not provide any evidence of current safe practice.

The panel also found that Ms Moghanlou has brought the profession into disrepute and breached fundamental tenets of the profession. It considered Ms Moghanlou's actions to have fallen significantly short of the standards expect of a registered nurse. The panel considered that a member of the public would be deeply troubled to hear of a nurse making repeated and serious errors, as well as seeking to blame colleagues and patients for some of these errors.

The panel considered that the misconduct and dishonesty found in charges 16a, 17a and 17b demonstrated a deep seated attitudinal concern and it had no evidence of these concerns being remedied. The panel considered that Ms Moghanlou's failure to engage with NMC proceedings since 2019, and there being no evidence of remediation, indicates that there remains a risk of her clinical errors and misconduct being repeated. Having determined that there is a risk of repetition, the panel subsequently considered there to be a risk to the public if Ms Moghanlou were able to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

The panel also determined that a finding of current impairment is also necessary on public interest grounds in order to declare and uphold proper professional standards and maintain confidence within the profession and the NMC as the regulator. The panel considered the public interest in this case to be significant and that a member of the public would be appalled to hear of a nurse blaming patients and colleagues for her own mistakes.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This 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 Miss Moghanlou's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Moghanlou's name off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance published by the NMC. The panel accepted the advice of the legal assessor who referred the panel to the relevant NMC guidance and the cases of *Parkinson v NMC* [2010] EWHC 1898 (Admin), *PSA v GDC and Hussain* [2019] EWHC 2460 (Admin), *GMC v Patel* [2018] EWHC 171 (Admin).

Representations on sanction

The NMC outlined what it considered to be the aggravating and mitigating factors. It submitted that the proportionate sanction in this case is a 12 month suspension order or a striking-off order. The NMC submitted this range of order is necessary to protect the public, maintain confidence and standards within the profession and to mark the seriousness of the conduct.

Decision and reasons on sanction

Having found Ms Moghanlou'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 Sanctions Guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Ms Moghanlou's lack of competence and misconduct put patients at risk of harm and, in some cases, had the potential to cause fatal consequences;
- There were a large number of incidents and a pattern of misconduct;
- Ms Moghanlou has not taken responsibility for her errors, has sought to blame others, and has shown a lack of insight;
- Ms Moghanlou failed to cooperate with other staff, demonstrated a hostile attitude, and complained when staff raised issues or escalated matters regarding the incidents;
- Ms Moghanlou's dishonesty was repeated.

The panel took into account the following mitigating features:

- Ms Moghanlou has been a nurse for a considerable number of years, with no previous referrals to the NMC;
- She has engaged with the NMC to an extent and provided responses to the allegations.

As this case involved dishonesty, the panel had particular regard to the case law and NMC guidance regarding dishonesty, in particular the following section of the NMC's guidance on *'Considering sanctions for serious cases'*:

> *'In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
> - *misuse of power*
> - *vulnerable victims*
> - *personal financial gain from a breach of trust*
> - *direct risk to patients*
> - *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate'.*

The panel noted that Ms Moghanlou's dishonesty had occurred in the context of her work as a registered nurse. She had deliberately breached the professional duty of candour by covering up her errors, which placed her patients at significant risk of harm. Her dishonesty was repeated, and could not be characterised as a one-off incident. For these reasons, the panel concluded that Ms Moghanlou's dishonesty was at the upper end of the spectrum of seriousness.

The panel then moved on to consider the sanctions in ascending order.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. Taking no further action would not restrict Ms Moghanlou's practice and therefore would not protect the public from the identified risk of harm. The panel also decided that it would not be proportionate or 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 with particular regard to the public interest issues identified, an order that does not restrict Ms Moghanlou'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.'* As already discussed, the panel considered that Ms Moghanlou's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case.

The panel next considered whether placing conditions of practice on Ms Moghanlou's registration would be a sufficient and appropriate response. It bore in mind that any conditions must be proportionate, measurable and workable.

The panel bore in mind that, despite significant support from the Trust, Ms Moghanlou's competence and misconduct issues had persisted and there had been no improvement in her practice. It also had regard to the telephone note between Ms Moghanlou and the NMC, dated 29 July 2020, in which Ms Moghanlou informed her case officer that she no longer wished to practise as a nurse and wanted to be removed from the NMC register. The panel therefore had no reason to believe that Ms Moghanlou would be willing to engage with any conditions placed on her registration. The panel was also of the view that, even if it formulated conditions to address the competence concerns, there were no practical or workable conditions which would address the serious dishonesty in this case.

The panel therefore concluded that a conditions of practice order would not adequately address the serious nature of this case and would not meet the public interest or adequately protect the public.

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

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

As noted above, Ms Moghanlou's actions in this case are at the upper end of the spectrum and were repeated over a period of time. Ms Moghanlou has not demonstrated any insight into her actions and, in the panel's view, her behaviour is indicative of a harmful deep-seated attitudinal problem. Honesty and integrity are fundamental tenets of the nursing

profession and, when things go wrong, it is important that nurses abide by the duty of candour and are honest about their mistakes. Ms Moghanlou failed to adhere to the duty of candour and attempted to cover up her mistakes. In doing so, she placed her patients at further risk of harm.

The panel considered that, while a suspension order would protect the public for the time it was in force and satisfy the public interest in relation to Ms Moghanlou's competency issues, it would not be sufficient to address her misconduct.

The panel therefore moved on to consider a striking-off order. The Sanctions Guidance indicates that this sanction is likely to be appropriate when:

> *'… what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
> - *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

The panel also regard to the NMC's guidance in relation to dishonesty, in particular:

> *'The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care.*
>
> *However, because of the importance of honesty to a nurse, midwife or nursing associate's practice, dishonesty will always be serious.*

In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception*

…

The law about healthcare regulation makes it clear that a nurse, midwife or nursing associate who has acted dishonestly will always be at risk being removed from the register.

Nurses, midwives and nursing associates who behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again. …. If they do this, they may be able to reduce the risk that they will be removed from the register.'

Ms Moghanlou's dishonesty was a serious departure from the standards of honesty and integrity expected of registered nurses, and could have had fatal consequences for the patients in her care. She failed to abide by the duty of candour in order to conceal her own mistakes. She has shown no insight into her actions and continues to blame others. The panel recognised that Ms Moghanlou has had a lengthy nursing career with no previous referrals. However, it considered that her dishonesty in this case raises such fundamental questions about her professionalism as to be incompatible with ongoing registration. The panel was of the view that to allow Ms Moghanlou to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel

therefore determined that the only sanction which would protect the public and meet the public interest was a striking-off order. Nothing short of this would be sufficient in this case.

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Moghanlou's interests until the striking-off 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 that an interim order is necessary for the protection of the public and otherwise in the public interest to impose an interim suspension order for a period of 18 months to cover the appeal period.

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.

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

This decision will be confirmed to Ms Moghanlou in writing.

That concludes this determination.