Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
17, 18, 21, 22 and 23 August 2023

Virtual Hearing

Name of Registrant:	Daniela-Cristina Mihai
NMC PIN	14L0004C
Part(s) of the register:	RN1: Adult nurse, level 1 (2 December 2014)
Relevant Location:	Tameside
Type of case:	Misconduct
Panel members:	Judith Webb (Chair, Lay member) Allwin Mercer (Registrant member) Caroline Rollitt (Lay member)
Legal Assessor:	Cyrus Katrak
Hearings Coordinator:	Taymika Brandy
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Ms Mihai:	Not present and not represented
Facts proved:	All
Facts not proved:	None
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Mihai was not in attendance and that the Notice of Hearing letter had been sent to Ms Mihai's registered email address by secure email on 6 July 2023.

Mr Kabasinskas, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Mihai's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Mihai has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Mihai

The panel next considered whether it should proceed in the absence of Ms Mihai. It had regard to Rule 21 and the written and oral submissions of Mr Kabasinskas who invited the panel to continue in the absence of Ms Mihai. He submitted that Ms Mihai had voluntarily absented herself.

Mr Kabasinskas referred the relevant cases of *R v Hayward* [2001] EWCA Crim 168, *R v Jones* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162. He also referred the panel to following correspondence contained within the bundle sent by an NMC Case Officer to Ms Mihai prior to this hearing:

- An email dated 20 April 2023. This email was to confirm that the case management form ('CMF') and the draft hearing bundles had been sent to Ms Mihai in a separate secure email on the same date;
- An email dated 6 July 2023, which attached the Notice of Hearing for this substantive hearing; and
- Two emails dated 3 August 2023. The first attaching the final bundles for this substantive hearing and a further email asking Ms Mihai to confirm whether she would be attending this hearing.

In addition, Mr Kabasinskas explained that the Case Officer had made a final attempt to contact Ms Mihai via telephone on 16 August 2023 and the number was not recognised. He also confirmed that Ms Mihai had not responded to any of these emails.

Mr Kabasinskas submitted that Ms Mihai has not engaged with these proceedings since 10 February 2022. He submitted that Ms Mihai has made no application for an adjournment and there is no reason to suppose that adjourning would secure her attendance at some future date.

Mr Kabasinskas submitted that two witnesses are due to attend today to give live evidence and a further two witnesses a warned for day two and three of this hearing. He submitted that not proceeding may inconvenience the witnesses, their employer and, for those involved in clinical practice, the clients who need their professional services. He further submitted that the charges relate to events that occurred in 2020 and additional delay may have an adverse effect on the ability of witnesses accurately to recall events. Finally, he submitted that there is a strong public interest in the expeditious disposal of the case and invited the panel to proceed in the absence of Ms Mihai.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones.*

The panel has decided to proceed in the absence of Ms Mihai. In reaching this decision, the panel has considered the oral and written submissions of Mr Kabasinskas and the correspondence outlined above from the NMC to Ms Mihai. It has had regard to the factors set out in the decision of *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Mihai;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are due to attend this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020, and further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- There is a strong public interest in the expeditious disposal of the case; and
- The Notice of Hearing has been sent to the same email that Ms Mihai had sent an email from on 10 February 2022. Ms Mihai has a duty to notify the NMC of any changes to her contact details.

There is some disadvantage to Ms Mihai in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Mihai. The panel will draw no adverse inference from Ms Mihai's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas to amend the wording in the stem of charge 1).

The proposed amendment was to change the month stated in the charge to June 2020. Mr Kabasinskas submitted that this was an administrative typographical error and that the proposed amendment would accurately reflect the evidence in this case.

Proposed amendment

'That you, a registered nurse:

1) On 16 ~~April~~ **June** 2020 in relation to Resident A:

    a) At approximately 6:45 am failed to carry out any clinical observations.
    b) At approximately 7:30 am failed to carry out any clinical observations.
    c) Failed to recognise and/or escalate concerns about Resident A's deteriorating health.

2) Failed to make adequate records in relation to Resident A, in that you:

    a) Did not record that Resident A had vomited.
    b) Did not document any changes to Resident A's condition.
    c) Did not document any clinical observations.

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

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

The panel was of the view that such an amendment, as applied for, was relevant, fair and provided clarity. The panel noted there is no dispute about when these incidents occurred and that the NMC witness statements refer to 16 June 2020. The panel was satisfied that there would be no prejudice to Ms Mihai and no injustice would be caused to either party by the proposed amendment being allowed. It therefore granted the application to amend the charge as applied for above.

After granting this application, the panel, of its own volition, invited Mr Kabasinskas to consider a further amendment to the stem of charge 2) in order to provide clarity and particularity to the charge, namely, to add the words 'on or about 16 June 2020'.

The panel accepted the advice of the legal assessor.

Mr Kabasinskas accepted that an amendment to the stem charge 2) would assist with providing clarity and particularity to the charge.

The agreed amendment is as follows:

'That you, a registered nurse:

1) On 16 June 2020 in relation to Resident A:

a) At approximately 6:45 am failed to carry out any clinical observations.
b) At approximately 7:30 am failed to carry out any clinical observations.
c) Failed to recognise and/or escalate concerns about Resident A's deteriorating health.

2) Failed **on or about 16 June 2020,** to make adequate records in relation to Resident A, in that you:

a) Did not record that Resident A had vomited.
b) Did not document any changes to Resident A's condition.
c) Did not document any clinical observations.

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

Details of charge (as amended):

That you, a registered nurse:

1) On 16 June 2020 in relation to Resident A:

a) At approximately 6:45 am failed to carry out any clinical observations.
b) At approximately 7:30 am failed to carry out any clinical observations.
c) Failed to recognise and/or escalate concerns about Resident A's deteriorating health.

2) Failed on or about 16 June 2020, to make adequate records in relation to Resident A, in that you:

a) Did not record that Resident A had vomited.
b) Did not document any changes to Resident A's condition.
c) Did not document any clinical observations.

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

Background

Ms Mihai was referred to the NMC on 17 September 2020. At the time of the incident, Ms Mihai was employed as a Registered Nurse at Kings Park Home ('the Home') managed by HC-One Limited. The referral relates to a resident at the Home, Resident A. The concerns arose on a night shift that started the evening of 15 June 2020 and ended the morning of 16 June 2020.

In the morning around 6 am, Witness 1, a Carer and Witness 3, a Care Assistant went to assist Resident A with personal care. They noted that he had vomited, that he was coughing and also having difficulty with his breathing. Witness 3 pressed the emergency buzzer and Ms Mihai came to assist. It is alleged that Ms Mihai did not complete any clinical observations when she attended to Resident A. It is alleged that Ms Mihai asked Witness 3 and Witness 1 to sit Resident A up and she then left the room.

Later in the shift, around 7:30 am, Witness 3 and Witness 1 went back to Resident A's room to check on him where they found that he had vomited again, noted it was green in colour and it appeared that his condition had deteriorated further and he looked unwell. Witness 3 went to get Ms Mihai to come and assist Resident A. It is alleged that Ms Mihai did not assist Resident A and she did not complete any clinical observations. It is also alleged that Ms Mihai failed to document any changes in Resident A's condition in his daily notes.

The day nurse, Witness 4, came on duty at about 8:07am and was met by Colleague 1, another carer who said Resident A was unwell and asked Witness 4 to check on Resident A. Witness 4 stated that Resident A could not speak, he was breathless, cyanosed and clammy to touch. Witness 4 took a set of clinical observations which were; saturation 83%; temperature 37.9; blood pressure 118/68; pulse 98; respirations 24. Witness 4, therefore, called for an ambulance and Resident A was taken to

Tameside General Hospital. Resident A died in the hospital on 24 June 2020 after being treated for aspiration pneumonia.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kabasinskas on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms Mihai.

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 heard oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: A Carer at the Home currently and at the time of the allegations.
- Witness 2: A Registered Nurse and the Registered Manager at the Home at the time of the allegations.
- Witness 3: A Care Assistant at the Home at the time of the allegations (now a Senior Care Assistant at the Home).
- Witness 4: A Registered General Nurse at the Home currently and at the time of the allegations.

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

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

Charge 1a)

That you, a registered nurse:

1) On 16 June 2020 in relation to Resident A:

    a) At approximately 6:45 am failed to carry out any clinical observations.

This charge is found proved.

In reaching this decision, the panel took into account all of the witness evidence in this case and the local investigation report.

The panel first considered whether there was a duty upon Ms Mihai to carry out clinical observations of Resident A on 16 June 2020.

The panel took into account Witness 1's statement which states:

> *'Around 6am we ([Witness 3] and me) went to Resident A to do the pad change and we noticed he had vomited on himself. His vomit was green and he seemed to be choking. I raised the head of the bed immediately and [Witness 3] pressed the emergency buzzer. [Ms Mihai] came up about as quickly as she could have done as she was working downstairs.'*

The panel also took into account Witness 3's statement which states:

'I think I then pressed the emergency alarm and the nurse is supposed to come running. There was only one nurse on shift, [Ms Mihai]'

The panel then took into account the oral evidence of Witness 2 and 4, in which they both confirmed that as the only registered nurse on duty on 16 June 2020, Ms Mihai did have a duty to carry out Resident A's clinical observations. The panel considered that Witnesses 2 and 4 were registered nurses in the Home, albeit Witness 2 was the Registered Manager, and therefore the panel accepted their evidence in respect of this. The panel was of the view this evidence had also been supported by the evidence of Witness 1 and 3, who had attended to Resident A, noticing he had been sick and had reasonably sought help from Ms Mihai, the only nurse on duty.

In this regard, the panel concluded there was a duty upon Ms Mihai to carry out Resident A's clinical observations as she was the registered nurse on duty for that shift and to whom the concerns initially raised by the Witnesses 1 and 3 were reported. Further, the panel also considered that in the circumstances of this case, at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2.

Accordingly, it went on to consider whether Ms Mihai had failed to carry out any clinical observations at approximately 6:45 am on 16 June 2020.

The panel took into account Witness 1's statement that states:

'[Ms Mihai] came up about as quickly as she could have done as she was working downstairs. She told us to change him and then left. She didn't do any observations. We changed and put him in clean clothes. I wasn't happy with that and I don't think [Witness 3] was either. I think needed more help than just being changed. I would have wanted [Ms Mihai] to check his temperature, his blood pressure, things like that.'

The panel also took into account Witness 3's statement that states:

‘[Ms Mihai] told me to sit him up and I told her he was sat up and asked her to come and look at him. She came and stood at the side of the bed. She didn’t touch him. She didn’t do observations, no temp no blood pressure. I raised with [Ms Mihai] that his leg looked a bit of a funny colour and his stomach looked swollen. [Ms Mihai] said his stomach was because of how he was rolled. I disagreed but she didn’t do anything. She then left the room.’

The panel noted that this is supported by Witness 3’s local investigation statement that states:

‘[Witness 3] stated that she had no concerns with Resident A until about 06.00am.
…
[Witness 3] stated that she pressed the emergency buzzer and [Ms Mihai]came up to the first floor.
…
[Witness 3] stated that [Ms Mihai] said sit [Resident A] up.
[Witness 3] stated that [Ms Mihai] did not assist Resident A touch him or complete observations’

The panel considered that Witness 3’s local investigation statement dated 16 June 2020, was contemporaneous and is also supported by her NMC witness statement and her oral evidence. The panel therefore found Witness 3’s evidence to be consistent and reliable. The panel noted that her recollection of events was corroborated by Witness 1, who had also been present at the time of this incident.

The panel then took into account Witness 2’s statement that states:

‘As a nurse myself I would have expected [Ms Mihai] to respond quickly to the emergency alarm and then have taken a full set of observations when she went in to see the resident after being called by the carers, and acted on those results. Particularly as the carers expressed concerns about the resident’s colour […]’

The panel also bore in mind Ms Mihai's local investigation statement dated 17 June 2020, that states:

> *'[Ms Mihai] stated that she did no complete observations, as Resident A had been sick a few times before'*

The panel considered that Ms Mihai had accepted during the local investigation that she did not complete Resident A's observations after responding to the emergency buzzer. The panel considered that in the context of a vulnerable patient known to be at high risk of choking and who had vomited more than once and both Witness 1 and 3 had raised concerns about Resident A's condition. Ms Mihai as the sole nurse on shift, had a responsibility to assess Patient A by carrying out basic observations. In these circumstances, the panel found that Ms Mihai failed to carry out Resident A's clinical observations at approximately 6:45 am on 16 June 2020.

Accordingly, this charge is found proved.

Charge 1b)

That you, a registered nurse:

1) On 16 June 2020 in relation to Resident A:

    b) At approximately 7:30 am failed to carry out any clinical observations.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 3, 4 and the local investigation report.

The panel first considered its earlier findings in respect of charge 1a), in that at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2.

Having established Ms Mihai's responsibility, the panel went on to consider whether Ms Mihai had failed to carry out any clinical observations in relation to Resident A on 16 June 2020 at approximately 7:30am.

The panel took into account Witness 1's statement that states:

> *'At maybe 7.30 [Witness 3] came to get me and she told me had vomited again. I went up to see while [Witness 3] went and got [Ms Mihai]. [Ms Mihai] came up, with [Witness 3], to see again. Again, she just told us to change and make him comfortable. looked obviously worse than the first time we'd seen him. He was coughing and seemed like he was struggling to breathe – if you knew Resident A, you'd know this wasn't his normal breathing. I would have expected [Ms Mihai] to notice and be worried about this. I would have expected [Ms Mihai] to do more again this time. I would have expected her to do observations. I would have expected her to call an ambulance if that was needed. I have had situations like this happen before and other nurses do obs and call ambulances if needed. I don't know why she didn't.'*

The panel also took into account Witness 3's statement which states:

> *'I went into check him again about 7.30am and he had been sick again, so I shouted at [Witness 1] and went to get [Ms Mihai] again. I said that he looked like he had deteriorated and she said it was probably because we were rolling him all the time. She didn't do anything to him, again no touching, no checks. It seemed like she just wanted to get home. She said she would speak to [Witness 4] (RGN) about it.'*

The panel noted that Witness 1 and 3 had been present during this incident and that this had been the second time these carers had raised concerns to Ms Mihai in respect of Resident A's condition and vomiting.

The panel then took into account Witness 4's statement that states:

‘Before I could start handover [Colleague 1] who was a care assistant came up to me and told me that Resident A was unwell and asked if I could go and check on him. This was about 8.15.

I immediately when to go to Resident A’s room. I met [Ms Mihai] in the hallway and asked her if Resident A was okay. She said that he had vomited. I asked her if she had done observations and she said she hadn’t. I then went to Resident A’s room.’

The panel noted that Witness 4 had expanded on this in his oral evidence by explaining how shocked he was at the time, that Ms Mihai had not carried out any clinical observations and had not acted on the concerns raised to her.

The panel also considered that his evidence is corroborated by Ms Mihai’s local investigation statement that states:

‘*[Ms Mihai] stated that at approximately 07.30 she was downstairs and [Witness 3] asked her to go upstairs and look at Resident A, as he was unwell. [Witness 1] was in the bedroom.*

[Ms Mihai] stated that compared to earlier Resident A was the same, she noticed green vomit on his mouth […]

[Ms Mihai] stated she did not take any observations.’

The panel accepted Witness 4’s evidence in respect of this as it found it to be clear and consistent with Ms Mihai’s contemporaneous local investigation statement, in that Ms Mihai did not take Resident A’s clinical observations. Taking into account the above, the panel found that Ms Mihai failed to carry out Resident A’s clinical observations at approximately 7:30 am on 16 June 2020.

Accordingly, this charge is found proved.

Charge 1c)

That you, a registered nurse:

1) On 16 June 2020 in relation to Resident A:

    c) Failed to recognise and/or escalate concerns about Resident A's deteriorating health.

This charge is found proved.

In reaching this decision, the panel took into account all the witness evidence in this case and the local investigation report.

The panel first considered its earlier findings in respect of charge 1a), in that at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2. Having established Ms Mihai's responsibility, the panel went on to consider whether Ms Mihai had failed to recognise and/or escalate concerns about Resident A's deteriorating health on 16 June 2020.

It first took into account Witness 1's statement that states:

> *'I would have expected her to call an ambulance if that was needed. I have had situations like this happen before and other nurses do obs and call ambulances if needed. I don't know why she didn't.'*

And Witness 3's statement in which she states:

> *'I'd expect [Ms Mihai] to at least take his temperature, take his sats, take his blood pressure, touch his stomach. He wasn't his normal self, I knew that and I'm not on that ward all the time. He was gagging, his eyes looked all greyed over, he had mottled legs. I'm not in a position to take his temperature. I can only say he seems a bit hot. That's why I went and spoke to the Nursing Assistant.'*

The panel also took into account Witness 4's statement that states:

> *'When I went into his room he was quite unwell. He couldn't speak, he was breathless, Cyonased [sic] which means his hands were blue/purple colour and he was clammy to touch. I took his observations […] It was quite clear to me even just from looking at him that he needed emergency attention'*
>
> *'I said to [Ms Mihai] that I needed to call for an ambulance. I went to the office to call for an ambulance and [Ms Mihai] followed me, [sic] She asked why am I calling the ambulance why not call digital health. I told her digital heath is not an emergency service. I told her that Resident A was very unwell and could die and needed emergency attention'*

The panel was of the view that from the evidence before it, there had been clear concerns raised by both the carers on shift and another registered nurse regarding Resident A's deteriorating health who had all been present at the relevant time. The panel considered that despite Witness 4 attending to Resident A and subsequently calling an ambulance, there was a duty upon Ms Mihai to have recognised Resident A's deteriorating condition and to escalate this.

The panel took into account the evidence of Witness 2 that states:

> *'[…] the resident was a high choke risk and a full set of observations should have been taken both times so that the resident could be monitored and assessed. The resident required 999 medical attention when the next nurse came in. [Ms Mihai] should have acted straight away […]*
>
> *I do not know of any previous emergency situations [Ms Mihai] was involved in however, the escalation process is standard and she should have known what to do.'*

The panel accepted Witness 2's evidence in this regard and considered that escalating Resident A's care in these circumstances was not an unusual expectation. Taking into account all of the above, the panel found that Ms Mihai had failed to recognise and/or escalate concerns about Resident A's deteriorating health on 16 June 2020.

Accordingly, this charge is found proved.

Charge 2a)

That you, a registered nurse:

2) Failed on or about 16 June 2020, to make adequate records in relation to Resident A, in that you:

    a) Did not record that Resident A had vomited.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 4, Resident A's daily care notes and a handover note dated 15 June 2020.

The panel first considered its earlier findings in respect of charge 1a), in that at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2. Having established Ms Mihai's responsibility, the panel went on to consider whether Ms Mihai had failed on or about 16 June 2020, to make adequate records in that she did not record that Resident A had vomited.

The panel took into account Witness 2's statement that states:

> *'[Ms Mihai] admitted that she had not been in to see him and wouldn't unless there was medication. There is nothing in the notes to say that the resident vomited from [Ms Mihai].'*

The panel then took into account Witness 4's statement that states:

> *'At about 09:30 after everything to do with the ambulance was done I went to update Resident A's care record and noticed that [Ms Mihai] had only made one entry and she had not recorded he had vomited.'*

The panel then considered the exhibited document (the same document exhibited by both witnesses), namely, Resident A's daily care notes and noted that there is an entry dated 16 June 2020. Witness 4 confirmed in his oral evidence that this was Ms Mihai's handwriting. The panel was of the view that this recording was barely legible and was unable to conclude that Ms Mihai had clearly recorded Resident A's episodes of vomiting.

The panel then considered the handover note dated 15 June 2020 and noted that Resident A *'vomited again'* had been recorded once with an unclear time. Both Witness 2 and Witness 4 confirmed that Ms Mihai was required to record this in Resident A's daily care notes and the panel accepted their evidence in regard to this as both witnesses (the Registered Home Manager and a Registered Nurse) had a clear understanding of record keeping expectations in the Home.

In all these circumstances, the panel found that Ms Mihai had failed adequately to record that Resident A had vomited.

Accordingly, this charge is found proved.

Charge 2b)

That you, a registered nurse:

2) Failed on or about 16 June 2020, to make adequate records in relation to Resident A, in that you:

b) Did not document any changes to Resident A's condition.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 4, Resident A's care notes and the meeting notes from the local investigation.

The panel first considered its earlier findings in respect of charge 1a), in that at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2. Having established Ms Mihai's responsibility, the panel went on to consider whether Ms Mihai had failed on or about 16 June 2020, to make adequate records in that she did not document any changes to Resident A's condition.

The panel first considered Resident A's daily care notes and noted that there was no entry recorded on 16 June 2020, that stated Resident A's condition had changed or deteriorated.

The panel took into account the meeting notes from the local investigation dated 17 June 2020, that states:

> *'[Witness 2]: So you did not write anything the notes*
>
> *[Ms Mihahi]: I had already done notes before this happened so I did not write in the notes, I just wrote on the handover that he had been sick, I don't understand what I have done wrong'*

In the absence of any further documentary evidence, the panel found that Ms Mihai had failed to make adequate records in that she did not document any changes to Resident A's condition.

According, this charge is found proved.

Charge 2c)

That you, a registered nurse:

2) Failed on or about 16 June 2020, to make adequate records in relation to Resident A, in that you:

c) Did not document any clinical observations.

This charge is found proved.

In reaching this decision, the panel took into account Resident A's daily care records and its earlier findings in respect of charge 1a) and 1b).

The panel first considered its earlier findings in respect of charge 1a), in that at all material times there existed a duty upon Ms Mihai as set out in Charges 1 and 2. Having established Ms Mihai's responsibility, the panel went on to consider whether Ms Mihai had failed on or about 16 June 2020, to make adequate records in that she did not document any changes to Resident A's condition.

The panel next referred to the Resident A's daily care notes and identified an entry recorded at 05:20 on 16 June 2020. The panel noted that this entry was made prior to the two occasion that carers noticed Resident A had vomited and was unwell and them alerting Ms Mihai to their concerns at these times. It also took into account its earlier findings in respect of charge 1a) and 1b), in that Ms Mihai had not taken any of Resident A's clinical observations at approximately 6:45 am and 7:30am.

Taking into account all of the above, the panel found that Ms Mihai had failed to make adequate records in that she did not document any clinical observations for Resident A.

Accordingly, this charge is found 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 misconduct and, if so, whether Ms Mihai'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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Mihai's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Kabasinskas referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin) and invited the panel to take the view that the facts found proved amount to misconduct and were in breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2018) ("the Code"). He then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, Ms Mihai's actions amounted to a breach of those standards.

Mr Kabasinskas invited the panel to consider the charges found proved and how Ms Mihai's actions negatively impacted on her colleagues, in that her colleagues had to escalate her actions to management and Witness 4 had to take over the care of Resident A. Mr Kabasinskas submitted that it is important to note that Resident A was vulnerable, and that Ms Mihai had failed to carry out basic observations, to recognise Resident A's deteriorating condition and make adequate records.

Mr Kabasinskas submitted that Ms Mihai's actions fell significantly short of the standards expected of a registered nurse and invited the panel to find that her actions above are sufficiently serious to amount to misconduct.

Mr Kabasinskas then addressed the panel on the issue of impairment and the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Mr Kabasinskas referred the panel to the cases of *Cohen v GMC* [2015] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). He submitted that limbs a), b) and c) of Dame Janet Smith's test as set out in the Fifth Report from Shipman were engaged by Ms Mihai's past actions.

Mr Kabasinskas submitted that registered nurses should be honest, open and act with integrity and ensure that their conduct, at all times, justifies both their patients and the public's trust in the profession. He reminded the panel that the issue of current impairment is a forward-looking exercise.

Mr Kabasinskas submitted that escalating concerns and accurate record keeping are basic and fundamental elements of safe and effective practice. He submitted that there is sufficient evidence to suggest that Ms Mihai's conduct placed Resident A at a significant risk of harm. He submitted that poor record keeping can also present potential risks to patient safety.

Mr Kabasinskas submitted that whilst the misconduct occurred over one shift, unless it is addressed, Ms Mihai could continue to expose patients in her care to an unwarranted risk of harm.

Referring to the case of *Cohen*, Mr Kabasinskas submitted that the concerns are capable of being addressed because they relate directly to the Ms Mihai's clinical practice and there are identifiable steps which can be taken, such as further training and evidence of meaningful insight that could assist to strengthen her practice.

Mr Kabasinskas referred the panel to the last correspondence from Ms Mihai, an email sent to her NMC Case Officer dated 10 February 2022. He explained that in this email, Ms Mihai states that following the incident, she returned to Romania and goes on to describes herself as '*a good nurse'*. She also states that:

> '*I understood then that I was in a situation where I could not prove my actions, because all that was then was just discrimination. I was aware that I could not "fight" with the manager who followed my slightest mistake because she was jealous of my competence […]*
>
> *the patient's condition was as I described it, which is why I did not act.*
>
> *[…]*
>
> *Given the fact that I could not prove that I was not guilty, I thought it would be better to resign and leave the place where I understood that many of the staff would not want me there.'*

Mr Kabasinskas also referred the panel to the NMC guidance entitled *'Has the concern been addressed?'* Reference: FTP-13b. This guidance states:

- *'A nurse, midwife or nursing associate who shows insight will usually be able to: step back from the situation and look at it objectively*
- *recognise what went wrong*

- *accept their role and responsibilities and how they are relevant to what happened*
- *appreciate what could and should have been done differently*
- *understand how to act differently in the future to avoid similar problems happening.'*

Mr Kabasinskas submitted that Ms Mihai sought to justify her actions and has not acknowledged how her actions impacted on Resident A, her colleagues, the wider profession and the public. He submitted that Ms Mihai has no insight into her misconduct and has made no attempts to address the regulatory concerns.

Mr Kabasinskas submitted that nurses are required to practice kindly, safely and professionally and as Ms Mihai has not addressed the clinical concerns, there remains a risk of repetition. He submitted that the evidence in this case suggests Ms Mihai remains a risk to the health, safety and wellbeing of the public.

The panel accepted the advice of the legal assessor which included reference to the relevant cases of: *Meadows v GMC* [2006] EWCA Civ 1390, *Cheatle v GMC* [2009] EWHC 645 (Admin), *Cohen*, *Roylance v GMC* (No.2) [2000] 1 AC 311, *Nandi*, *Schodlok v GMC* [2015] EWCA Civ 769, *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin) and *Dr Nicholas-Pillai v GMC* [2015] EWHC 305 Admin.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of 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 Mihai's actions amounted to a breach of the Code. Specifically:

*‘**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

…

1.2 make sure you deliver the fundamentals of care effectively

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

…

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

…

8 Work co-operatively

To achieve this, you must:

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

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

…

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

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

…

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

To achieve this, you must:

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

…

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

….

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

…

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

…

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

...

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

….

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In considering whether Ms Mihai's actions amounted to misconduct, the panel considered each charge individually.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 1a), the panel considered its earlier findings in that Ms Mihai had failed to carry out any clinical observations after concerns had initially been raised by Witnesses 1 and 3. The panel also considered that Resident A was a vulnerable patient, at high risk of choking, who had been vomiting and that Ms Mihai as the only nurse on shift, had a duty to carry out these basic observations and respond to the concerns raised. In all the circumstances, the panel concluded that Ms Mihai's actions in charge 1a) fell far below the professional standards expected of a registered nurse and would be regarded as deplorable by Ms Mihai's fellow colleagues and members of the public. The panel, therefore, determined that Ms Mihai's actions in charge 1a) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 1b), the panel considered that this was the second time Ms Mihai had been alerted to concerns by Witnesses 1 and 3, namely, that Resident A was unwell and had vomited again. The panel also considered that Resident A's condition, at this stage had noticeably deteriorated and Ms Mihai had not carried out any clinical observations. In all the circumstances, the panel concluded that Ms Mihai's actions in charge 1b) fell far below the professional standards expected of a registered nurse and would be regarded as deplorable by Ms Mihai's fellow colleagues and members of the public. The panel, therefore, determined that Ms Mihai's actions in charge 1b) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 1c), the panel considered its earlier findings in that Ms Mihai failed to recognise and escalate concerns about Resident A's deteriorating health. The panel also considered that whilst Ms Mihai had been responsible for the care of Resident A, it was Witness 4 that had taken his observations and appropriately escalated his care by calling an ambulance. The panel further considered that Ms Mihai had suggested contacting digital health (a non-emergency service) after learning of Witness 4 concerns about Resident A's deteriorating health. The panel was of the view that this demonstrated Ms Mihai's lack of knowledge and inability to escalate patient care appropriately. In all the circumstances, the panel concluded that Ms Mihai's actions in charge 1c) fell far below the professional standards expected of a registered nurse and would be regarded as deplorable by Ms Mihai's fellow colleagues and members of the public. The panel, therefore, determined that Ms Mihai's actions in charge 1c) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 2a), the panel considered that whilst it had found this fact proved, it concluded that Ms Mihai's actions in relation to charge 2a) did not fall significantly below the standards expected of a registered nurse and were not sufficiently serious to amount to misconduct.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 2b), the panel considered its earlier findings in that Ms Mihai had failed to make adequate records by not documenting any changes to Resident A's condition. The panel considered that it was both important and necessary for Resident A's deteriorating condition to be recorded to ensure that any other health professionals had an accurate record of Resident A's health. The panel was of the view that Ms Mihai should have been aware of how unwell Resident A was and yet she did not record any changes in his condition. In all the circumstances, the panel concluded that Ms Mihai's actions in charge 2b) fell far below the professional standards expected of a registered nurse and would be regarded as deplorable by Ms Mihai's fellow colleagues and members of the public. The panel, therefore, determined that Ms Mihai's actions in charge 2b) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Ms Mihai's actions amounted to misconduct in relation to charge 2c), the panel considered that record keeping, and accurate documentation are fundamental tenets of nursing practice and that Ms Mihai had failed to document any positive or negative clinical observations in relation to Resident A. In all the circumstances, the panel concluded that Ms Mihai's actions in charge 2c) fell far below the professional standards expected of a registered nurse and would be regarded as deplorable by Ms Mihai's fellow colleagues and members of the public. The panel, therefore, determined that Ms Mihai's actions in charge 2c) breached the Code and were sufficiently serious to amount to misconduct.

The panel concluded that whilst Ms Mihai's misconduct relates to one shift at the Home and there is no evidence to suggest any concerns were raised prior to this, Ms Mihai's actions were sufficiently serious to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of this misconduct, Ms Mihai'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. 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 *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)…'

The panel determined that limbs a), b) and c) are engaged in this case. The panel finds Ms Mihai's failures in respect of Resident A, namely, to carry out any clinical observations, recognise and escalate concerns about his condition and to document any clinical observations placed Resident A, a vulnerable patient, at an unwarranted risk of harm. The panel has determined that Ms Mihai's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute by her past actions. The panel are aware that this is a forward-looking exercise, and accordingly it went on to consider whether Ms Mihai's misconduct was remediable and whether it had been remediated.

The panel had regard to the case of *Cohen* and considered whether the misconduct identified is capable of remediation. It determined that the misconduct is such that it can be remediated through the demonstration of sufficient reflection on the behaviour, insight and evidence of strengthened practice.

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

Regarding insight, the panel first took into account Ms Mihai's email dated 10 February 2022 in which she outlines her response to the regulatory concerns. She states:

> *'There are many things I could not prove, but I want to specify once again: the patient's condition was as I described it, which is why I did not act.*
>
> *[…]*
>
> *I also want to specify that I know my skills and competence as a nurse, I like my job and in all the years I have been practicing in England, I have not had a single mistake or complaint. I know who I am, I love my job, and I've never put in danger the patients or staff I've worked with.'*

The panel then took into account the notes from the local investigation meeting, and it noted that Ms Mihai stated that she *'did not do anything wrong'*. Ms Mihai subsequently resigned from her position at the Home with immediate effect. The panel considered that Ms Mihai had not recognised her failings in respect of Resident A, nor has she shown any remorse for her actions, as she has sought to blame others for her failures.

The panel also considered that Ms Mihai has not engaged with these proceedings since her email on 10 February 2022 or provided any further information, even after being made aware of the allegations. Therefore, the panel concluded that Mrs Mihai has not demonstrated any insight into her misconduct and has not considered the seriousness

of her actions, the impact of her behaviour on patients, colleagues or the reputation of the profession.

The panel then considered what steps Ms Mihai has taken to strengthen her practice and to remediate her misconduct. In the absence of any steps to strengthen her practice such as evidence of relevant training or a reflective piece, the panel concluded that Ms Mihai had not remediated her misconduct. In all the circumstances, the panel considered that there is a risk of repetition and that should Ms Mihai return to practice, she remained liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objective of the NMC is: 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. The panel concluded, given the seriousness of Ms Mihai's misconduct, that public confidence in the profession and in the regulator would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds Ms Mihai's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 18 months. The effect of this order is that Ms Mihai's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kabasinskas outlined what the NMC considered to be the aggravating features of this case. He submitted that there are no mitigating factors in this case. He informed the panel that an interim suspension order was imposed on Ms Mihai's registration on 13 November 2020, and he submitted that as a result, she has had limited chance to address the risks associated with her practice.

Mr Kabasinskas took the panel through available sanctions in ascending order of severity. He submitted that that taking no action would not address the public protection and public interest issues, and that a caution order would not be appropriate, as this case did not involve misconduct at the lower end of the spectrum of impaired fitness to practise.

In addressing a conditions of practice order, Mr Kabasinskas submitted that it is possible to formulate workable and measurable conditions that would address the public protection concerns in this case. He submitted that it is also in the public interest to permit Ms Mihai to return to nursing practice with the appropriate safeguards in place.

Mr Kabasinskas submitted that conditions that include a requirement of training, supervision, learning and that would also address record keeping, identifying and escalating patient conditions would be appropriate. Particularly, a condition that limits Ms Mihai to one substantive employer or agency with a minimum placement of one month. He submitted that requiring Ms Mihai's placements to be for a minimum of one month will ensure accountability and supervision, and any lesser duration would not be appropriate for supervision or personal development.

Mr Kabasinskas submitted that a suspension order and a striking-off order would be disproportionate as Ms Mihai stated in her email dated 10 February 2022, that she is willing to be rehabilitated.

Mr Kabasinskas submitted that a conditions of practice order for a period of 18 months would give Ms Mihai the time to return to England, find employment and evidence a period of safe and effective practice under the conditions. He explained that Ms Mihai can also request an early review of the substantive order imposed.

Decision and reasons on sanction

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

The panel considered the following aggravating features in this case:

- Ms Mihai's misconduct put Resident A, a vulnerable patient, at risk of harm.
- Ms Mihai has shown a lack of insight.

The panel then considered the mitigating features in this case and noted that Ms Mihai's misconduct occurred on one shift within a relatively short period of time. Whilst the panel acknowledged this, it considered that concerns were raised by carers in respect of Resident A on two occasions, and on each occasion, Ms Mihai failed to respond appropriately to the concerns raised. The panel, therefore, did not consider Ms Mihai's misconduct to be a momentary lapse in her clinical judgment and in these circumstances, did not identify the short period of incident as a mitigating feature.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public interest and protection issues identified, an order that does not restrict Ms Mihai's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.*' The panel considered that seen as a whole Ms Mihai's failings were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified.

The panel next considered whether placing conditions of practice on Ms Mihai's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be relevant, proportionate, measurable and workable. The panel took into account the SG, which sets out when conditions may be appropriate, and it concluded that the following apply in this case:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel considered that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel was of view that the issues identified could be addressed through retraining and supervision and that this order would allow Ms Mihai to evidence a period of safe and effective practice. Further, the panel considered that a conditions of practice order would meet the public interest, Ms Mihai would be able to continue practising as a nurse when she returns to England as there is no evidence of general incompetence or

attitudinal issues and the public would be adequately protected by the imposition of appropriate conditions.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

Accordingly, the panel imposed a conditions of practice order for the period of 18 months. The panel considered that such a period of time would afford Ms Mihai the opportunity to develop her insight and evidence a period of safe and effective practice, whilst working under the conditions of practice order.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of Ms Mihai's case. The panel considered that it would also deprive Ms Mihai of the opportunity to evidence safe and effective practice.

Having regard to the matters it has identified, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must restrict your nursing practice to one substantive employer or one agency with a minimum placement with that entity of one month.

2. You must ensure that you are supervised by another registered nurse any time

you are working. Your supervision must be indirectly supervised at all times on the same shift as, but not always directly observed by a registered nurse.

3. You must work with your line manager/mentor/supervisor to create a personal development plan (PDP) within eight weeks of starting a job. Your PDP must address record keeping, clinical assessment skills including use of the National Early Warning Score ('NEWS') and Sepsis protocols, and recognising and escalating concerns. You must:

    - Meet with your line manager/mentor/supervisor monthly to discuss your progress towards achieving the aims set out in your PDP.

    - Send your case officer a report from your line manager/mentor/supervisor seven days prior to the NMC review of the substantive order. This report must show your progress towards achieving the aims set out in your PDP.

4. You must send to your case officer a reflective piece seven days prior to the NMC review of this substantive order. This should address your record keeping, clinical assessments and the impact of your actions on Resident A, colleagues and the reputation of the profession.

5. You must keep the NMC informed about anywhere you are working as a nurse by:
    a. Telling your case officer within seven days of accepting or leaving any employment.
    b. Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:
    a. Telling your case officer within seven days of accepting any course of study.
    b. Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:

a. Any organisation or person you work for.
b. Any agency you apply to or are registered with for work.
c. Any employers you apply to for work (at the time of application).
d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:
    - Any clinical incident you are involved in.
    - Any investigation started against you.
    - Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    - Any current or future employer.
    - Any educational establishment.
    - Any other person(s) involved in your retraining and/or supervision required by these conditions.

Before the order expires, a panel will hold a review hearing to see how well Ms Mihai has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Ms Mihai's engagement with the NMC, including attendance at any review hearing.
- References or testimonials relating to any paid or voluntary work.
- Evidence of training relating to record keeping, escalating concerns, Sepsis and clinical assessment skills.
- A reflective piece.

Interim order

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

Submissions on interim order

Mr Kabasinskas submitted that an interim conditions of practice order is necessary for the protection of the public and is otherwise in the wider public interest. He invited the panel to impose an interim conditions of practice order for a period of 18 months, with the same conditions as those detailed in the substantive order to cover the 28-day appeal period.

Decision and reasons on interim order

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

The panel concluded that in this case, the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order and for a period of 18 months to cover the period of any potential appeal.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Ms Mihai is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Ms Mihai in writing.