Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday 19 July – Thursday 4 August 2022

Virtual Hearing

Name of registrant:	Miss Susan Marjorie Hughes
NMC PIN:	08C0212E
Part(s) of the register:	Registered Nurse – sub part 1 Mental Health Nursing (20 April 2009)
Relevant Location:	Wirral
Type of case:	Misconduct
Panel members:	Deborah Hall (Chair, Registrant member) Beth Maryon (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Peter Jennings
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Louis Maskell, Case Presenter
Miss Hughes:	Not present and unrepresented at the hearing
Facts proved:	Charges 1b, c, d, e, f, g, 2a, b, c, 3, 4a, b, c, d, 6a, b, 7a, b, and c
Facts not proved:	Charges 1a and 5
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Hughes was not in attendance and not represented at the hearing. The electronic Notice of Hearing had been sent to her registered email address on 13 June 2022.

The panel took into account that the Notice of Hearing provided details of the substantive hearing, the time, date and the nature of the hearing and, amongst other things, information about Miss Hughes' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Maskell, 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.

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

Decision and reasons on proceeding in the absence of Miss Hughes

The panel next considered whether it should proceed in the absence of Miss Hughes. The panel had regard to Rule 21 and heard the submissions of Mr Maskell who invited the panel to continue in the absence of Miss Hughes.

Mr Maskell submitted that it is in the public interest to proceed with the hearing and any delay could cause significant inconvenience as several witnesses have arranged to give evidence. He submitted that Miss Hughes has not asked for an adjournment and there is nothing to suggest that adjourning would secure her attendance at some future date. Mr Maskell directed the panel's attention to the email sent by Miss Hughes' representative dated 17 June 2022 which states:

'It is correct that neither the Registrant or I will be in attendance. We are planning to submit written representations.'

The panel decided to proceed in the absence of Miss Hughes. In reaching this decision, the panel has considered the submissions made by Mr Maskell and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones (Anthony William) (No.2*) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment had been made by Miss Hughes;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Miss Hughes has confirmed that she will not be attending the hearing;
- Miss Hughes has provided a witness statement and her representative has submitted written representations; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Hughes.

Details of charge as originally worded

That you, on the 8 and/or 9 December 2019:

1) Used force and/or acted inappropriately towards Patient A in that you;
    a) Held Resident A against a door;
    b) Attempted to remove, or took, a jug of water from Resident A;
    c) In relation to 1(b) spilt water onto resident A;
    d) Put Resident A into a wheelchair, by holding or grabbing Resident A's arm and/or clothing;

e) Put Resident A onto a bed, by pulling Resident A's arm and/or clothing;
f) On one or more occasions pushed, pulled or dragged a Zimmer frame away from Resident A;
g) Placed your arm(s) underneath Resident A's arm and pulled Resident A whilst Resident A was in a wheel chair.

2) In relation to Resident A you:
   a) Raised your voice to Resident A when she was in a wheel chair namely by shouting "stand up" or words to that effect;
   b) Used the following or similar words;
      i. "Get me a fucking wheelchair"
      ii. "This is fucking behavioural"
      iii. "This is behavioural she knows what she's doing, it's a fucking joke"
      iv. "She's lost the fucking plot"
      v. "Stop being stupid you're acting like a child"
      vi. "Nobody love me, everybody hates me"
      vii. "I have been waiting for this all night".

   c) Called or referred to Resident A as:
      i. Stupid and/or;
      ii. Childish and/or;
      iii. Selfish.

3) Told colleague X to "drag" Resident A out of a wheelchair or words to that effect.

4) In relation to Resident A you:
   a) Did not take any or any adequate action when Resident A's condition deteriorated.
   b) Did not escalate Resident A's condition to a manger and/or doctor;
   c) Did not take the following baseline observations:

i. Pulse;
ii. Temperature;
iii. Blood pressure.

d) Did not take any or any adequate observations of Resident A after Resident A suffered a fall on 9 December 2019.

5) Did not notify the next of kin immediately or soon after Resident A had suffered a fall on 9 December 2019.

6) Did not record or adequately record details of Resident A's fall on 9 December 2019 in:
   a) The Datix;
   b) The Post Falls Protocol.

7) Whilst on duty:
   a) Slept;
   b) Watched Netflix or used a mobile phone:
      i. Without using headphones;
      ii. Using earphones;
   c) Did not respond to a call bell.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Maskell on behalf of the NMC, to amend the wording of charge 4(b) which contained a spelling error.

The proposed amendment was to change the word *'manger'* to *'manager'*. It was submitted by Mr Maskell that the proposed amendment would rectify the typographical error and it does not change the nature of the charge nor the evidence. The panel accepted the advice of the legal assessor.

The panel decided to amend charge 4 as asked. It had regard to Rule 28 of the Rules and was satisfied that the amendment was appropriate and could be made without injustice. The charge, with the amendment, is as follows:

That you, a registered nurse:

4) In relation to Resident A you:
    b) Did not escalate Resident A's condition to a ~~manger~~ **manager** and/or doctor.

Decision and reasons on application for hearing to be held in private

Mr Maskell made an application that parts of this case may need to be held in private on the basis that proper exploration of Miss Hughes' case may involve reference to her health. The application was made pursuant to Rule 19 of the Rules.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel decided to hold parts of the hearing which refer to Miss Hughes' health in private because it concluded that this was justified by the need to protect her private health matters and that this outweighed any prejudice to the public interest in holding those parts of the hearing in public. However, where there is no reference to Miss Hughes' health matters, the hearing would be held in public.

Decision and reasons on application to amend the charge further

At the beginning of the hearing the panel had allowed an application by Mr Maskell to amend charge 4 b to correct a spelling error. Following the close of the NMC's evidence the panel heard a further application by Mr Maskell:

to amend charges 4, 5, 6 and 7c so as to delete the words *'did not'* and insert the words **'**failed to'; and
to insert before charge 7 the words 'That you, on one or more occasions whilst working as a nurse at Charlotte House Care Home:'

The first of these proposed amendments was to clarify that the NMC's case is that Miss Hughes had an obligation to do the things set out in those charges, which may not be clear if the wording is only that she did not do them. The second proposed amendment was to make the charge reflect the evidence, which was that the matters alleged occurred on occasions, but not necessarily on the night of 8 to 9 December 2019. It was submitted by Mr Maskell that the proposed amendments would not cause injustice to Miss Hughes.

The original wording of charges 4 to 7 was as follows:

> That you, on the 8 and/or 9 December 2019:
>
> …
>
> 4) In relation to Resident A you:
> a) Did not take any or any adequate action when Resident A's condition deteriorated.
> b) Did not escalate Resident A's condition to a manager and/or doctor;
> c) Did not take the following baseline observations:
> i. Pulse;
> ii. Temperature;
> iii. Blood pressure.
> d) Did not take any or any adequate observations of Resident A after Resident A suffered a fall on 9 December 2019.
>
> 5) Did not notify the next of kin immediately or soon after Resident A had suffered a fall on 9 December 2019.
>
> 6) Did not record or adequately record details of Resident A's fall on 9 December 2019 in:

a) The Datix;
b) The Post Falls Protocol.

7) Whilst on duty:
a) Slept;
b) Watched Netflix or used a mobile phone:
i. Without using headphones;
ii. Using earphones;
c) Did not respond to a call bell.

The proposed new wording of those charges is as follows:

That you, on the 8 and/or 9 December 2019:

…

4) In relation to Resident A you:
a) ~~Did not~~ **Failed to** take any or any adequate action when Resident A's condition deteriorated.
b) ~~Did not~~ **Failed to** escalate Resident A's condition to a manager and/or doctor;
c) ~~Did not~~ **Failed to** take the following baseline observations:
i. Pulse,
ii. Temperature,
iii. Blood pressure;
d) ~~Did not~~ **Failed to** take any or any adequate observations of Resident A after Resident A suffered a fall on 9 December 2019.

5) ~~Did not~~ **Failed to** notify the next of kin immediately or soon after Resident A had suffered a fall on 9 December 2019.

6) ~~Did not~~ **Failed to** record or adequately record details of Resident A's fall on 9 December 2019 in:
a) The Datix;
b) The Post Falls Protocol.

That you, on one or more occasions whilst working as a nurse at Charlotte House Care Home:

7) Whilst on duty:
   a) Slept;
   b) Watched Netflix or used a mobile phone:
      i. Without using headphones;
      ii. Using earphones.
   c) ~~Did not~~ **Failed to** respond to a call bell.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that each of the proposed amendments was in the interest of justice. The panel was satisfied that substituting the words **'failed to'** clarified the intended meaning and that the original wording did not adequately convey the import of the charges. With regard to the second amendment, the panel was satisfied that the evidence was that the alleged conduct occurred on occasions, and that the original wording in which charge 7 appeared under the introductory words referring to 8 and 9 December 2019 appeared to be an error of drafting. The proposed changed wording better reflected the evidence.

The panel took account of all the circumstances including Miss Hughes' written statement and was satisfied that there would be no prejudice to Miss Hughes and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments.

The panel has accordingly decided to make the amendments as asked. However, because the amendments are more than merely typographical, the panel regards it as appropriate and in the interests of justice to direct that the NMC Case Officer should send a copy of this determination allowing the amendments to Miss Hughes and her representative so that they have an opportunity to adduce any further evidence or add

to their written submissions in the light of the amended charges. The hearing was therefore adjourned to Tuesday 26 July 2022 to allow Miss Hughes and her representative to respond if they so wish.

When the panel was in retirement it noticed that the stem of charge 1 incorrectly refers to the resident as '*Patient A'*, when this should be *'Resident A'.* Also, the word *'you'* in the stems of charge 2 and 4 is grammatically redundant. The panel invited Mr Maskell's observations on this and he agreed that these errors should be corrected. The panel is satisfied that these corrections involve no injustice to any party and has therefore amended these charges accordingly under Rule 28 of the Rules.

Charges in their final version

That you, on the 8 and/or 9 December 2019:

1) Used force and/or acted inappropriately towards Patient A in that you;
    a) Held Resident A against a door;
    b) Attempted to remove, or took, a jug of water from Resident A;
    c) In relation to 1(b) spilt water onto resident A;
    d) Put Resident A into a wheelchair, by holding or grabbing Resident A's arm and/or clothing;
    e) Put Resident A onto a bed, by pulling Resident A's arm and/or clothing;
    f) On one or more occasions pushed, pulled or dragged a Zimmer frame away from Resident A;
    g) Placed your arm(s) underneath Resident A's arm and pulled Resident A whilst Resident A was in a wheel chair.

2) In relation to Resident A:
    a) Raised your voice to Resident A when she was in a wheel chair namely by shouting "stand up" or words to that effect;
    b) Used the following or similar words;
        i. "Get me a fucking wheelchair"

ii. “This is fucking behavioural”
iii. “This is behavioural she knows what she’s doing, it’s a fucking joke”
iv. “She’s lost the fucking plot”
v. “Stop being stupid you’re acting like a child”
vi. “Nobody love me, everybody hates me”
vii. “I have been waiting for this all night”.

c) Called or referred to Resident A as:
i. Stupid and/or;
ii. Childish and/or;
iii. Selfish.

3) Told colleague X to “drag” Resident A out of a wheelchair or words to that effect.

4) In relation to Resident A:
a) Failed to take any or any adequate action when Resident A’s condition deteriorated;
b) Failed to escalate Resident A’s condition to a manger and/or doctor;
c) Failed to take the following baseline observations:
i. Pulse;
ii. Temperature;
iii. Blood pressure.
d) Failed to take any or any adequate observations of Resident A after Resident A suffered a fall on 9 December 2019.

5) Failed to notify the next of kin immediately or soon after Resident A had suffered a fall on 9 December 2019.

6) Failed to record or adequately record details of Resident A’s fall on 9 December 2019 in:

a) The Datix;
b) The Post Falls Protocol.

That you, on one or more occasions whilst working as a nurse at Charlotte House Care Home:

7) Whilst on duty:
a) Slept;
b) Watched Netflix or used a mobile phone:
i. Without using headphones;
ii. Using earphones;
c) Did not respond to a call bell.

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

Decision and reasons on facts

The panel noted that the written representations made on behalf of Miss Hughes made admissions to some of the charges. However, in some cases those admissions were qualified by explanations and it was unclear that an unequivocal admission was intended.

The panel therefore, in the exercise of its powers under Rule 24(1), deferred finding any matters proved until the conclusion of the evidence. Following the amendments to charges 4 to 7 Miss Hughes' representative provided further written submissions withdrawing some of the admissions initially made.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case, including Miss Hughes' witness statement and an audio recording, together with the submissions made by Mr Maskell on behalf of the NMC and the written representations submitted on Miss Hughes' behalf.

The panel has drawn no adverse inference from the non-attendance of Miss Hughes.

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: Home Manager at Charlotte House Care Home
- Witness 2: Care Worker at Charlotte House Care Home
- Witness 3 Care Assistant at Charlotte House Care Home
- Witness 4 Care Assistant at Charlotte House Care Home/Colleague X
- Witness 5 Former Deputy Manager at Charlotte House Care Home

Background

Miss Hughes first came onto the NMC register in April 2009 and began working at Charlotte House Care Home (the Home) in November 2018. Just over a year later issues emerged which form the subject of the charges. On 14 January 2020 a referral was received by the NMC from the regional manager of Brighterkind who run the Home.

The conduct complained of occurred principally on the night of 8 to 9 December 2019 and the conduct largely relates to one resident and the treatment of that resident, (Resident A). The allegations relate to using inappropriate force - charges 1 and 3, being verbally abusive towards Resident A - charge 2, failing to properly care for them or take the necessary action - charges 4, 5 and 6. Also, allegations more generally relating to Miss Hughes' conduct are in charge 7.

On the morning of 9 December 2019 the staff on the shift in question raised their concerns with the Home Manager, Witness 1. An investigation was undertaken and the incident was referred to the police who took no further action. Miss Hughes was dismissed from the Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

That you, on 8 the and/or 9 December 2019:

> Used force and/or acted inappropriately towards Resident A in that you;
> a) Held Resident A against a door.

This charge is found NOT proved.

The panel is satisfied that Resident A was at the door of the Home when Miss Hughes confronted her. However, in reaching its decision, the panel took the words *'held against'* to refer to a physical holding of Resident A. Miss Hughes denied this charge. The only evidence it had of that, was in the oral evidence of Witness 4 where she described a physical pinning of the resident against the wall. All the other evidence of this incident does not describe Miss Hughes as physically holding Resident A against the door and

the panel is not persuaded on the balance of probabilities that this occurred. The panel therefore finds this charge not proved.

b) Attempted to remove, or took, a jug of water from Resident A.

This charge is found proved.

In reaching this decision, the panel took into account Miss Hughes' admission that she did try to take the jug of water from Resident A. Miss Hughes stated that she tried to take the water because she felt Resident A could cause a hazard by spilling the water but her colleagues described it as a *'struggle'* and *'aggressively'* taking the water. Another colleague described it to the local investigation as *'snatching'* and *'peeling her fingers off the jug'.* The panel noted that Witness 4 stated that water was spilt onto Resident A during the struggle.

The panel considered that the evidence describes a situation where force has been used which was certainly causing distress and potentially causing harm to the resident for no justifiable reason when there was no particular danger. The panel therefore was satisfied that this behaviour was inappropriate and finds this charge proved.

c) In relation to 1(b) spilt water onto resident A.

This charge is found proved.

The panel noted that one employee stated in her local statement that the water was spilt onto Resident A when Miss Hughes was attempting to remove the jug of water. As a matter of fact, the panel determined that water from the jug was spilled and Resident A got wet. The panel therefore was satisfied that this behaviour was inappropriate because of its findings in 1b, that Miss Hughes removed the jug of water by force and her behaviour was an inappropriate act towards Resident A and therefore the consequential spillage was also inappropriate. The panel finds this charge proved.

d) Put Resident A into a wheelchair, by holding or grabbing Resident A's arm and/or clothing.

This charge is found proved.

The panel had regard to Miss Hughes' statement that she would not have been physically capable of holding or grabbing Resident A's arm and/or clothing due to the physical stature of Resident A and her own health needs. While it accepted that Resident A was a large woman, the panel also accepted that she regularly used a Zimmer frame to walk and was unsteady on her feet. Therefore, the panel considered that it would take little force to put her off balance or to grab and pull her into a wheelchair. The panel took into account Witness 3's statement, which describes Miss Hughes grabbing Resident A's arm and pants. The panel took into account Witness 2's statement which again describes Miss Hughes as grabbing Resident A's arm and pants. The panel also took into account Witness 4's statement which talks about Miss Hughes pushing and pinning Resident A. The panel is satisfied that force was used to physically manoeuvre Resident A into the wheelchair. The panel therefore finds this charge proved.

e) Put Resident A onto a bed, by pulling Resident A's arm and/or clothing.

This charge is found proved.

In reaching this decision, the panel took into consideration Witness 3's statement, in which she states *'I saw Sue pick Resident A up again pulling at her pants and put her on the bed. It looked like Sue had used force to do so.'* The panel considered that there are a number of witnesses testifying that force was used in a range of ways such as pulling Resident A's arms, pulling her pants, and throwing or placing her with force onto the bed. It accepted this evidence and was satisfied that all accounts demonstrate the use of inappropriate force and that there was no reason why Resident A needed to be put to bed. It concluded that it was not appropriate to place a vulnerable elderly resident into their bed by force.

The panel noted that Miss Hughes denied this charge but did not provide an account as to what did occur, just what she would do hypothetically to assist a resident into bed. The panel therefore finds this charge proved.

f) On one or more occasions pushed, pulled or dragged a Zimmer frame away from Resident A.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's statement, which states *'I witnessed Sue dragging Resident A's Zimmer frame forcing her to walk forward.'* She states *'I think this is when she was trying to drag Resident A's Zimmer frame.'* Witness 2 also stated this in her statement to the local investigation. Witness 3 stated that *'Sue was trying to pull Resident A's Zimmer frame to get her to walk faster as she wanted her to go to her room.'*

The panel heard no evidence to suggest that these residents were required for any particular reasons to stay in their rooms but heard much to the effect that Miss Hughes preferred residents to remain in their rooms.

The panel determined that colleagues, whose accounts it found consistent, stated that they witnessed Miss Hughes pushed, pulled or dragged the Zimmer frame away from Resident A. The panel concluded that this behaviour was inappropriate and unnecessary. The panel therefore finds this charge proved.

g) Placed your arm(s) underneath Resident A's arm and pulled Resident A whilst Resident A was in a wheel chair.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence. She stated in her written statement, *'I went down and entered the room and Susan was dragging Resident A underneath her arm clearly causing her distress and pain as she was crying.*

Resident A was sat in her wheelchair and Susan was pulling her right arm up in the air trying to pull her out of the chair.' The panel also noted that Witness 4 stated this in her local statement. The panel heard the audio recording and determined that it is clear in the recording that Resident A was distressed at that time; it heard her say *'you are going to break my bones'* and heard Witness 3 refusing to pull her. The panel found Witness 4's account credible and consistent, and determined that it is more likely than not that this occurred. The panel therefore finds this charge proved.

Charge 2)

In relation to Resident A:

a) Raised your voice to Resident A when she was in a wheel chair namely by shouting *"stand up"* or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the audio recording and the transcripts, and determined that Miss Hughes certainly escalated her voice and by the end of the recording she was shouting. The audio recording transcript records *'right you need to stand up'* and *'all that you need to do is stand up and sit on your bed. That is it.'* The panel concluded from the audio recording that Miss Hughes was shouting. The panel therefore finds this charge proved.

b) used the following or similar words:
i. Get me a fucking wheelchair.

The panel noted that there is no dispute that Miss Hughes asked for a wheelchair. The panel considered that the language quoted by Witness 4 is consistent with the other evidence it heard that Miss Hughes used bad language and the recording of her using such language. The panel determined that Witness 4's evidence was credible and reliable, and she stated clearly in her oral evidence as well as in her statement that she heard Miss Hughes say *'Get me a fucking wheelchair'.* The panel noted that Miss

Hughes neither denied nor accepted this charge. The panel therefore finds this charge proved.

This charge is found proved.

ii. This is fucking behavioural.

The panel took into account the evidence of Witness 4 who stated in her local statement *'she then continued to shout "this is fucking behavioural".'* The panel found this witness reliable and credible and she has been consistent since she wrote her local statement. The panel also found it is consistent with the behaviour Miss Hughes demonstrated throughout, including in the recording. The panel therefore finds this charge proved.

This charge is found proved.

iii. This is behavioural she knows what she's doing, it's a fucking joke.

The panel took into account the evidence of Witness 4's statement, which states *'After I refused Susan said 'this is behavioural, she knows what she's doing, it's a fucking joke'.'* The panel again found Witness 4 credible and reliable, and determined that she has been consistent in her evidence. It also determined that Miss Hughes' behaviour in relation to this charge is consistent with other language of hers and it is more likely than not that she did say these words. The panel therefore finds this charge proved.

iv. She's lost the fucking plot.

This charge is found proved.

The panel took into account the audio recording and the transcript. The panel noted that Miss Hughes admitted saying these words, although she claims they were said under her breath. It determined that these words were audible in the recording. The panel therefore finds this charge proved.

v. Stop being stupid you're acting like a child.

This charge is found proved.

In reaching this decision, the panel took into account the audio recording and the transcripts. It also took into account the evidence of Witness 2. She states in her statement, *'I can remember that Sue said to Resident A something like 'stop being stupid, you're acting like a child'.'* Witness 2 also said in her local statement that Miss Hughes used these or similar words. Witness 4 also stated in her statement, *'Susan was calling Resident A 'stupid', 'childish' and 'selfish.'*

The panel determined that these words can be heard in the recording. It therefore finds this charge proved.

vi. Nobody loves me, everybody hates me.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4 and the audio transcripts and heard the audio recording. Witness 4 stated in her statement *'Susan was also mimicking Resident A saying 'nobody loves me, everybody hates me'.'* The panel took into account that Miss Hughes admitted to saying this and the words can be heard on the recording. The panel therefore finds this charge proved.

vii. I have been waiting for this all night.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence. She states in her witness statement *'I saw Sue with a smirk on her face when she saw what had happened and she said 'I have been waiting for this all night'.'* It also took into account that Miss Hughes admitted to saying this. The panel took account of Miss Hughes'

explanation but considered it was not necessary to establish her motivation in order to find this charge proved.

The panel therefore finds this charge proved.

c) Called or referred to Resident A as:

i. Stupid and/or;

ii. Childish and/or;

iii. Selfish.

This charge is found proved.

In reaching this decision, the panel took into account the audio recording and the transcripts where Miss Hughes is clearly heard referring to the resident as *'stupid', 'selfish'* and *'acting like a child'.* It also took into account Witness 4's evidence. She states in her witness statement, *'Susan was calling Resident A 'stupid', 'childish' and 'selfish.'* The panel is confident in Witness 4's evidence and has no reason to question her credibility. The panel therefore finds this charge proved.

Charge 3)

Told colleague X to *"drag"* Resident A out of a wheelchair or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the audio recording, the transcripts and Witness 4's evidence. She states in her statement *'I tried to calm the situation down and Susan told me to drag her out of the wheelchair and I refused.'* Witness 4 also states this in her local statement. The panel heard in the audio recording a discussion about pulling her out of the chair.

On the basis of this evidence and the fact that the panel found Witness 4 to be a credible witness, it determined that this charge is found proved.

Charge 4)

4) In relation to Resident A:

a) Failed to take any or any adequate action when Resident A's condition deteriorated;
b) Failed to escalate Resident A's condition to a manager and/or doctor;
c) Failed to take the following baseline observations:
    i. Pulse,
    ii. Temperature,
    iii. Blood pressure.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence and heard from witnesses that Resident A was acting out of character. The panel saw evidence that a handover was provided two days earlier to Miss Hughes, alerting her to the possibility of deterioration and communicating that the GP had highlighted the appropriate action of hospitalisation should Resident A deteriorate. The panel was satisfied that from the changes Resident A displayed and the concern of the other people that were there, there was a deterioration that was concerning.

When Witness 1, the Home Manager, arrived the following morning it was apparent to her that Resident A's presentation was unusual for her. Miss Hughes' witness statement, and her comments about Resident A heard on the audio recording make it clear that she recognised that Resident A's condition and behaviour that night were not typical for her.

Miss Hughes stated that she attempted to take observations of Resident A, yet she refused, and since Resident A had capacity, she had to respect her choice. Miss Hughes further explains that she did not escalate her concerns to a doctor as the resident also refused consent to this. Miss Hughes further stated that she did not

escalate her concerns to a manager as they had failed to respond on several occasions in the past. However, the panel heard evidence from other witnesses that the out-of-hours manager or deputy manager would generally respond promptly.

Witness 4, who was working with Miss Hughes that night, saw no evidence of attempts made to take observations of Resident A. The panel saw no evidence of any record of attempts to take observations. The panel also noted that Witness 1 had little difficulty in taking observations when she arrived the following morning, the outcome of which necessitated the calling of an ambulance, and the resident's admission to the intensive care unit.

The panel accepted the evidence that basic observations such as pulse, temperature and blood pressure should have been taken in these circumstances. It also accepted the evidence that if a nurse had difficulty in obtaining a resident's cooperation with an assessment of her condition they should try to manage the situation in some other way, for example by getting another member of staff to speak with the resident. Accordingly, even if the panel had accepted Miss Hughes' explanation for not taking the observations (which it did not) the panel is satisfied that Miss Hughes did not take any other adequate action in the light of the situation.

The panel determined that Miss Hughes had a duty to assess, respond to and escalate the deterioration and that she failed in that duty. The panel is content that not only did Miss Hughes not take any adequate action when Resident A's condition deteriorated, she did not escalate to a manager and/or doctor or carry out the observations, which she acknowledged and admitted. It determined that there was a failure in not doing so. The panel therefore finds charges 4a, 4b and 4c proved.

d) Failed to take any or any adequate observations of Resident A after Resident A suffered a fall on 9 December 2019.

This charge is found proved.

The panel determined that there was no evidence before it which demonstrates Miss Hughes took observations of Resident A after her fall. The panel noted that Miss Hughes was the nurse in charge and it was she who had the duty to ensure that an adequate assessment and observations of Resident A were made following her fall, in accordance with the Home's Falls policy.

The panel took account of the Datix relating to that fall which contains limited information. Miss Hughes states that Resident A refused observations. However, the panel noted that the Datix lacks any evidence of observations which can be completed without the Resident's consent, such as her presentation and position when found, any evidence of a head injury, her respiratory rate, her response to vocal stimuli etc.

The panel considered that Resident A suffered an unwitnessed fall and Miss Hughes failed to complete basic observations to determine if Resident A needed an ambulance. The panel determined that there was no appropriate justification for this failure by Miss Hughes and patient consent would in any event not be a barrier to visual observations such as presentation and response to stimuli. The panel therefore finds this charge proved.

Charge 5)

> Failed to notify the next of kin immediately or soon after Resident A had suffered a fall on 9 December 2019.

This charge is found NOT proved.

The panel took into account all the evidence, including the oral evidence and determined that notifying the next of kin after a resident had suffered a fall is often done by the nurse in charge. The panel noted that the Datix states that the day nurse had informed the next of kin.

The panel heard from the witnesses that the priority after a fall is dealing with the resident to ensure they are safe, and getting them off the floor, which Miss Hughes is

said to have done, and which in this case involved a hoist. The panel heard that the fall had occurred around the handover time when the day staff were coming in. The fall is recorded in the Datix as occurring at 07:30 and the panel accepts that the nurse in charge of the day shift, and also the Home Manager, arrived. There is no suggestion that the next of kin was not in fact informed: the Datix records that this was done by the day shift nurse.

While there is a duty to inform the next of kin, the panel was not satisfied that this should necessarily be done by the nurse initially dealing with the fall, if a day nurse who was taking over the shift agreed to do it. The panel therefore finds this charge not proved.

Charge 6)

Failed to record or adequately record details of Resident A's fall on 9 December 2019 in:

a) The Datix;

This charge is found proved.

Miss Hughes completed a Datix relating to Resident A's fall the following day at about 03:00. The panel accepted the evidence that there should have been more information in a Datix. The very brief account does not include matters such as visual observations of whether the resident could move her limbs, the resident's account of what has occurred, if she was in any pain, which members of staff took part in dealing with the incident, whether there were any trip or slip hazards which could have been involved in the fall and other matters which may be relevant to how the fall occurred and whether steps can be taken to minimise the risk of recurrence. While the detail in a Datix is a matter of degree, the panel is satisfied that this record is not merely brief but inadequate. The panel therefore finds charge 6a proved.

b) The Post Falls Protocol.

This charge is found proved.

The panel determined that there is no evidence before it that demonstrates Miss Hughes adequately recorded details of Resident A's fall either in this document or elsewhere. The Post-Falls protocol is a local document used by the Home and the panel is conscious that professional duties should not involve an unnecessary burden of form filling when there are other more important things for the practitioner to do, particularly in dealing with an occurrence such as this. However, the matters to be recorded on this form are well within what the panel regards as standard nursing practice. Completing the form would not be onerous and there is no evidence that the information had been recorded anywhere else except for the brief information in the Datix, and the panel found this inadequate. Accordingly, the panel is of the view that this information should be recorded and this is the form that the employer has produced for making that record. Miss Hughes was under a duty to complete that form and did not do so. The panel therefore finds this charge proved.

Charge 7)

That you, on one or more occasions whilst working as a nurse at Charlotte House Care Home:

7) Whilst on duty:
a) Slept.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence *'I saw Sue sleeping on duty, it was in the reception area and she would have her feet on the table and she was snoring.'* It further took into account the evidence of Witness 3. She states in her statement, *'I did see Sue sleeping on duty as she used to sleep in the reception area. I would see her sleeping there usually between 6am-7am just before medication round at 7am. I knew she was sleeping as she was snoring and she also used to take her shoes off and put her feet on the reception desk. It looked like she was making*

herself comfortable. I worked with Sue about 2 shifts a week and I would see her sleeping on duty most shifts.'.

The panel also took into account Witness 4's evidence. She states in her written statement, *'I saw Susan sleep on duty every shift I worked with her. She would be on reception with her feet on the desk. The reception area is open plan and the reception desk was in plain view. I could tell that Susan was asleep because she used to snore. She used to sleep for an hour and a half around 5.30am/5.45am before starting the morning medication round at 7am.'*

Miss Hughes denies sleeping on duty, and states that she has an eye condition which may make it appear that she is asleep when she is not. The panel considered that this would not account for the observations of her snoring, with her feet on the desk, both of which were observed by witnesses.

The panel determined that there is compelling evidence which shows that Miss Hughes slept on duty and it therefore finds this charge proved.

b) Watched Netflix or used a mobile phone:
   i. Without using headphones;
   ii. Using earphones.

This charge is found proved.

In reaching this decision, the panel took into account Miss Hughes' admission that she watched Netflix as it helped her concentrate. It also took into account the evidence of witnesses who worked alongside Miss Hughes, in their statements and their oral evidence, that they witnessed Miss Hughes regularly watch Netflix with or without headphones.

The panel paid particular attention to Witness 4's evidence. She stated in her written statement that *'Susan used to watch Netflix every night and would finish watching it at around 10.30pm after she had finished the medication. She would watch it for hours on*

end. She would watch it in the reception area on her phone with ear phones in. I know it was a series she was watching on Netflix but I am not sure what it was.' The panel also accepted that there was a period, when witness 4 first worked with Miss Hughes when she did not use the headphones.

The panel found the witnesses credible and reliable and therefore determined that it is more likely than not that Miss Hughes watched Netflix whilst on duty, both with and without headphones.

c) Failed to respond to a call bell.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence in relation to a particular shift where a resident, who was on the end of life pathway, had died and Witness 4 pressed the bell for assistance. Witness 4 states in her written statement, *'Susan refused to come to the room and I witnessed her saying 'what do you want me to do, jump on her fucking chest'. When an emergency buzzer went off on another occasion with a different resident, Susan said 'bagsy not doing CPR'.'*

Miss Hughes' evidence was that she always answered the call bell. However, the panel also heard from Witness 3 who told the panel, in her oral evidence, that Miss Hughes would rarely respond to the emergency buzzer. While the panel appreciates that on a particular occasion there may be a reason why one cannot respond to a call bell immediately, the panel accepted the evidence of Witnesses 3 and 4 and found that Miss Hughes rarely responded and that on the occasion described by Witness 4 it is clear that Miss Hughes failed to respond to the bell as a deliberate decision. The panel therefore finds this charge 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 Miss

Hughes' 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 amounted to misconduct. Secondly, only if the facts found proved did amount to misconduct, the panel must decide whether, in all the circumstances, Miss Hughes' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Maskell invited the panel to take the view that the facts found proved amount to misconduct.

Mr Maskell identified the specific and relevant standards where the NMC contends that Miss Hughes' actions amounted to misconduct. He referred to case-law relating to misconduct and made the following submissions:

> *'The NMC submit that the charges proved amount to misconduct as the Registrant's actions were serious and fell below what would been expected of a reasonable and competent nurse. The Registrant's actions showed a complete disregard to several parts of the code… and could be considered bullying in nature. This is serious in itself, but in the NMC's submission is even more so when one considers the victim was a service user.'*

Submissions on impairment

Mr Maskell moved on to the issue of impairment and addressed the panel on 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. He made the following submissions in relation to Miss Hughes' current impairment:

> *'Current impairment is not defined in the Nursing and Midwifery Order or the Rules. The NMC have defined fitness to practise as the suitability to remain on the register without restriction.*
>
> *The panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin)….*
>
> *Dealing with the first of the three questions in the Shipman Report, the actions by the Registrant, in the NMC submissions, did put others at an unwarranted risk of harm. The Registrant did not refer Resident A to the GP or hospital when their condition was deteriorating, this undoubtedly created a risk of harm to Resident A of further deterioration. The Registrant also applied unnecessary force to Resident A, in pulling her arms and clothing, or forcing her to walk faster by pulling her frame. Although no injury was caused by this, there was a risk of bruising or other injury. The panel is reminded of* [the audio recording] *during which Resident A can be heard saying "you're going to break my bones" when the Registrant is trying to get her onto the bed. In addition to the actions with resident A, the NMC also highlight charge 7. Sleeping during shift, not answering call bells and watching Netflix on duty, all would impact a nurse's ability to respond to patients and emergencies, and by doing all three regularly, according to several witnesses, the Registrant put the patients/residents at an unwarranted risk of harm.*

Considering the second of the above three questions in paragraph 8 above, the NMC submits that the actions of the Registrant brought the profession into disrepute and contravened the expectation of a registered nurse behaving professionally. A nurse is expected to be, amongst other things, kind, compassionate and caring, however the Registrant's actions demonstrate a disinterest, bullying and oppression.

With regard to the fundamental tenets of the profession, the NMC submit that these have been breached by the Registrant. The NMC submits this due to the breaches of the Code of Conduct referred to in paragraph 6 above.

The panel should also consider paragraph 71 and 74 of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin)….

… the panel should consider the need to uphold proper standards and public confidence, and whether these will be undermined if impairment were not found. The NMC submits that these would be undermined if impairment were not found in the case of an experienced registered nurse who acted in the way the Registrant did in this matter.

The Panel may also wish to consider the case of Cohen v General Medical Council [2008] EWHC 581 (Admin) in which it was stated that:

> *"... It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

The NMC submit that when considering the above paragraph, the panel need to consider any risk of repetition. Relevant to this is the fact that although most of the charges took place during one shift, there was repeated misconduct throughout that shift. As for remediation, the Registrant claims to have no plans or desire to return to nursing, the NMC submit this should form no part of the panel's

consideration on impairment. At paragraph 49 of the Registrant's statement, she says that she has been unable to secure work due to the ongoing NMC investigation, and due to COVID she has not been able to take part in face-to-face training. Therefore, it appears that the Registrant has not worked nor had any training since the matters these proceedings are concerned with. The NMC submits that this raises concerns that there has been no remedying of the Registrant's behaviour, or a period where she has worked post concerns without issue.'

Decision and reasons on misconduct

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.'*

The panel accepted the advice of the legal assessor.

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 panel was of the view that Miss Hughes' actions did fall significantly short of the standards expected of a registered nurse, and that Miss Hughes' actions amounted to breaches of the Code, including:

'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
1.5 respect and uphold people's human rights

2.2: Recognise and respect the contribution that people can make to their own health and wellbeing

2.6: Recognise when people are anxious or in distress and respond compassionately and politely

3.1: Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4.1: Balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

8.2: Maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
8.6: Share information to identify and reduce risk

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13.1 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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved in this case amounted to serious misconduct and significant breaches of the standards expected of proper nursing practice. The panel found that the charges proved were serious departures from standard practice and there were numerous breaches of the Code relating to Miss Hughes' behaviour, actions, omissions and the language she used.

The panel determined that Miss Hughes acted in a way that put Resident A at risk of physical harm, through pulling her arms and dragging her Zimmer frame. The shouting and the tone of voice used by Miss Hughes on the audio recording and Resident A's distressed responses suggest that she was also at risk of emotional harm. The panel further considered that this behaviour and language in the presence of care assistants presented an indirect risk of creating a culture of abuse in the workplace.

The panel determined that Miss Hughes failed to act when Resident A's condition seriously deteriorated. Miss Hughes failed to complete and document observations following the fall which had the potential for serious harm. The panel also bore in mind Miss Hughes' widespread misconduct in relation to charge 7, in sleeping on duty, watching Netflix and failing to respond to the call bell. This fell far below the standard expected of a nurse and had the potential for harm to be caused to vulnerable residents.

The panel found that Miss Hughes' actions and omissions, represented by the charges found proved, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Miss Hughes' 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 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… 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…'

In considering impairment, the panel bore in mind 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 proper professional standards for members of those professions.

The panel determined that Miss Hughes' insight is extremely limited. Whilst Miss Hughes in her statement does accept that she should have called the doctor for advice and support for Resident A, she also lays the blame elsewhere stating that the on-call telephone was never answered and that the care assistants were not trained to cope with Residents A's behaviour.

In the areas where Miss Hughes does not lay the blame elsewhere, such as watching Netflix, she is of the view that this was acceptable and beneficial for her practice because it helped her concentrate whilst working. Therefore, in the panel's judgement Miss Hughes has little insight into the impact of her misconduct.

The panel determined that Miss Hughes' language was completely unacceptable in front of a resident and members of staff. The panel regarded Miss Hughes' behaviour in charges 1 and 2 as not only unacceptable but amounting to abuse. It bore in mind that Miss Hughes was the nurse in charge and should have acted as a role model, and noted that she did not demonstrate insight into why the abuse of this vulnerable resident was unacceptable. She sought to excuse some of that behaviour by claiming that she said those things under her breath or that she did not intend for the resident to hear them, and seems to consider that this made it acceptable. The panel noted in any event that the language was audible on the recording.

Miss Hughes' conduct in failing to recognise and act on Resident A's deteriorating condition during the shift and her failure to take appropriate action to assess her condition following the fall similarly created a risk to service users, as did her conduct in sleeping and watching Netflix while on duty and failing to respond to a call bell.

The panel determined that all of the first three limbs from the case of *Grant* are engaged, both in the past and in the future.

The panel is of the view that there is a risk of repetition because Miss Hughes has very limited insight into her misconduct and does not seem to accept responsibility for most of her failings. There is no or little evidence that Miss Hughes has taken any steps towards strengthening her practice or addressing her shortcomings. The panel finds that Miss Hughes' practice presents a risk to service users and the public and brings the profession into disrepute, and that she has breached the fundamental professional principles of putting the interests of service users first and upholding professional standards. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds Miss Hughes' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Hughes' 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 Miss Hughes off the register. As a result of this order, the NMC register will show that Miss Hughes has been struck off the register.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case and to the submissions and representations received 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 Maskell informed the panel that the NMC sought the imposition of a suspension order for a period of six to nine months.

Mr Maskell submitted that there is a risk to patient and public safety if Miss Hughes is allowed to practise unrestricted. He submitted that there are both attitudinal and professionalism concerns in relation to Miss Hughes' behaviour. She blamed others for her failures and described a resident's deterioration in health as *'behavioural'*. She used bad language and swore in front of residents and staff, and demonstrates almost no insight into her misconduct.

Mr Maskell informed the panel that Miss Hughes is currently subject to a conditions of practice order for 12 months arising out of medication errors in 2018.

Mr Maskell submitted that the overarching objective of the panel is public protection, and in light of that, the appropriate sanction for these charges, is a suspension order for a period of six to nine months.

In his written representation on behalf of Miss Hughes, Mr Wilkinson emphasised the importance of proportionality and submitted that the most appropriate sanction would be a caution order.

Decision and reasons on sanction

Having found Miss Hughes' 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 that,

although not intended to be punitive in its effect, it may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a vulnerable resident
- Failure to respond appropriately to the needs of a resident whose condition was deteriorating
- Lack of insight into failings
- Conduct put vulnerable residents at risk of serious harm
- The use of swearing and bad language in front of residents and junior colleagues
- Abuse of professional position
- Nature of abuse demonstrates deep-seated attitudinal problems
- Previous referral to the NMC

The panel took account of the following mitigating features submitted by Miss Hughes' representative. However, it found that they provided limited mitigation in this case:

> *'It is respectfully submitted to the panel that the factors identified provide some mitigation for the Registrants actions.*
>
> *I relation to allegations 1.a-g,…, it is submitted that the Registrant had good reason to try remove the jug of water from the Resident as it posed a 'slips, trips and falls' hazard. Unfortunately, the Resident struggled with the Registrant during this interaction as expected some water splashed out of the jug onto the Resident. It is submitted this was not a malicious or callous act on behalf of the Registrant. We therefore ask the panel to consider no misconduct in relation to allegations 1.a-g.*
>
> *Regarding allegations 2, it is put to the panel that the Registrant did not raise her voice with the Registrant. Despite obvious frustration, we submit that asking a Resident who is deemed to have capacity to stand does not amount to conduct*

that falls below the standards expected. In relation to the allegations under 2.b, it is put to the panel that 'swear words' are often used as filler words and do not necessarily denote an individual's behaviour or character. It is put to the panel they would need to understand the Registrants body language, tone of voice, volume and perhaps other contextual factors to determine whether the words used amount to a serious departure from the standards or a simple 'slip of the tongue'. Additionally, whilst some comments on paper may appear questionable, in the context of the events that took place they do not amount to a serious departure from the standards. From the audio file… the Registrant appears to be bargaining and trying to persuade a Resident who was deemed to have capacity. The panel will note the Registrant comments, whereby she waited 45 minutes for assistance. Therefore, the Registrant was understandable distressed. Whilst the tone may have been questionable, it does not pose a risk to the Resident or others... We would therefore submit to the panel that the actions of the Registrant do not amount to a serious departure from the standards in the context provided and therefore do not amount to misconduct.

We submit that allegation 3 does not amount to misconduct on the basis that the allegation itself is denied. Regarding allegation 4, it is accepted the Registrant did not conduct extensive observations of the patient, or provide additional intervention through a doctor or ambulance. In the Registrant statement the circumstances for this are set out, namely that the Resident, who was deemed to have capacity at the time, refused to allow observation or intervention to happen. We submit that the Registrant was bound by the Resident wishes and therefore conducted herself to the extent she was allowed. As such we submit that no misconduct occurred. Regarding allegation 5, the resident again provides mitigation. The Registrant handed the situation over to the deputy manager and expected the deputy manager to contact the Resident next of kin. If this was not the case, the Registrant would have stayed to do this. We would respectfully submit to the panel that this may be a communication error between the Registrant and deputy manager. This is a one off incident and we therefore respectfully submit this does not amount to a serious breach of the standards or therefore, as a result, misconduct.

The reasons as given in relation to allegations 4 and 5 are compounded with regards to allegation 6. I do not seek to repeat the above. As a result we submit to the panel that the actions of the Registrant do not amount to misconduct. Finally, in relation to allegation 7, we ask the panel to carefully consider the representations of both parties, including the mitigation provided by the Registrant.'

The panel further noted Miss Hughes' statement in which she referred to a medical condition and the stressful nature of the situation for her.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and its finding that there is a continuing risk to the public. Also, in the panel's view it would undermine the public confidence and trust in the nursing profession should the panel take no action. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Hughes' 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 Miss Hughes' misconduct was not at the lower end of the spectrum. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing a conditions of practice order on Miss Hughes' registration would be a sufficient and appropriate response. The panel bore in mind Miss Hughes' conduct, both in relation to Resident A and more generally in her sleeping and watching Netflix while on duty and failing to respond to the call bell. In the panel's judgement Miss Hughes' behaviour and her limited insight demonstrate

underlying attitudinal problems which are not amenable to being addressed by conditions or retraining. The panel is of the view that there are no workable conditions that could be formulated, given the nature of the findings in this case. Furthermore, the panel concluded that the placing of conditions on Miss Hughes' registration would not adequately address the seriousness of this case and would not sufficiently protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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.'*

While the panel heard no evidence of repetition of the abusive behaviour since the incident, it attached little weight to this as it noted that Miss Hughes has apparently not been working as a nurse. In the panel's judgment Miss Hughes' behaviour towards Resident A, her lack of professionalism and her lack of insight into her misconduct demonstrate a deep-seated attitudinal problem. Further, the panel was of the view that this was not a single instance of misconduct. There were a number of incidents of misconduct during the night of 8-9 December 2019, in addition to the separate failure to respond adequately to Resident A's fall the following morning and the incidents in charge 7 of sleeping, watching Netflix and failing to respond to the call bell. The panel was also of the view that Miss Hughes has failed to demonstrate insight into her failings and as a consequence there remains a significant risk that she may repeat the behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel regarded the serious breaches

of the fundamental principles of the nursing profession evidenced by Miss Hughes' actions as fundamentally incompatible with her remaining on the register.

The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel took note of the following paragraphs of the SG:

- *'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 found deep-seated attitudinal problems in Miss Hughes' abuse and neglect of a vulnerable resident which Miss Hughes sought to justify and to lay the blame on others in many ways. The panel was of the view that Miss Hughes has an extremely limited insight into her failings and that her words at the time and her statement and representations to this hearing demonstrate that this attitudinal problem persists.

The panel further determined that any nurse who sleeps during a shift or watches Netflix while doing nursing paperwork and important documentation such as care plans, and thinks it appropriate to watch Netflix in those circumstances raises a fundamental question about her professionalism. Miss Hughes admitted to watching Netflix and tried to justify this by suggesting it was beneficial for her concentration.

The panel determined that there is an almost total lack of evidence of remorse, reflection or any efforts to demonstrate that Miss Hughes has strengthened her nursing practice. Her actions were significant departures from the standards expected of a registered nurse and in the panel's judgment her behaviour to those in her care and her

approach to her duties as a member of the nursing profession are fundamentally incompatible with remaining on the register.

The panel considered that an informed, reasonable member of the public would be shocked and concerned if a nurse who had intimidated and abused a vulnerable patient were allowed to continue to be registered as a nurse. The panel was of the view that, given the findings in this case, to allow Miss Hughes to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel bore in mind the submissions of Mr Maskell in relation to the sanction that the NMC was seeking in this case. However, the panel considered that the charges found proved are so serious that a striking-off order was the appropriate sanction to mark the seriousness of the case and to maintain public confidence in the profession.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is a striking-off order. Having regard to the effect of Miss Hughes' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

This decision will be confirmed to Miss Hughes in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, or until the conclusion of an appeal if one is brought, the panel has considered whether an interim order is required in the specific circumstances of this case, to cover the period before the substantive order comes into effect. 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 is in Miss Hughes' own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Maskell. He submitted that an interim suspension order is necessary to cover the period until the striking-off order comes into effect, and invited the panel to impose an order for a period of 18 months. Mr Maskell submitted that an interim suspension order is necessary for the protection of the public given the panel's findings on current impairment. He also submitted that such an order is otherwise in the wider public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel is satisfied that the risk of repetition of Miss Hughes' misconduct makes an interim order necessary in order to protect patients. It is also satisfied that an order is required in the public interest so as to maintain public confidence in the profession, in the light of the panel's view that a reasonable and informed member of the public would be concerned if someone in Miss Hughes' position were allowed to continue in practice.

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. In reaching its decision the panel has kept in mind the effect which an interim order will have on Miss Hughes and has taken account of the principle of proportionality.

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

That concludes this determination.