Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
31 January – 4 February 2022

Virtual Hearing

Name of registrant:	Mrs Mary Fraser Yule
NMC PIN:	72Y0095S
Part of the register:	RN7 – (1975)
Area of registered address:	Dundee
Type of case:	Misconduct
Panel members:	Peter Cadman (Chair, lay member) Linda Pascall (Registrant member) Keith Murray (Lay member)
Legal Assessor:	Cyrus Katrak
Panel Secretary:	Leigham Malcolm
Nursing and Midwifery Council:	Represented by Ms Sarah Lewis, NMC Case Presenter
Mrs Yule:	Not present and not represented in absence
Facts proved:	Charges 1a, 1b, 1e, 1f, 2, 3, 5, 6, 7a, 9, 10a & 10b
Facts not proved:	1c, 1d, 4a, 4b, 7b, 8a & 8b
Fitness to practise:	Impaired
Sanction:	Suspension Order (12 months)
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 Mrs Yule was not in attendance and that the Notice of Hearing letter had been sent on 9 December 2021 to an email address used by her for correspondence with the NMC.

Ms Lewis, 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 allegations along with the dates, time and details for accessing the virtual hearing. Amongst other things, the Notice of Hearing included information about Mrs Yule'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 Mrs Yule had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain effective and up-to-date contact details.

Decision and reasons on proceeding in the absence of Mrs Yule

The panel next considered whether it should proceed in the absence of Mrs Yule. It had regard to Rule 21 and heard the submissions of Ms Lewis who invited the panel to continue in Mrs Yule's absence. Ms Lewis referred the panel to an email from Mrs Yule to the NMC on 25 August 2021 which stated:

> *"Hi personally I won't be attending any of the meetings. Need to discuss this with my solicitor."*

Ms Lewis informed the panel that despite the NMC's best efforts there had been no engagement by Mrs Yule since this email in August 2021. Ms Lewis told the panel that the NMC had made attempts to contact and engage Mrs Yule. On 26 January 2022 in a telephone conversation she confirmed that she definitely would not be attending nor would she be represented.

In these circumstances, Ms Lewis invited the panel to proceed in Mrs Yule's absence.

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'*.

The panel has decided to proceed in the absence of Mrs Yule. In reaching this decision, the panel had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties.

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, appropriate and proportionate to proceed in the absence of Mrs Yule. The panel will draw no adverse inference from Mrs Yule's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) *Whilst employed as a staff nurse at Castle Lodge Nursing Home made inappropriate comments in Resident's care notes including:*

    a) *on 13 April 2019 in relation to Resident A wrote "incontinent of urine +++ in bed and just lying in it";*
    b) *on 18 February 2019 in relation to Resident B wrote "what hair" on the checklist for comb/brush hair;*
    c) *on 24 March 2019 in relation to Resident C wrote "urine +++";*
    d) *on 30 April 2019 in relation to Resident D wrote "incontinent of urine +++ overnight";*
    e) *on 13 March 2019 in relation to Resident E wrote "buzzing for attention when awake";*
    f) *on 2 April 2019 in relation to Resident E documented that their bowel movement was "rank smelling";*

2) *On 25 April 2019 having had a conversation with Resident F's family member, made a note of the call on the handover sheet instead of documenting this in the Resident's care plan and the diary;*

3) *On 19 February 2018 incorrectly recorded that there were 10 vials of Midazolam in the Controlled Drugs cupboard when there were 9;*

4) *On 1 March 2019 in relation to Resident G who was displaying signs of being unwell:*

   a) *failed to escalate and contact the out of hours doctor;*
   b) *did not carry out any observations;*

5) *On 7 April 2019 having noted that Resident H had moved themselves down the bed, failed to escalate and seek the assistance of a doctor which resulted in a delay in Resident H receiving medical treatment;*

6) *On 9 April 2019 having carried out observations on Resident E which were noted as abnormal, failed to escalate and seek the assistance of a doctor;*

7) *On 25 April 2019, having been informed by Resident I that they were in pain:*

   a) *failed to escalate and contact the out of hours doctor;*
   b) *inaccurately documented that Resident I was fine;*

8) *On 29 April 2019 having noted that Resident J had sustained an injury and their vital signs were abnormal:*

   a) *failed to escalate and seek the assistance of a doctor;*
   b) *failed to carry out full observations as required;*

9) *On 20 July 2018 administered Digoxin to Resident K when it had been prescribed to Resident L;*

10) *On 28 February 2019:*

a) *asked Colleague 1 to dispense and administer antibiotics to Resident M when Colleague 1 was not trained to so do;*
b) *gave the medication approximately 45 minutes later than required to do so;*

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 Ms Lewis to amend charges 1d, 3 and 8, as follows:

1) *Whilst employed as a staff nurse at Castle Lodge Nursing Home made inappropriate comments in Resident's care notes including:*

    d) *on 30 April 2019 in relation to Resident D wrote "incontinent of urine +++* ***~~overnight~~****";*

3) ***Between 15 and 19*** *February 2018 incorrectly recorded that there were 10 vials of Midazolam in the Controlled Drugs cupboard when there were 9;*

8) *On 29 April 2019 having noted that Resident* ***C*** *had sustained an injury and their vital signs were abnormal:*

Ms Lewis submitted that the proposed amendments would provide clarity and more accurately reflect the evidence before the panel.

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 amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Yule and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

The NMC received a referral from the Manager of Castle Lodge Nursing Home on 13 May 2019 in relation to Mrs Yule's nursing practice. The referral alleged that Mrs Yule made inappropriate entries in a resident notes, as set out in the charges. There were additional allegations in relation to Mrs Yule's record keeping, such as writing a resident was not in pain when they were in pain, and failing to record observations, as set out in the charges.

Between 15 and 19 February 2018 Mrs Yule allegedly signed for 10 vials of midazolam being in the Controlled Drugs ("CD") cupboard despite there being 9. On 20 July 2018, Mrs Yule allegedly dispensed and administered the wrong medication to a Resident A.

On 1 March 2019, Resident G was not well as he was coughing up green phlegm, high pulse and temperature but Mrs Yule allegedly failed to take any action. On 7 April 2019, Resident H was found moved down on his bed but there was allegedly no escalation carried out by Mrs Yule. On 9 April 2019, Resident E fell unwell and complained of feeling dizzy but Mrs Yule allegedly failed to contact an out of hours GP or any other emergency services. On 25 April 2019, Resident I complained of being in pain but this allegedly was not documented nor escalated by Mrs Yule.

Decision and reasons on amending Charge 5

Before deciding on the facts of Mrs Yule's case the panel first looked at the wording of Charge 5. The panel considered Charge 5 to be a serious charge as it included an allegation that Mrs Yule had failed to escalate Resident H's deterioration, for which there was evidence before the panel, causing a delay in the provision of care. The panel was concerned that that Charge 5, in its original form, did not reflect the real mischief in this case, as per the case of The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi [2015] EWHC 764 (Admin).

On this basis, the panel invited Ms Lewis to make submissions on its proposal to make the following amendments to Charge 5:

> 5) *On 7 April 2019 having noted that Resident H had moved themselves down the bed,* ***had a temperature of 34.9 degrees Celsius, blood pressure of 102/78, SATS of 77% and was cyanosed under finger nails,*** *failed to escalate and seek the assistance of a doctor* ~~***which resulted in a delay in Resident H receiving medical treatment***~~*;*

Ms Lewis supported the panel's invitation to amend Charge 5 and made the application.

The panel subsequently accepted the advice of the legal assessor and allowed the amendment. It bore in mind that the evidence of Resident H's state of health at the material time on 7 April 2019 had been sent to Mrs Yule by the NMC in advance of these proceedings. The evidence included include Resident H's temperature, blood pressure, and SATS. The panel therefore determined that no unfairness or injustice would be caused by amending Charge 5 to better reflect the evidence before it.

Decision and reasons on facts

In reaching its decisions on the facts the panel took into account all of the oral and documentary evidence in this case together with the submissions made by Ms Lewis.

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 live evidence from the following three witnesses called on behalf of the NMC:

- Colleague 1, Care Worker, Castle Lodge Nursing Home;
- Ms 2, Home Manager, Castle Lodge Nursing Home;
- Ms 3, Staff Nurse, Castle Lodge Nursing Home.

Mrs Yule did not appear and had made no written representations for this substantive hearing. However, out of fairness to Mrs Yule the panel did have sight of an email from her dated 24 April 2020 in respect of initial concerns. The panel also had sight of a hand-written reflective piece dated 22 July 2018. The panel treated these documents with care, and only in so far as they assisted Mrs Yule and related to the current charges being considered. It also recognised that these documents were compiled before the charges had been formulated. In the round the panel considered these documents to be of limited assistance.

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

The panel then went on to consider each of the charges and it made the following findings:

Charge 1

1) *Whilst employed as a staff nurse at Castle Lodge Nursing Home made inappropriate comments in Resident's care notes including:*

Charge 1a

a) *on 13 April 2019 in relation to Resident A wrote "incontinent of urine +++ in bed and just lying in it";*

The panel first considered whether there was evidence before it that Mrs Yule did in fact write the comment set out in Charges 1a, before moving on to decide if it was inappropriate.

The panel took account of Resident A's notes for 13 April 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in Charge 1a. The comments alleged at Charge 1a was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1a.

The panel then considered whether the comment set out in Charge 1a was inappropriate.

The panel was of the view that *"incontinent of urine +++"* was an expression commonly used in patient records to indicate that a large volume of urine had been passed. The panel saw no issue in this and considered it to be common practice. However, the additional note "*in bed and just lying in it"* added no value and was disrespectful to Resident A. The panel therefore decided that the note was inappropriate and found Charge 1a Proved.

This charge is found proved.

Charge 1b

b) *on 18 February 2019 in relation to Resident B wrote "what hair" on the checklist for comb/brush hair;*

Mrs Yule said in her email of 24 August 202 "this was not intended to be derogatory as suggested…"

The panel took account of Resident A's notes for 18 February 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in Charge 1b. The comments alleged at Charge 1b was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1b.

The panel then considered whether the comment set out in Charge 1b was inappropriate.

The panel was of the view that the statement "what hair" was a flippant note which would have been negatively received by Resident B's family. The note also added no value and was not necessary for the provision of care. The panel decided that the comment set out in Charge 1b was inappropriate and found this charge proved.

This charge is found proved.

Charge 1c

c) *on 24 March 2019 in relation to Resident C wrote "urine +++";*

Again, the panel took account of Resident A's notes for 24 March 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in

Charge 1c. The comments alleged at Charge 1c was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1c.

The panel then considered whether the comment set out in Charge 1c was inappropriate.

The panel reached the view that the note simply communicated that Resident C had passed a large volume of urine and was not disrespectful or inappropriate. The panel therefore found this charge not proved.

This charge is found NOT proved.

Charge 1d

d) on 30 April 2019 in relation to Resident D wrote "incontinent of urine +++";

Again, the panel took account of Resident A's notes for 30 April 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in Charge 1d. The comments alleged at Charge 1d was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1d.

The panel then considered whether the comment set out in Charge 1d was inappropriate.

The panel reached the view that the note simply communicated that Resident D had passed a large volume of urine and was not disrespectful or inappropriate. The panel therefore found this charge not proved.

This charge is found NOT proved.

Charge 1e

e) *on 13 March 2019 in relation to Resident E wrote "buzzing for attention when awake";*

The panel took account of Resident A's notes for 13 March 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in Charge 1e. The comments alleged at Charge 1e was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1e.

The panel then considered whether the comment set out in Charge 1e was inappropriate.

The panel was of the view that the statement was disrespectful and inappropriate as it suggested that Resident E was a nuisance. It also added no value and was not necessary for the provision of care. The panel decided that the comment set out in Charge 1e was inappropriate and found this charge proved.

This charge is found proved.

Charge 1f

f) *on 2 April 2019 in relation to Resident E documented that their bowel movement was "rank smelling";*

The panel took account of Resident A's notes for 2 April 2019 as well as the statement of Ms 2, which confirmed that Mrs Yule had written the comment set out in Charge 1f. The comments alleged at Charge 1f was before the panel in Resident A's patient notes, and it had been confirmed by Ms 2. The panel therefore determined that Mrs Yule did in fact write the note in Charge 1f.

The panel then considered whether the comment set out in Charge 1f was inappropriate.

The panel was of the view that the statement was unnecessary and not something expected of a professional nurse. Similarly, the note set out in Charge 1f added no value for the provision of care. The panel decided that the comment set out in Charge 1f was inappropriate and found this charge proved.

This charge is found proved.

Charge 2

2) *On 25 April 2019 having had a conversation with Resident F's family member, made a note of the call on the handover sheet instead of documenting this in the Resident's care plan and the diary;*

The panel took account of the 'Handover Sheet' for Resident F along with the witness statement of Ms 2. Resident F's 'Handover Sheet' contains a note made at 20:50 documenting a call from a family member in Canada. Ms 2 in her witness statement also confirmed that the note was made by Mrs Yule.

The panel also considered that this note should have been in Resident F's care plan and diary.

On the evidence before it the panel found Charge 2 proved.

This charge is found proved.

Charge 3

3) *Between 15 and 19 February 2018 incorrectly recorded that there were 10 vials of Midazolam in the Controlled Drugs cupboard when there were 9;*

The panel had sight of a 'letter of concern' dated 19 February 2018 from The Manager of Kennedy Care Group to Mrs Yule. The letter raised the issue that Mrs Yule had carelessly and erroneously recorded that there were 10 vials of Midazolam in the Controlled Drugs cupboard when there were 9. On the basis of this letter the panel found Charge 3 proved.

This charge is found proved.

Charge 4

4) On 1 March 2019 in relation to Resident G who was displaying signs of being unwell:

Charge 4a

a) failed to escalate and contact the out of hours doctor;

The panel took account of Resident G's patient notes for 1 March 2019. There was evidence before the panel that Mrs Yule took Resident G's observations and took steps to monitor his state of health. The panel reached the view that the NMC had failed to establish that Mrs Yule ought to have escalated Resident G's state of health and contact the out of hour's doctor. The panel therefore found Charge 4a not proved.

This charge is found NOT proved.

Charge 4b

b) did not carry out any observations;

The panel took account of Resident G's patient notes for 1 March 2019. The notes contained observations starting from 22:30, and therefore the panel found Charge 4b not proved.

This charge is found NOT proved.

Charge 5

5) *On 7 April 2019 having noted that Resident H had moved themselves down the bed, had a temp of 34.9 degrees Celsius, blood pressure 102/78, SATS of 77% and was cyanosed under finger nails, failed to escalate and seek the assistance of a doctor;*

The panel took account of Resident H's care notes for 7 April 2019 along with the witness statement of Ms 2.

There was evidence before the panel that Resident H had deteriorated and required the assistance of a doctor. His care notes indicated that he had a temp of 34.9 degrees Celsius, blood pressure 102/78, SATS of 77% and was cyanosed under finger nails. Ms 2's witness statement sets out that Resident H was in a concerning state which ought to have been escalated:

> *"Mary did not escalate this to a doctor she made a note in his record. Resident H ended up on end of life care after this incident. Whilst Resident H was progressively getting worse Mary should have escalated how she found him."*

The panel was of the view that Mrs Yule ought to have been concerned by Resident H's deterioration and ought to have escalated it. On the evidence before it, the panel found Charge 5 proved.

This charge is found proved.

Charge 6

6) *On 9 April 2019 having carried out observations on Resident E which were noted as abnormal, failed to escalate and seek the assistance of a doctor;*

The panel had regard to Resident E's care notes as well as the witness statement of Ms 2, which states:

> *"Mary had carried out observations but did not contact a doctor and based on the observations noted on 9 Aril 2019. I would have expected Mary to escalate this to a doctor. I would have done if I was in the same situation. Resident E required to be seen by a doctor and was later seen by a doctor."*

Resident E's observations were abnormal. The panel considered Mrs Yule ought to have escalated Resident E's state of health and sought assistance from a doctor. The panel therefore found Charge 6 proved.

This charge is found proved.

Charge 7

7) *On 25 April 2019, having been informed by Resident I that they were in pain:*

Charge 7a

a) *failed to escalate and contact the out of hours doctor;*

The panel had regard to Resident I's notes and the statement of Ms 2. There was evidence before the panel that Mrs Yule had recorded that Resident I experienced 'severe pain when jolted'. Ms 2 in her oral evidence confirmed that in the circumstances she would have expected Mrs Yule to contact a doctor and request an analgesia. However, there was no evidence before the panel that a doctor had been called.

The panel decided that Mrs Yule should have escalated Resident I's pain to a doctor, and there was no evidence that she did this. The panel therefore found this Charge 7a proved.

This charge is found proved.

Charge 7b

b) *inaccurately documented that Resident I was fine;*

The panel took account of Resident I's care notes. It considered that although Mrs Yule had failed to escalate Resident I's pain or call a doctor, she had made accurate records in Relation to Resident I.

The panel found Charge 7b not proved.

This charge is found NOT proved.

Charge 8

8) *On 29 April 2019 having noted that Resident C had sustained an injury and their vital signs were abnormal:*

Charge 8a

a) *failed to escalate and seek the assistance of a doctor;*

The panel considered that on balance there was no evidence that Resident C sustained an injury and that this Charge accordingly failed.

Further, in relation to charge 8a, the panel reached the view that he NMC had not established that Resident C's vital signs were abnormal nor that the matter should have been escalated and a doctor called.

This charge is found NOT proved.

Charge 8b

b) failed to carry out full observations as required;

The panel considered that on balance there was no evidence that Resident C sustained an injury and that this Charge accordingly failed.

Given the evidence contained in Resident C's records that there were apparently no signs of injury and no abnormal signs for this lady, the panel did not consider that there was a requirement to carry out full observations.

The panel considered, from the limited documentation before it, the NMC had not established that there was anything further that Mrs Yule should have done.

This charge is found NOT proved.

Charge 9

9) *On 20 July 2018 administered Digoxin to Resident K when it had been prescribed to Resident L;*

The panel had regard to the care notes of both Resident K and Resident L. It also took account of the witness statement and oral evidence of Ms 3. Ms 3's written statement stated:

"Mary came to me saying 'I've given her the wrong medication'."

The panel determined, on the balance of probabilities, that Mrs Yule administered Digoxin to Resident K when it had been prescribed to Resident L on 20 July 2019.

This charge is found proved.

Charge 10

10) On 28 February 2019:

Charge 10a

a) *asked Colleague 1 to dispense and administer antibiotics to Resident M when Colleague 1 was not trained to so do;*

The panel took account of the witness statements of both Ms 2 and Colleague 1. Colleague 1 was clear in her oral evidence that Mrs Yule asked her to dispense and administer antibiotics to Resident M when she was not trained to so do.

On the evidence before it, and on the balance of probabilities, the panel found Charge 10a proved.

This charge is found proved.

Charge 10b

b) *gave the medication approximately 45 minutes later than required to do so*;

The panel took account of all of the evidence before it and including the written and oral evidence of Colleague 1. Colleague 1 stated that medication should have been given by 7:30 or 7:40 and had not been given by 8:10.

On the balance of probabilities, found Charge 10b proved.

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 Mrs Yule'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, Mrs Yule's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Lewis invited the panel to take the view that the facts found proved amount to misconduct. She highlighted the following sections of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) which the NMC considered Mrs Yule to have breached:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion.

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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.

5 Respect people's right to privacy and confidentiality

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

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

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;

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

Ms Lewis submitted that the large number of breaches clearly indicated that the standard of professionalism expected of a registered nurse had not been adhered to. She submitted that Mrs Yule displayed an attitude and behaviour which was not proper and which called into question her ability to practise safely and effectively as a registered nurse.

Ms Lewis then 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Lewis highlighted that there was no evidence to suggest that since being dismissed from the Home Mrs Yule had been able to remediate the issues identified in her nursing practice. She submitted that in the absence of any evidence of remediation limbs a) – c) of the test set out in the case of Grant are engaged:

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) *…*

Ms Lewis invited the panel to find Mrs Yule's current fitness to practise impaired on the grounds of public protection as well as in the public interest.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 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.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel was of the view that Mrs Yule's actions did breach the following standards:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion.

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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.

10 Keep clear and accurate records relevant to your practice

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

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

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

13 Recognise and work within the limits of your competence

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

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

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

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;

20.5 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 Mrs Yule's conduct was not a one-off incident, but spanned several months and amounted to a pattern of unacceptable behaviour. The panel found that Mrs Yule's actions did fall short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Yule's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

d) *…*

The panel finds that patients were put at risk of harm as a result of Mrs Yule's serious misconduct. Mrs Yule's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, there was no evidence before the panel to suggest that Mrs Yule had taken any steps to remediate the issues identified. Further, the panel had no information as to her current employment. In the absence of any information whatsoever around Mrs Yule's

current level of insight, remorse, or any efforts at remediation, the panel determined that her fitness to practise safely and effectively as a registered nurse remains impaired. The panel considered limbs a) – c) of test set out in the case of Grant to be engaged.

The panel was of the view that there is a risk of repetition and therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Yule's fitness to practise impaired on the grounds of public interest.

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

Submissions on sanction

Ms Lewis submitted that in the circumstances of Mrs Yule's case a 12 month suspension order, with a review, would be the most appropriate sanction. She submitted that a 12 month period of suspension would allow Mrs Yule time to reflect on her misconduct and make efforts to remediate.

In terms of aggravating factors, Ms Lewis set out the following:

- Mrs Yule's misconduct involved vulnerable residents;

- Mrs Yule has demonstrated limited insight, if any;
- There is no evidence of training or remediation.

In terms of mitigating factors, Ms Lewis set out the following:

- Mrs Yule has not previously been referred to the NMC;
- Mrs Yule has had a lengthy nursing career.

Decision and reasons on sanction

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

Having found Mrs Yule'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel considered the following to be aggravating features in Mrs Yule's case:

- Mrs Yule's misconduct involves three instances of failing to escalate deteriorating residents;
- The residents involved were vulnerable;
- Mrs Yule was the only registered nurse on duty at the time.

In terms of mitigation the panel took into account Mrs Yules lengthy nursing career.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of Mrs Yule's misconduct and the current risk to the public. 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 similarly, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Yule'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 Mrs Yule's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Yule's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, as to when conditions of practice are appropriate, and in particular:

- *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;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *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 had no information as to Mrs Yule's current employment or her future intentions. The panel was not assured that Mrs Yule would be willing or able to comply

with any conditions imposed. The panel therefore concluded that the placing of conditions on would not be sufficient to protect the public or to address the public interest in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel bore in mind Mrs Yule's lengthy nursing career. It reached the view that a 12 month period of suspension would allow Mrs Yule time to reflect on her misconduct, engage with the NMC, and make efforts to remediate her misconduct. In addition, it would protect the public as well as address the public interest.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and Mrs Yule's lengthy and previously unblemished career, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Yule's case to impose a striking-off order.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Yule's participation in proceedings;
- Information from Mrs Yule as to any recent/current paid or unpaid work;
- Recent relevant references;

- An up-to-date reflective statement;
- Information on any training or professional development;
- Information on if/how Mrs Yule has kept her nursing knowledge up-to-date.

This will be confirmed to Mrs Yule in writing.

Decision and reasons on interim order

As the suspension 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 Mrs Yule's own interest until the suspension sanction takes effect.

The panel took account of the submissions made by Ms Lewis and accepted the advice of the legal assessor.

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for any potential appeal period.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Yule is sent the decision of this hearing in writing.

That concludes this determination.