Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 March 2022 – Friday, 18 March 2022

Virtual Hearing

Name of registrant:	Elizabeth Nyoni
NMC PIN:	97I0080E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – September 2000
Area of registered address:	Leicester
Type of case:	Misconduct
Panel members:	Caroline Healy (Chair, Registrant member) Jennifer Childs (Registrant member) Caroline Friendship (Lay member)
Legal Assessor:	William Hoskins
Hearings Coordinator:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Sophia Kerridge, Case Presenter
Miss:	Not present and not represented in absence
Facts proved:	Charges 1, 3
Facts not proved:	Charge 2
Fitness to practise:	Impaired
Sanction:	Suspension order, 6 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 Miss Nyoni was not in attendance and that the Notice of Hearing letter had been sent to Miss Nyoni's registered email address on 25 January 2022.

Ms Kerridge, 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 the Notice of Hearing which provided details of the allegation, the time, dates and the fact that this hearing is being held virtually. Additionally, the notice contained a link to access the virtual hearing, information about Miss Nyoni'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 Miss Nyoni has 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 an effective and up-to-date registered address and email address.

Decision and reasons on proceeding in the absence of Miss Nyoni

The panel next considered whether it should proceed in the absence of Miss Nyoni. It had regard to Rule 21 and heard the submissions of Ms Kerridge who invited the panel to continue in the absence of Miss Nyoni. She submitted that Miss Nyoni has not responded to the NMC's attempts to contact her nor has she engaged in a meaningful way. She submitted that one of the telephone numbers on file for Miss Nyoni seems to be correct as the NMC had been able to make contact on 2 March 2022. Ms Kerridge submitted that this suggests that previous voice messages had been received. However, following the successful call there was no further contact made with Miss Nyoni. She submitted that Miss Nyoni has been given the opportunity to respond and to attend, however, Miss Nyoni chose not to do so, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Miss Kerridge submitted that it is in the public interest to proceed with the hearing as these are serious charges which allegedly occurred in 2017.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Miss Nyoni. In reaching this decision, the panel has considered the submissions of Ms Kerridge and the advice of the legal assessor. It has 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. It noted that:

- No application for an adjournment has been made by Miss Nyoni;
- Miss Nyoni has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend today to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Nyoni in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. The panel does, however, have the written account which she gave during the investigation of the incident and her responses at the investigation meeting that was held on 1 October 2017 . She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Nyoni's

decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and not to provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Kerridge, on behalf of the NMC, to amend the wording of charge 1.

The proposed amendment was to change 'four' residents to 'three'. It was submitted by Ms Kerridge that the proposed amendment would provide clarity and more accurately reflect the evidence. She submitted that the amendment does not affect the nature of the charge, however, it is important that the charge reflects the incident accurately so that the public can be protected accordingly.

Original Charge:

1. Did not follow a management direction to move ~~four~~ residents from the Tudor Unit to Windsor Unit.

Amended Charge:

1. Did not follow a management direction to move <u>three</u> residents from the Tudor Unit to Windsor Unit.

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 such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Nyoni 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 the charge accurately reflects the evidence.

Details of charge (as amended)

That you, a registered nurse, on 30 September 2017,

1. Did not follow a management direction to move three residents from the Tudor Unit to Windsor Unit. **[proved]**

2. Left resident A unattended on Tudor Unit save for when hourly checks were conducted. **[not proved]**

3. Contributed to resident A suffering serious injury by leaving the Tudor Unit unattended on one or more occasions. **[proved]**

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

Background

The charges arose whilst Miss Nyoni was employed as a registered nurse by Manor Care Home in Leicester (the Home). Miss Nyoni was employed as a bank nurse at the Home for several years before she was employed as a permanent staff nurse on 25 July 2017.

The Home consisted of three units:

- Tudor Unit – contained 23 beds over two floors;
- Windsor Unit – contained 26 beds over two floors; and
- Sovereign Unit – 18 beds over a single floor, this unit was particularly for residents with advanced dementia and higher dependencies.

As a Staff Nurse, Miss Nyoni was responsible for the delivery of day-to-day care to residents at the Care Home, reviewing care plans and conducting risk assessments, managing and overseeing care staff, administering medication and monitoring the safety and wellbeing of the residents.

Resident A was an 84-year old woman at the Home with a number of complex health issues including transient ischaemic attack, bilateral total hip replacements, depression, atrial fibrillation, Alzheimer's, osteoporosis, kidney disease, left ventricular failure, double vision caused by thyroid disease, coeliac disease, arthritis and vertigo. Resident A was understood to have a tendency to wander within the ward and a recorded history of falling resulting in significant injuries such as a vertebrae fracture and humeral fracture. Resident A was assessed as being at high risk of falls.

On 30 September 2017 Miss Nyoni was working the night shift from 7.30pm to 8am the next morning. She was working alongside two Healthcare Assistants, Ms 2 and Ms 3.

On that evening, a night carer called in sick. The Acting Care Home Manager, Mr 1, tried to secure an agency replacement but none was available. Mr 1 spoke with Miss Nyoni on the telephone and told her to move the four residents from the Tudor Unit to the Windsor

Unit overnight to ensure adequate supervision despite the reduced number of care staff. Mr 1 phoned back a little later to amend his instruction and said that one of the residents could remain on Tudor Unit overnight if that was his preference.

It is alleged that despite there being enough beds in the Windsor Unit, Miss Nyoni moved the residents, including Resident A, back to the Tudor Unit (the residents had spent the day in the lounge of Windsor Unit), without informing Mr 1 of her decision.

Resident A was checked by Ms 3 hourly between 23:00 and 05:00. It is alleged that Miss Nyoni during this time remained predominantly at the Windsor Unit, which meant there was no care or nursing staff at the Tudor Unit to ensure the safety of the residents outside these checks. This was done in the knowledge that Resident A had a habit of “wandering” and was also at high risk of falls.

Resident A was found shortly before 06:10 by another resident, having suffered a fall in the hallway of the Tudor Unit. When Miss Nyoni became aware that Resident A had suffered the fall, an ambulance and Mr 1 were contacted. At that stage it appeared that Resident A had sustained a laceration above her left eye, was bleeding and could not be moved due to being in significant pain.

Resident A was taken to hospital where she was diagnosed with a pelvic fracture, spinal fracture, fractured left wrist, a hairline fracture on her head and a subsequent bleed in the brain.

Miss Nyoni was dismissed from the Care Home on 01 October 2017 during the investigatory meeting.

Decision and reasons on facts

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

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

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 witnesses called on behalf of the NMC:

- Mr 1: Acting Care Home Manager at Manor Care Home;
- Ms 2: Health Care Assistant at Manor Care Home.
- Ms 3: Health Care Assistant at Manor Care Home.

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

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

Charge 1

1. Did not follow a management direction to move three residents from the Tudor Unit to Windsor Unit.

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's, Ms 2's and Ms 3's oral and written evidence, a handwritten statement by Miss Nyoni, dated 02 October 2017, in addition Miss Nyoni made a second statement which appears to have been made at a police station on 20 October 2017 as well as a police statement made by Ms 3, dated 15 October 2017 and an undated statement made by Ms 3 described as her local statement.

The panel noted that Mr 1 stated in his written statement to the NMC:

> '[…] *I then telephoned* [Miss Nyoni] *and told her to move the 4 residents who were in Tudor unit, including Resident A, to the Windsor Unit to sleep there for the night. This is because the Windsor Unit had more beds and the 3 staff members could check on them more safely and easily.* [Miss Nyoni] *said to me that she would do this.*'

Mr 1 confirmed this in his oral evidence to the panel. He explained that the residents had spent the day at Windsor Unit and were familiar with it. He stated that moving the residents would not have caused them any issues during the night. Mr 1 further explained his reasoning as to why he asked Miss Nyoni to move the residents as follows:

- If any residents remained on Tudor Unit, staff on Windsor Unit would not hear any sensor alarms going off if a resident got out of bed;
- There were sufficient and suitable rooms in the Windsor Unit;
- There were carers on each floor of the Windsor Unit to properly monitor patient safety and welfare;

- There were no logistical difficulties in moving the Tudor residents to the Windsor Unit overnight;
- Even for the residents that might be on the second floor, which would not have been Patient A, they would not have access to the staircase (unlike at the Tudor Unit) and if the lift was called it would be immediately apparent to staff on both floors of the Windsor Unit; and
- Any increased risk arising from patient distress was mitigated by the fact that the residents of the Tudor Unit were familiar with the Windsor Unit and the additional supervision they would receive at the Windsor Unit.

The panel noted that both Ms 2's and Ms 3's evidence confirmed Mr 1's evidence that Miss Nyoni was told to move the residents to the Windsor Unit. In her local undated statement Ms 3 states:

> '[Mr 1] *rang back* […] *he gave an instruction to Elizabeth to keep Tudor unit residents at Windsor for the night for health and safety bases and to keep an eye on them. Elizabeth informed me of this, so I asked for the keys to unlock the available rooms at the Windsor unit.* […]
> *Elizabeth said "No, but we can take them back to Tudor to sleep in their beds and keep an eye on the unit, by keep checking every hour or less or I can stay there and do my paperwork."'*

The panel further noted that Ms 3 confirmed her initial statement during her oral evidence to the panel and confirmed that she did not agree with Miss Nyoni's decision. However, she stated that due to Miss Nyoni being superior in position she did not question her decision at that point.

In a statement, dated 20 October 2017, made at Keyham Lane Police Station, Miss Nyoni states:

> '*On the night in question we were Short staffed and I was asked to move resident from one unit to another.*
> *The move was not feasible and so I decided to leave the residents where they were and monitor hourly.*'

In his oral evidence, Mr 1 explained to the panel that he was available to take phone calls, and that he had left his phone on, throughout the night. It would have been possible for Miss Nyoni to contact him to discuss her decision to leave the residents on Tudor Unit and he would have been receptive to such a discussion.

The panel was of the view that a management direction was given by Mr 1, as has been confirmed by Ms 2 and Ms 3, and acknowledged by Miss Nyoni. The panel noted that Miss Nyoni said '[…] *I used my own discretion* [..]' in her handwritten statement, dated 2 October 2017, and did not move the residents to the Windsor Unit. The panel concluded that Miss Nyoni made a different assessment of the situation, contrary to that of Mr 1. The panel was of the view that having made a different assessment Miss Nyoni should have called Mr 1 to discuss a different solution or inform him of her decision, however, she did not do so. The panel concluded that Miss Nyoni therefore did not comply with the management direction given to her.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that Miss Nyoni did not follow a management direction to move three residents from the Tudor Unit to Windsor Unit.

Charge 2

2. Left resident A unattended on Tudor Unit save for when hourly checks were conducted.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr 1's, Ms 2's and Ms 3's oral and written evidence, a handwritten statement by Miss Nyoni, dated 02 October 2017, in addition Miss Nyoni made a second statement which appears to have been made at a police station on 20 October 2017 as well as a police statement made by Ms 3, dated 15 October 2017 and an undated statement made by Ms 3 described as her local statement.

The panel noted that the observations/safety check chart and progress notes confirmed that hourly checks were conducted by Ms 3 and Miss Nyoni. It noted that Ms 3 confirmed in her oral evidence that there was no Healthcare assistant based on the Tudor Unit for the night.

In the notes of an investigatory meeting conducted by Mr 1 with Miss Nyoni, dated 1 October 2017, it is stated:

> '[Miss Nyoni] *advised herself and the carers were to go every hour and as we were going along.* [Miss Nyoni] *stated she took that decision without realising.*
>
> [Mr 1] *advised that* [Miss Nyoni] *is aware we have 2 floors in Windsor?* [Miss Nyoni] a*greed she was aware.* [Mr 1] *then showed an observation sheet where the observations recorded were sometime over an hour.* [Miss Nyoni] *said she had also gone to check in between.* [Mr 1] *asked* [Miss Nyoni] *where her evidence was that she had checked the resident regularly in the unit?* [Miss Nyoni] *was unable to answer this.*'

Ms 3 confirmed in her oral evidence that someone would have gone to check on the residents in the Tudor Unit at least hourly. She stated that if nothing changed between the hourly checks, the observations/safety check chart and progress notes may have not been updated. The panel had no reason to doubt Ms 3's statement.

The panel also noted that in her local statement Ms 3 mentioned that Miss Nyoni stated to her:

> '[…] *keep checking every hour, or less or I can stay there and do my paperwork.*

Ms 3 further states:

> '*at 23:00 Resident A was assisted to bed in Tudor unit to spend the night as she fell asleep on the chair in Windsor, I went to get my personal stuff from Tudor's kitchen when I went there the nurse was still in Windsor unit but when I left Tudor I found the nurse sitting in the lounge* [of Tudor Unit] *sitting on the sofa.*'

The panel was of the view, that there is evidence from Ms 3 demonstrating that Miss Nyoni did attend Tudor Unit in addition to the hourly checks.

The panel noted Miss Nyoni's signature on the observation sheet, in addition to that of Ms 3, on three separate occasions during the night. On each occasion resident A was 'asleep' and the panel heard that as resident A was mobile, she did not require 2 people to provide care to her during the hourly checks. These entries suggest that, in accordance with the evidence of Ms 3, nothing had changed in residents A's needs since the hourly observation and therefore an additional entry in the notes, was not made.

The panel was therefore not satisfied, that the NMC provided sufficient evidence to demonstrate, that it is more likely than not that Miss Nyoni left resident A unattended on Tudor Unit save for when hourly checks were conducted.

Charge 3

3. Contributed to resident A suffering serious injury by leaving the Tudor Unit unattended on one or more occasions.

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's, Ms 2's and Ms 3's oral and written evidence, a handwritten statement by Miss Nyoni, dated 02 October 2017, in addition Miss Nyoni made a second statement which appears to have been made at a police station on 20 October 2017 as well as a police statement made by Ms 3, dated 15 October 2017 and an undated statement made by Ms 3 described as her local statement.

The panel noted that Resident A was found shortly before 06:10 by another resident, having suffered a fall in the hallway of the Tudor Unit. She was found on the floor near the toilet, a significant distance from her room, this was confirmed by Mr 1 and Ms 3. The panel also noted that it is not clear how long after the fall the other resident found her and alerted staff. The panel noted that Resident A suffering a pelvic fracture, spinal fracture, fractured left wrist, a hairline fracture on her head and a subsequent bleed in the brain and was of the view that this constituted a serious injury.

The panel reminded itself of its findings in regard to charge 1 and 2. It concluded that whilst there is some evidence that Miss Nyoni did check on the residents on Windsor Unit in addition to the hourly checks, it is also clear that Tudor Unit did not have a member of staff permanently on the floor during the night. The panel therefore concluded that the Tudor Unit was left unattended on one or more occasions.

The panel noted that Resident A's bed was fitted with a motion sensor, setting off an alarm should Resident A get out of bed during the night. Both Mr 1 and Ms 3 had explained that the alarm would only work within the unit of the room that had triggered it. Accordingly, an alarm triggered in a room on Tudor Unit would not be heard on Windsor Unit. The panel

was of the view that had someone been on Tudor Unit when Resident A got up they would have heard the alarm and could have possibly intervened and helped Resident A before she sustained a serious injury.

The panel noted that Miss Nyoni was aware of Resident A's health issues and the fact that she had a tendency to wander around during the night. This was confirmed by Mr 1, Ms 2 and Ms 3.

The panel further noted Ms Nyoni's responses at the investigatory meeting, dated 1 October 2017. When asked where she had been between 5am and 6:10am when Resident A was found on the floor Miss Nyoni replied:

> '[I] *was preparing to give medication as* [I] *was also watching* [another resident] *as he had slept in the lounge and the carers were doing their rounds and we were short staffed.*'

The panel determined that as Miss Nyoni was the only registered nurse on that shift, she had a duty to ensure the wellbeing and safety of all residents on Windsor and Tudor Unit. It was of the view that by disregarding Mr 1's management direction and by having Tudor Unit left unattended on one or more occasions Miss Nyoni failed in her duty to ensure the wellbeing and safety of the residents on Tudor Unit.

The panel concluded that had Miss Nyoni followed the management direction and had the Tudor Unit not been left unattended on one or more occasions Resident A may not have suffered a serious injury.

The panel was therefore satisfied, on the balance of probabilities, that it is more likely than not that Miss Nyoni contributed to resident A suffering serious injury by leaving the Tudor Unit unattended on one or more occasions.

Additional statement received from Miss Nyoni on 17 March 2022

Before the panel handed down on facts it received a further statement from Miss Nyoni which she asked to be put before the panel to consider during this hearing.

In light of receiving this communication from Miss Nyoni, the panel asked Ms Kerridge to ask the NMC to enquire of Miss Nyoni if she would prefer the proceedings to be paused to enable her to participate.

This option was put to Miss Nyoni, however, she confirmed that it was her preference for the hearing to continue, in her absence.

Ms Kerridge submitted that it was fair for the panel to receive and consider this document as Miss Nyoni is not attending and the statement set out her current position on the allegations.

Ms Kerridge submitted that there are some contradictions in the document to previous statements made by Miss Nyoni and the witnesses. These related to Miss Nyoni's seniority and position at the Home at the time of the incident, her responsibility regarding the Tudor Unit, the directions given to Ms 2 and Ms 3 in relation to Tudor Unit, the decision to not move residents and the staffing levels on the night in questions. However, Ms Kerridge submitted that these contradictions had been covered by the questions the witnesses were asked during their live evidence.

The panel heard and accepted the advice of the legal assessor.

The panel acknowledged receipt of the document and determined that it was fair and just to consider this statement as part of the evidence for this case.

However, the panel noted the inconsistencies of the new statement pointed out by Ms Kerridge. The panel attributed these to the fact that the statement was written a considerable period of time, almost five years, after the incident. It noted that it had the notes of the investigatory meeting which were written closer to the time of the incident. The panel therefore decided to put more weight on that evidence, as it was likely to be more accurate.

The panel also noted that, in her new statement, Miss Nyoni did accept that she was the nurse in charge, took the instruction from Mr 1 and did not dispute his instructions. This was consistent with the evidence the panel had already considered.

The panel therefore determined that the new statement produced by Miss Nyoni did not alter its finding of facts.

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

Submissions 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.'*

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

Ms Kerridge identified the specific, relevant standards where Miss Nyoni's actions amounted to misconduct. She submitted that Miss Nyoni's actions were serious and resulted in actual patient harm. Miss Kerridge submitted that Miss Nyoni was the nurse in charge of the Windsor and Tudor Unit and as such she was responsible for the delivery of day-to-day care to residents, conducting risk assessments, managing and overseeing care staff, administering medication and monitoring the safety and wellbeing of the residents. However, Miss Kerridge submitted that Miss Nyoni chose to take an unreasonable risk with the safety of the residents in her care when she went against the direction of Mr 1, who was the Acting Care Home Manager at the time. She submitted that there was no good reason for Miss Nyoni to move the residents back to Tudor Unit since it put the residents of both units at an increased risk due to staff being spread thinly.

Ms Kerridge submitted that leaving the residents at Tudor Unit unattended for periods of time put them at an unnecessary risk of harm. Miss Nyoni was aware that Resident A was at a high risk of falling and injuring herself and that she and had a tendency to get up during the night and walk around. Ms Kerridge submitted that Miss Nyoni did not put an adequate system in place to ensure that a member of staff was always present on Tudor Unit and therefore left the residents unattended at times, including when Resident A fell.

Ms Kerridge submitted that Miss Nyoni's actions and omissions meant that Resident A did not receive safe and effective care from the staff at the Home, which contributed to the fall and related injury. She submitted that this amounts to serious misconduct given the risks to patient safety. She also submitted that not finding misconduct would undermine the public confidence in the profession.

Submissions on impairment

Ms Kerridge 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Kerridge invited the panel to find that Miss Nyoni's current fitness to practice is impaired by virtue of her misconduct on the grounds of public protection and public interest. She submitted that whilst Miss Nyoni accepts that Resident A was left unattended at certain points during the night, she does not recognise that her acts and omissions on that night may have contributed to Resident A's fall. Further, Ms Kerridge submitted that Miss Nyoni has not expressed any concerns regarding Resident A, she has demonstrated a lack of accountability and shown a desire to shift the blame.

Ms Kerridge submitted that in the various statements made by Miss Nyoni she seeks to justify her decision instead of recognising that it put the residents on both units at risk. She acknowledged that in Miss Nyoni's most recent statement she identifies that she accepted more responsibility than she felt capable of managing at the time and that she has learned from this mistake.

Ms Kerridge therefore submitted that Miss Nyoni has shown little to no evidence of insight, remorse or recognition that her decisions and actions may have played a contributory role in the harm that came to Resident A.

Miss Kerridge submitted that there is little information regarding Miss Nyoni's recent and current employment status. She submitted that whilst Miss Nyoni has stated that in the future she would raise concerns with her manager, there is no evidence before the panel to demonstrate that she has taken any steps to address or recognise learning opportunities around issues of delegation, communication, staff management or resident health and safety.

Miss Kerridge submitted that the lack of insight and remorse and the fact that there is no evidence that Miss Nyoni has strengthened her practice led to the conclusion that there is a risk of repetition should Miss Nyoni be allowed to practice unrestricted. She therefore submitted that a finding of impairment is necessary on the ground of public protection.

Further, Miss Kerridge submitted that professional standards and public confidence in the profession would be undermined if a finding of impairment on the grounds of public interest was not made in these particular circumstances given the seriousness of the incident, the injury suffered by a vulnerable resident under Miss Nyoni's care and the lack of associated insight or remorse.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Miss Nyoni's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Nyoni's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this you must:

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this you must:

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

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

4 Act in the best interests of people at all times

8 Work cooperatively

To achieve this you must:

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

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

20 Uphold the reputation of your profession at all times

To achieve this you must:

20.1 keep to and uphold the standards and values set out in the Code

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

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 with regards to charge 1 none of the various explanations given by Miss Nyoni as to why she did not follow Mr 1's management direction were ensuring the safe and effective care. The panel determined that disregarding the management direction left residents on Tudor Unit unattended for periods of time and also meant that fewer staff were available to deliver safe and effective care on Windsor Unit. The panel concluded that this left the residents of Tudor and Windsor Unit at a serious risk of harm as they were left vulnerable to incidents happening. Additionally, the panel determined that Miss Nyoni knew of the risks that Resident A was at risk of falls and injury. The panel found that this was particularly concerning as Miss Nyoni was aware of another resident on Windsor Unit with a similarly high risk of falls who she stated needed constant supervision and to whom she had been very attentive. The panel acknowledged

that Miss Nyoni had been dealing with two understaffed units and was extremely busy, particularly at the beginning of the night shift when medications had to be administered.

The panel also recognised that it was within Miss Nyoni's professional scope for her to use her discretion and come to a different conclusion to that of Mr 1 and noted the rationale that had led Miss Nyoni to go against his direction;

- she thought there were only two rooms to accommodate three residents;
- she was concerned if residents were placed upstairs they may wander around, get into lifts and might fall;
- she discussed the situation with the two healthcare assistants and with the other nurse on the same night shift and made a decision how regularly the residents should be checked;
- she wanted Ms 3 to stay on Tudor Unit with the residents as she had worked there for a long time and knew the residents well;
- she wanted to minimise the movement of the residents; and
- she wanted to ensure the safety of the residents by ensuring they were in an environment which was familiar to them.

The panel noted that Miss Nyoni chose not to discuss her reasoning with Mr 1. The panel was of the view that the justifications that Miss Nyoni had applied for keeping the residents on Tudor Unit as well as her choosing not to discuss her decision with Mr 1 and disregarding the management's direction were, in combination, a serious departure from the conduct expected of a registered nurse and amounted to misconduct.

The panel reminded itself of its findings regarding charge 3 and that it had found that Miss Nyoni's actions and omissions contributed to Resident A's serious injuries. The panel was of the view that Miss Nyoni did not provide safe and effective care to Resident A, knowing her risk of falling and her tendency to injure herself by falling. However, despite this knowledge, by not following the instructions and leaving Resident A on occasion

unattended on Tudor Unit, she put her at risk, which contributed to her suffering serious injury when she fell. The panel was of the view that this amounted to misconduct.

The panel found that Miss Nyoni's actions and omissions in both charges 1 and 3 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 Nyoni'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 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 residents were put at risk and Resident A suffered actual physical harm as a result of Miss Nyoni’s misconduct. Miss Nyoni’s misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that the statements from Miss Nyoni demonstrate a varying amount of insight. The panel accepted that Miss Nyoni states that she should have raised her concerns with Mr 1, however, it also noted that in Miss Nyoni’s latest statement she demonstrates a lack of remorse, lack of accepting responsibility and attempts to shift blame onto others, namely the healthcare assistants and Mr 1. The panel was particularly concerned that Miss Nyoni has shown no compassion or concerns for Resident A, who was seriously injured, while she was responsible for her care. It noted

that Miss Nyoni's latest statement demonstrates that she has learned very little from the incident. The panel was therefore of the view that Miss Nyoni demonstrated a lack of insight.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Nyoni has taken steps to strengthen her practice. The panel had no evidence before it to demonstrate that Miss Nyoni had sufficiently addressed the concerns. It was therefore of the view that she has not yet remediated her practice.

Therefore, the panel is of the view that there is a risk of repetition based on the lack of insight and the lack of remediation. The panel 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.

The panel determined that a finding of impairment on public interest grounds is required. It was of the view that a member of the public in knowledge of all the information would be concerned should Miss Nyoni be allowed to practice unrestricted. The panel was of the view that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Nyoni's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that Miss Nyoni's registration has been suspended.

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 accepted the advice of the legal assessor.

Submissions on sanction

Miss Kerridge submitted that an eight month suspension order was appropriate in this case. She outlined the aggravating and mitigating features of the case. Miss Kerridge submitted that Miss Nyoni's actions resulted in serious harm to Resident A, posed a real risk of harm to the residents on Windsor and Tudor Unit and noted Miss Nyoni's lack of insight, remorse and remediation. Regarding the mitigating features Miss Kerridge submitted that this was an isolated incident in Miss Nyoni's long history of working as a nurse and that there were no further incidents following the incident on 30 September 2017.

Miss Kerridge submitted that taking no action, a caution order or a conditions of practice order were not sufficient in this case and would not reflect the seriousness of the misconduct. She submitted that a suspension order was the appropriate and proportionate order in this case and that eight months would be sufficient for Miss Nyoni to develop further insight into her failings.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Resident A suffered serious injuries as a result of Miss Nyoni's misconduct;
- Miss Nyoni's misconduct posed a real risk of harm to the patients on Windsor and Tudor Unit; and
- Miss Nyoni demonstrated a lack of insight, remorse and remediation.

The panel also took into account the following mitigating features:

- It was an isolated incident in Miss Nyoni's longstanding career as a registered nurse, which was not repeated; and
- Early admission of charge 1 at the local investigatory meeting.

The panel considered whether the short staffing levels were a mitigating feature. However, the panel was of the view that had Miss Nyoni moved, or delegated the move of, the residents of Tudor Unit to Windsor Unit as directed by management, Windsor Unit would have been sufficiently staffed to keep the residents safe and properly cared for throughout the night.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. 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 Nyoni'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 Miss Nyoni'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 Miss Nyoni'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, 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;*
- *No evidence of general incompetence;*
- *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.*

However, the panel is of the view that there are no practical or workable conditions that could be formulated. The panel reminded itself that Resident A suffered serious injury due to Miss Nyoni's misconduct. The panel concluded that there was no way to determine how long Resident A had been injured on the floor before she was discovered. The panel was further concerned about the lack of concern Miss Nyoni has shown for Resident A. It also took into account Miss Nyoni's minimal engagement in the NMC proceedings, her lack of insight and lack of remorse. The panel further noted that the main concern in this case

was Miss Nyoni not following management direction and concluded that it could not be reassured that Miss Nyoni will comply with a conditions of practice order until she has gained further insight into her misconduct.

The panel therefore concluded that the placing of conditions on Miss Nyoni's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, 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 Miss Nyoni's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Miss Nyoni. However this is outweighed by the public interest in this case.

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 determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct. It was also of the view that six months would allow Miss Nyoni to gain further insight into her misconduct and demonstrate that she is remorseful and able to strengthen her practice.

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:

- A reflective piece in a recognised format, such as Gibbs' Reflective Cycle, focussing on the impact of the incident on the residents on Windsor and Tudor Unit, but particularly on Resident A, and the nursing profession as a whole;
- Miss Nyoni's engagement and participation at the review hearing; and
- Any references or testimonials from paid or unpaid work.

This will be confirmed to Miss Nyoni in writing.

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 Miss Nyoni's own interest until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Kerridge. She submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in their determination until the suspension order comes into effect. She therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

The panel heard and accepted the advice of the Legal Assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

That concludes this determination.