Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 January - Wednesday, 5 February 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Susan Jane Thompson**
NMC PIN:	84Y1775E
Part(s) of the register:	Nurses Part of the Register – Sub Part 1 RN1: Adult Nurse (Level 1) – 28 February 1988
Relevant Location:	Derbyshire
Type of case:	Misconduct
Panel members:	John Penhale (Chair, Lay member) Vanessa Bailey (Registrant member) June Robertson (Lay member)
Legal Assessor:	Suzanne Palmer
Hearings Coordinator:	Hanifah Choudhury (13 – 17 January 2025) Ruth Bass (20 – 31 January 2025) Samantha Aguilar (3 – 5 February 2025)
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Thompson:	Not present and not represented
Facts proved:	1ai, 1aii, 1aiii, 1bi, 1bii, 1c, 2a, 3ai, 3aii, 3b, 3ci, 3cii, 3ciii, 4, 5, 6, 7aiii, 7aiv, 7avi, 7bii, 7c, 8, 9, 10a, 10bii, 10c, 11a, 11b, 12a, 12b, 13, 15a, 15b, 16a, 16b, 17bi, 17bii, 17c, 17di, 17dii, 17e, 17fi, 17fii, 19ci, 19cii, 22, 23a, 23b, 23c, 23d and 23e.
Facts not proved:	3c iv, 7ai, 7aii, 7av, 7bi, 10bi, 10biii, 14a, 14b, 16ci, 16cii, 16ciii, 17a, 18, 19a, 19b, 20 and 21

Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Thompson was not in attendance and that the Notice of Hearing had been sent to Mrs Thompson's registered email address by secure email on 12 December 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Thompson'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 Thompson has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Thompson

The panel next considered whether it should proceed in the absence of Mrs Thompson. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in the absence of Mrs Thompson. He submitted that Mrs Thompson had voluntarily absented herself.

Mr Radley submitted that Mrs Thompson has not engaged with the NMC since her email sent on 15 September 2022 which said:

'Responce [sic] *to email at present I am not working nor am I looking for further employment as a nurse…'*

Mr Radley submitted that the NMC has made all reasonable efforts to contact Mrs Thompson but she has not engaged with the NMC at all in relation to these proceedings. He further submitted that, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel decided to proceed in the absence of Mrs Thompson. In reaching this decision, the panel considered the submissions of Mr Radley and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *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 Mrs Thompson;
- Mrs Thompson has not engaged with the NMC since her email sent on 15 September 2022 and has not responded to any of the telephone calls or emails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 10 witnesses are scheduled 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 2021 and 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Thompson in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. Mrs Thompson 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 Mrs Thompson's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

1) On or around 16 October 2021, following Resident C suffering a fall,

    a) Did not record Resident C's fall in their:

        i) Daily Record of Care notes
        ii) Multidisciplinary Record
        iii) Daily Handover Report

    b) Did not seek appropriate medical advice and/or attention for Resident C in that you did not call:
        i) 111 Services
        ii) An ambulance

c) Did not escalate Resident C's injuries and/or poor mobility in a timely manner.

2) On 24 December 2021,

a) Left Resident C's medication pot in Resident C's room, unattended.

3) On or around 25 February 2022, after witnessing that Resident D had suffered a fall and/or injuries,

a) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 services for Resident D

ii) An ambulance for Resident D

b) Incorrectly recorded and/or stated that aspirin is not an anticoagulant

c) Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

i) Falls - Accident Observation Record

ii) Accident/Incident Notification Record

iii) Daily Handover Report

iv) Falls Risk Assessment.

4) Your actions in one or more of charges 3) c) i); 3) c) ii); 3) c) iii); and 3) c) iv) above were dishonest in that you falsified records as you sought to conceal that Resident D had suffered an injury/injuries after their fall.

5) On 1 March 2022, inaccurately informed Colleague Y that Resident D did not sustain any injuries after their fall.

6) Your actions in charge 5) above were dishonest in that you sought to conceal that Resident D had suffered an injury/injuries after their fall.

7) On or around 2 April 2022:

   a) Outside the scope of your practice, inserted an unprescribed size 12 catheter into Resident A without:

      i) Any clinical justification

      ii) Seeking and/or recording advice from a GP

      iii) Seeking and/or recording advice from the Multi-Disciplinary Team

      iv) Seeking and/or recording consent and/or advice from Resident A's [PRIVATE]

      v) Seeking and/or recording advice from the Manager/Deputy Manager

      vi) Monitoring and/or recording a fluid output chart

   b) Whilst inserting the catheter into Resident A, did not:

      i) Explained the procedure to Resident A

      ii) Reassure Resident A

   c) Inaccurately informed Colleague X that you had obtained permission from a GP to catheterise Resident A.

8) Your actions in charge 7) c) above were dishonest in that you sought to misrepresent that you had obtained permission from a GP to carry out the procedure.

9) On 12 April 2022 applied a new buprenorphine patch to Resident H, without removing the old buprenorphine patch.

10) Between 19 May 2022 and 20 June 2022,

    a) After informing Dr V of Resident B's adverse reaction to a memantine 10mg prescription, incorrectly completed an order sheet for more memantine

    b) Failed to appropriately discontinue Resident B's memantine 10mg prescription:

        i) As instructed by Dr V

        ii) By updating the electronic medication administration system

        iii) By updating Resident B's care plan

    c) On one or more occasion, incorrectly administered discontinued memantine 10mg to Resident B.

11) Did not administer 2 tablets of memantine 10mg at 08:00 as prescribed to Resident I on:

    a) 29 June 2022

    b) 30 June 2022.

12) Did not administer 2 tablets of tolterodine 1mg at 08:00 as prescribed to Resident I on:

    a) 29 June 2022

    b) 30 June 2022.

13) In or around July 2022 did not follow Resident F's care plan, in that you inappropriately instructed Colleague W to shower Resident F alone.

14) On or around 1 July 2022:

a) Discontinued Resident B's 15mg mirtazapine prescription, without adequately explaining the reason and/or clinical justification

b) Increased Resident B's mirtazapine prescription to 30mg without adequately explaining the reason and/or clinical justification.

15) Incorrectly administered double the quantity of tolterodine 2mg tablets to Resident I on:

a) 18 July 2022

b) 19 July 2022.

16) On 29 July 2022 after being alerted that Resident G was non-responsive,

a) On one or more occasion shook Resident G, using excessive force

b) Did not undertake/record any observations of Resident G

c) Did not appropriately escalate Resident G's non-responsive state, in that you did not:

i) Lightly pinch Resident G's ear

ii) Place your hands on Resident G's shoulder

iii) Call an ambulance for Resident G.

17) On 10 August 2022 after Resident B had suffered a fall:

a) Did not attend to Resident B in a timely manner

b) On one or more occasion inappropriately:

i) Moved Resident B's right leg up and/or down and/or backwards and/or forward

ii) Bent Resident B's right leg

c) Inappropriately lifted and/or moved Resident B from the floor into a wheelchair, in that you did not use a hoist

d) Spoke to and/or about Resident B using words to the effect:

i) '*Stop being dramatic/a drama queen'*

ii) '*She is being a drama queen'*

e) Did not assess Resident B for any head injuries

f) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 Services for Resident B

ii) An ambulance for Resident B.

18) On an unknown date inappropriately asked Colleague Z, a House Keeper to watch an unlocked and/or unattended medication trolley.

19) On 10 August 2022,

a) Left a bottle of liquid paracetamol in Resident E's bedroom unattended

b) Left medication unattended in a corridor

c) Left a medication trolley in a corridor:

i) Unattended

ii) Unlocked.

20) On one or more occasion on unknown dates administered lorazepam to Resident D, without clinical justification.

21) On an unknown date, left medication unattended on Resident I's bedside table.

22) On an unknown date took Resident L's insulin pen home.

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

23) On one or more occasion, on unknown dates, attended work whilst you were unfit to practise safely, in that you were:

a) [PRIVATE]
b) [PRIVATE]
c) [PRIVATE]
d) [PRIVATE]
e) [PRIVATE]

AND in light of the above, your fitness to practise is impaired by reasons of [PRIVATE].

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Radley to amend the charge 23.

23) On one or more occasion, on unknown dates, attended work whilst you were unfit to practise safely, in that you were:

a) [PRIVATE]
b) [PRIVATE]
c) [PRIVATE]
d) [PRIVATE]
e) [PRIVATE]

~~AND in light of the above, your fitness to practise is impaired by reasons of~~ [PRIVATE]~~.~~

Mr Radley submitted that charge 23 would fit more appropriately as a misconduct charge, in light of the absence of evidence relating to [PRIVATE]. He submitted that no

injustice would be caused to Mrs Thompson as the wording of the charge has not changed.

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 Mrs Thompson and no injustice would be caused to either party by the proposed amendment being allowed. The amendment did not change the charge itself or the evidence. It simply changed the basis of the NMC's allegation of impairment if the charge is found proved. The panel considered that the NMC should have sought the amendment earlier. However, although Mrs Thompson was not made aware of the application to amend, this is because she has chosen not to participate in this hearing. In all the circumstances, it was therefore appropriate to allow the amendment as applied for.

Details of charges (as amended)

1) On or around 16 October 2021, following Resident C suffering a fall,
    a) Did not record Resident C's fall in their:
        i) Daily Record of Care notes
        ii) Multidisciplinary Record
        iii) Daily Handover Report

    b) Did not seek appropriate medical advice and/or attention for Resident C in that you did not call:
        i) 111 Services
        ii) An ambulance

c) Did not escalate Resident C's injuries and/or poor mobility in a timely manner.

2) On 24 December 2021,

a) Left Resident C's medication pot in Resident C's room, unattended.

3) On or around 25 February 2022, after witnessing that Resident D had suffered a fall and/or injuries,

a) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 services for Resident D

ii) An ambulance for Resident D

b) Incorrectly recorded and/or stated that aspirin is not an anticoagulant

c) Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

i) Falls -Accident Observation Record
ii) Accident/Incident Notification Record
iii) Daily Handover Report
iv) Falls Risk Assessment.

4) Your actions in one or more of charges 3) c) i); 3) c) ii); 3) c) iii); and 3) c) iv) above were dishonest in that you falsified records as you sought to conceal that Resident D had suffered an injury/injuries after their fall.

5) On 1 March 2022, inaccurately informed Colleague Y that Resident D did not sustain any injuries after their fall.

6) Your actions in charge 5) above were dishonest in that you sought to conceal that Resident D had suffered an injury/injuries after their fall.

7) On or around 2 April 2022:

a) Outside the scope of your practice, inserted an unprescribed size 12 catheter into Resident A without:

i) Any clinical justification

ii) Seeking and/or recording advice from a GP

iii) Seeking and/or recording advice from the Multi-Disciplinary Team

iv) Seeking and/or recording consent and/or advice from Resident A's [PRIVATE]

v) Seeking and/or recording advice from the Manager/Deputy Manager

vi) Monitoring and/or recording a fluid output chart

b) Whilst inserting the catheter into Resident A, did not:

i) Explained the procedure to Resident A

ii) Reassure Resident A

c) Inaccurately informed Colleague X that you had obtained permission from a GP to catheterise Resident A.

8) Your actions in charge 7) c) above were dishonest in that you sought to misrepresent that you had obtained permission from a GP to carry out the procedure.

9) On 12 April 2022 applied a new buprenorphine patch to Resident H, without removing the old buprenorphine patch.

10) Between 19 May 2022 and 20 June 2022,

a) After informing Dr V of Resident B's adverse reaction to a memantine 10mg prescription, incorrectly completed an order sheet for more memantine

b) Failed to appropriately discontinue Resident B's memantine 10mg prescription:

i) As instructed by Dr V

ii) By updating the electronic medication administration system

iii) By updating Resident B's care plan

c) On one or more occasion, incorrectly administered discontinued memantine 10mg to Resident B.

11) Did not administer 2 tablets of memantine 10mg at 08:00 as prescribed to Resident I on:

a) 29 June 2022

b) 30 June 2022.

12) Did not administer 2 tablets of tolterodine 1mg at 08:00 as prescribed to Resident I on:

a) 29 June 2022

b) 30 June 2022.

13) In or around July 2022 did not follow Resident F's care plan, in that you inappropriately instructed Colleague W to shower Resident F alone.

14) On or around 1 July 2022:

a) Discontinued Resident B's 15mg mirtazapine prescription, without adequately explaining the reason and/or clinical justification

b) Increased Resident B's mirtazapine prescription to 30mg without adequately explaining the reason and/or clinical justification.

15) Incorrectly administered double the quantity of tolterodine 2mg tablets to Resident I on:

a) 18 July 2022
b) 19 July 2022.

16) On 29 July 2022 after being alerted that Resident G was non-responsive,

a) On one or more occasion shook Resident G, using excessive force

b) Did not undertake/record any observations of Resident G

c) Did not appropriately escalate Resident G's non-responsive state, in that you did not:

i) Lightly pinch Resident G's ear

ii) Place your hands on Resident G's shoulder

iii) Call an ambulance for Resident G.

17) On 10 August 2022 after Resident B had suffered a fall:

a) Did not attend to Resident B in a timely manner

b) On one or more occasion inappropriately:

i) Moved Resident B's right leg up and/or down and/or backwards and/or forward

ii) Bent Resident B's right leg

c) Inappropriately lifted and/or moved Resident B from the floor into a wheelchair, in that you did not use a hoist

d) Spoke to and/or about Resident B using words to the effect:

i) ‘*Stop being dramatic/a drama queen’*

ii) ‘*She is being a drama queen’*

e) Did not assess Resident B for any head injuries

f) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 Services for Resident B

ii) An ambulance for Resident B.

18) On an unknown date inappropriately asked Colleague Z, a House Keeper to watch an unlocked and/or unattended medication trolley.

19) On 10 August 2022,

a) Left a bottle of liquid paracetamol in Resident E’s bedroom unattended

b) Left medication unattended in a corridor

c) Left a medication trolley in a corridor:

i) Unattended

ii) Unlocked.

20) On one or more occasion on unknown dates administered lorazepam to Resident D, without clinical justification.

21) On an unknown date, left medication unattended on Resident I’s bedside table.

22) On an unknown date took Resident L’s insulin pen home.

23) [PRIVATE]

a) [PRIVATE]

b) [PRIVATE]

c) [PRIVATE]

d) [PRIVATE]

e) [PRIVATE]

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

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

Having noted from the material presented to it, that there may be references to Mrs Thompson's [PRIVATE], the panel of its own volition invited Mr Radley's submissions on whether it should hear parts of the hearing in private.

Mr Radley supported this application.

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

Following the submissions made by Mr Radley and the advice of the legal assessor, the panel decided to hold parts of the hearing in private when matters relating to [PRIVATE] are raised. The panel is satisfied that the considerations outlined above justify that course, and that this outweighs any prejudice to the general principle of hearings being in public.

Background

The charges arose whilst Mrs Thompson was employed as a registered nurse by The Gables Residential Home ("the Home"). Mrs Thompson started working at the Home in 2019.

The NMC received three referrals regarding concerns over Mrs Thompson's fitness to practise whilst working at the Home. The first referral was received on 7 April 2022, the second referral was received on 22 June 2022 and the third referral was received on 22 August 2022 from Hill Care.

The referrals resulted in an investigation by the NMC, which culminated in the charges before the panel.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Thompson.

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:

- Witness 1 Housekeeper at the Home at the time of the

Incidents (Colleague Z)

- Witness 2 — Home Manager at the Home at the time of the incidents (Colleague Y)
- Witness 3 — Care Assistant at the Home at the time of the incidents
- Witness 4 — Care Assistant at the Home at the time of the incidents (Colleague W)
- Dr V. — Senior Speciality Doctor for the Intensive Community Liaison Service
- Witness 5 — Care Assistant at the Home at the time of the incidents
- Witness 6 — Care Assistant at the Home at the time of the incidents (Colleague X)
- Witness 7 — Registered Nurse at the Home at the time of the incidents
- Witness 8 — Regional Manager at the Home at the time of the incidents
- Person 1 — [PRIVATE] of Resident C

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.

Charges 1a) i), ii) and iii)

1) On or around 16 October 2021, following Resident C suffering a fall,

    a) Did not record Resident C's fall in their:

        i) Daily Record of Care notes

        ii) Multidisciplinary Record

        iii) Daily Handover Report

These charges are found proved.

In considering this charge, the panel first had regard to Resident C's Falls Risk Assessment and noted that no record of a fall had been made on 16 October 2021 under the section headed *'ASSESSMENT RESULTS'*, but the fall had been recorded under the *'FALLS HISTORY'* section:

'16/10 found on floor. Went to JCUH on 18/10 for xrays'

The panel also had regard to Resident C's daily care records and noted that Mrs Thompson had recorded on 17 October 2021 that Resident C was in pain but did not record that there had been a fall.

The panel also had regard to the witness statement of Witness 7, which states:

> *'28. On 18 October 2021, I attended work and the night staff nurse* [Person 9] *reported that Resident C was non-weight bearing. I asked* [Person 9] *why this was and* [Person 9] *said that Resident C had a fall on 16 October 2021. I asked* [Person 9] *whether medical attention was requested for Resident C and* [Person 9] *said no. Sue was on shift on 16 October 2021 and would have been responsible for assessing Resident C and seeking medical attention. Resident C was documented to have been non- weight bearing following her fall. I refer to* [Person 9] *entry on Resident C's daily record of care notes on 17 October 2021.'*
>
> *'30. Sue did not document Resident C's fall on 16 October 2021 within their daily record of care notes…. The falls policy…confirmed that following a fall the 'daily information record' (daily record of care notes) should be updated…There was also no mention of the fall or medical advice within Resident C's multidisciplinary record until my entry on 18 October 2021…'*

The panel noted that Witness 7 did not witness the fall but was relying on what she was told by a colleague. It was not clear whether that colleague witnessed the fall. Nothing in Witness 7's evidence indicates whether or not Mrs Thompson was ever made aware of the fall on or around 16 October 2022. Therefore, whilst technically the charge is proved in that Mrs Thompson did not document the fall, there is no evidence that she was required to do so.

The panel noted from Resident C's multi-disciplinary record that there was no entry recorded for Resident C on 16 October 2022. It noted that, in accordance with Witness 7's evidence, the only entry made in relation to Resident C's falls, was Witness 7's entry on 18 October 2021, which states:

'Called due to fall on Saturday [16 October 2021] *and now not weight-bearing. Also on apixaban. Taken to JCUH at 13:30.'*

With regard to the Daily Handover Report, the panel noted again that that there was no mention of Resident C's fall recorded in the document.

The panel had regard to the fact that Mrs Thompson was the Registered Nurse on shift at the time of Resident C's fall, and someone had recorded in Resident C's Falls Risk Assessment document under the *'Falls History*' section *'16/10 found on floor. Went to JCHU on 18/10 for xrays'*. The panel was therefore not satisfied that Mrs Thompson was told that Resident C had a fall on 16 October 2022. As with the record of care notes, technically the charge was proved but the panel was of the view that there was no requirement in these circumstances to make an entry in the multidisciplinary record or the daily handover report.

Charge 1b) i) and ii)

1) Did not seek appropriate medical advice and/or attention for Resident C in that you did not call:
    i) 111 Services
    ii) An ambulance

These charges are found proved.

On the same basis as its findings in charge 1a), the panel considered that because it was not satisfied that Mrs Thompson was made aware of the fall on/or around 16 October 2022, she could not reasonably be expected to seek medical advice and/or attention for Resident C. Again, the panel found the charge proved technically, in that she did not call 111 or an ambulance; however, it was not satisfied that she was required to do so in these circumstances.

Charge 1c)

1) On or around 16 October 2021, following Resident C suffering a fall,
   c) Did not escalate Resident C's injuries and/or poor mobility in a timely manner.

This charge is found proved.

For the same reasons as before, the panel finds this charge technically proved, but it found there was no duty to escalate matters which there was no evidence Mrs Thompson was aware of on/or around 16 October 2022.

Charge 2a)

2) On 24 December 2021,
a) Left Resident C's medication pot in Resident C's room, unattended.

This charge is found proved.

In considering this charge the panel first had regard to Person 1's witness statement which states:

> *'5. When I entered* [Resident C's] *room,* [PRIVATE] *pointed out to me that there was a beaker of medication left unattended on the tray. I looked and saw that there was a beaker containing different tablets left on the tray. I am not sure which medication this would have been as the nurses dealt with my* [Resident C] *'s medications. However, I do know that* [Resident C] *was prescribed oramorph.*
>
> *5. There was nobody else present in the room but me,* [PRIVATE] *Sue had left the medication unattended. Around five minutes or so later, Sue entered the*

room with laxative medication for [PRIVATE]*. I questioned this as I had just cleaned* [PRIVATE]*. She did not need the laxative as she had already just been. Sue insisted on giving her the laxative and said that* [PRIVATE] *needed the laxative in order to go to the toilet. I found this strange as* [PRIVATE] *had just been to the toilet but I did not question this further as Sue was the nurse.*

…

10. The NMC asked me whether [PRIVATE] *tried to grab or consume the medication whilst Sue was out of the room.* [PRIVATE] *did not try to do this, the medication just sat there on the tray and when Sue returned, she administered the medication* [PRIVATE]*.'*

The panel noted that Person 1 was a direct witness to the allegation that the medication had been left in Resident C's room and that her oral evidence was consistent with her witness statement.

The panel also had regard to the evidence of Witness 5, that Mrs Thompson had left a pot of medication unattended in Resident C's room. In their witness statement Witness 5 stated:

'26. There was also an incident that involved [Resident C]. I cannot recall the date. However, Resident C's [PRIVATE] *visited them at the Gables. Sue was supposed to administer Resident C's medication, however left the pot of medication in Resident C's room. When I went into Resident C's room, their* [PRIVATE] *said that Sue looked drunk and had left medication unattended. They also raised concerns that Sue was giving Resident C laxative medication when not required. I reported the incident to the previous Home Manager* [Witness 2]*...'*

The panel took into account the fact that Person 1 had taken the time to report their concern to another member of staff, and accordingly accepted their evidence in this regard.

The panel also had regard to the notes of conversation with Mrs Thompson on 4 January 2022. It noted that when asked directly whether Mrs Thompson had left any medication in Resident C's room when Person 1 was there, Mrs Thompson responded *'maybe but it was her meds no one else's'*. Further, when asked whether it was right to leave the medication unattended, Mrs Thompson responded *'well no but I won't expect* [PRIVATE] *to take them',* and *'*[PRIVATE] *said she wanted some for* [PRIVATE] *so I had to get someone to counter sign and check.'*

The panel accepted the evidence of Person 1 that medication had been left unattended in Resident C's room by Mrs Thompson. It was satisfied from Mrs Thompson's responses given in the conversation with Witness 2 on 4 January 2022, that Mrs Thompson had left the room to get pain relief for Resident C, and on the balance of probabilities, had left medication unattended in the room while doing this. Mrs Thompson appeared to accept, when she was asked about this incident, that she should not have done so. The panel therefore found charge 2a) proved.

Charge 3a) i) and ii)

3) On or around 25 February 2022, after witnessing that Resident D had suffered a fall and/or injuries,

a) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 services for Resident D

ii) An ambulance for Resident D

These charges are found proved.

In considering these charges, the panel first considered the Accident/Incident notification record for Resident D dated 25 February 2022. It noted that the form had been completed by Mrs Thompson and recorded that at 17:55 Resident D was *'Pushed by* [Resident B] *– resulting in falling onto floor, red mark to Rt F. arm – small bump to occipital area of head'.*

The panel also had regard to Resident D's daily record of care notes and noted that Mrs Thompson had recorded the following at 18:00:

> *'…*[Resident B] *just walked up to* [Resident D] *and push her resulting in Resident D falling to the floor…small bump on head. Cold cloth applied. No bleeding skin intact. Small red area to Rt forearm. Lots of reassurance. Mobilising well. Settled at this time.'*

The panel was satisfied from the contemporaneous medical notes, recorded by Mrs Thompson, that Resident D had fallen and sustained an injury.

The panel next considered the witness statement of Witness 5, which states:

> *'13. …I went to Resident D's room to check that she was okay. Resident D was distressed so I stoked her head in order to calm her down. When I stroked Resident* [D's] *head, I felt a small lump in the middle of the back of her head. There were no signs of bruising or blood. I did not see any other injuries and Resident* [D] *did not communicate that she was in pain.*
>
> *14. Sue completed the accident form following Resident D's fall. I saw the accident form on Sues desk and I checked the form to ensure that Resident D's head injury had been documented on the body map…*

15. *I spoke to Sue about whether we needed to seek medical advice from 111 or call an ambulance. Resident D was prescribed aspirin medication.* [PRIVATE] *takes aspirin medication and I am aware of the side effects. Sue said that aspirin was not a blood thinner and that we did not need to seek medical advice for Resident D. As Sue was the nurse in charge, I did not question her further. When Sue made a decision, she would stick by this no matter what you said.'*

The panel noted that Witness 5 had also confirmed the existence of an injury and that Resident D was taking aspirin, which is an anticoagulant. This was also confirmed from the Resident D's medical records.

The panel next had regard to the National Institute for Health and Care Excellence ("NICE") clinical guidance which states:

> *'Telephone advice services (for example NHS 111 or emergency department helplines) should refer patients who had sustained a head injury to a hospital emergency department if they have any of the following risk factors:*
>
> *…*
>
> - *Current anticoagulant therapy*
>
> *…'*

Further the Home's Care After an Accident or Fall Policy stated that an *'action to be taken where an injury is apparent or suspected'* is to *'Delegate staff member to summon the emergency services the 999 system'.*

The panel was satisfied from the Home's policy and the NICE guidelines that Mrs Thompson should have sought medical advice and/or attention and/or 111, and called an ambulance for Resident D, which she did not do.

The panel also had regard to Mrs Thompson's interview with Witness 8, where Mrs Thompson stated that she had called the General Practitioner ("GP"). However, Mrs Thompson was not present to give evidence in this respect and it was not clear to the panel when Mrs Thompson was saying she had called the GP. Furthermore, there was no evidence to support this claim.

The panel also had regard to Resident D's Accident/Incident Notification Record and noted that Mrs Thompson had written *'N/A'* next to *'GP Notified'* and *'Emergency services required'* on the form. It was therefore satisfied on the balance of probabilities that Mrs Thompson had not contacted Resident D's GP or the emergency services, on the day of the fall.

The panel was satisfied from the contemporaneous records before it, to include Mrs Thompson's recorded note on the Accident/Incident Notification record that the immediate action taken by her was *'Examined [Resident D] – moved* [Resident B] *aware (sic) from situation',* that Mrs Thompson did not carry out the actions in charges 3a)i) and ii. It therefore found these charges proved.

Charge 3b)

b) Incorrectly recorded and/or stated that aspirin is not an anticoagulant

This charge is found proved.

In considering this charge, the panel had regard to the Witness 5's statement, which states:

'13. I spoke to Sue about whether we needed to seek medical advice from 111 or call an ambulance. Resident D was prescribed aspirin

medication. [PRIVATE] *takes aspirin medication and I am aware of the side effects. Sue said that aspirin was not a blood thinner and that we did not need to seek medical advice for Resident D. As Sue was the nurse in charge, I did not question her further. When Sue made a decision, she would stick by this no matter what you said.'*

The panel also had regard to the daily handover sheet for 25 February 2022 and noted that *'Aspirin'* had been crossed out and someone had written *'Not classed as blood thinner'* in its place.

In the interview notes dated 22 August 2022, the panel noted the following conversation between Witness 8 and Mrs Thompson:

'[Witness 8] - *Why cross out Aspirin?*
'ST - I don't recall
…
[Witness 8] - *do you still think aspirin is not an anticoagulant*
ST -Aspirin is an anticoagulant, I soke (sic) to the GP and they said it was not a concern.
[Witness 8] – *You have evidence of this conversation with the GP?*
ST – I didn't record it.'

The panel was satisfied that Mrs Thompson's response *'I don't recall'* was tacit acceptance by Mrs Thompson that she was the person who had crossed out *'Aspirin'*. Further, in light of the fact that there was no evidence that Mrs Thompson had contacted a GP and had written *'N/A'* next to *'GP Notified'* on the accident form, the panel accepted the evidence of Witness 5 that Mrs Thompson had stated that Aspirin was not a blood thinner. It also found that Mrs Thompson was the person who had also written this on the daily handover sheet. It accordingly found charge 3b) proved.

Charge 3c)i)

c) Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

i) Falls -Accident Observation Record

This charge is found proved.

In considering this charge, the panel had regard to the Falls Accident Observation Record and noted that, at 18:00 on 25 February 2022, Mrs Thompson had recorded the following:

'No injuries – bumps /bruises'.

Having previously found that resident D had suffered an injury to their head, which Mrs Thompson was aware of, the panel was satisfied that Mrs Thompson's record on the Falls – Accident Observation Record, was inaccurate. It therefore found this charge proved.

Charge 3c) ii)

c) Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

ii) Accident /Incident Notification Record

This charge is found proved.

The panel had before it two different versions of the Accident/Incident Notification Record, both completed by Mrs Thompson. It noted that one stated at *'17:55 pushed by* [Resident B] *resulting in falling onto floor. Red mark to Rt [Fore] arm – small bump to occipital area of head …'* and the other form recorded *'18:00 pushed over Resident D was vocal, Resident B passed her and pushed resulting in her falling to floor…examined – check head – no injuries'*

The panel heard evidence that accident/incident notification records were usually pinned to the Home Manager's notice board or pushed under his door, and that it was not unusual for them to fall down behind the cabinet and get lost. The original record in this case has never been found. The panel was told that the version of the original record in the bundle of exhibits was a copy taken by Witness 7 soon after the incident.

The panel noted that the most contemporaneous form completed by Mrs Thompson (at 17:55) recorded that there was a small bump to occipital area of head. The panel had regard to the fact that this form had gone missing, and after being asked by Witness 2 for the form a few days later, Mrs Thompson subsequently produced the second form recording that there had been *'no injuries'*.

The panel noted that both forms were completed by Mrs Thompson, and that the later form was inaccurate in its recording that there was no injury. The panel was therefore satisfied that Mrs Thompson had inaccurately recorded that Resident D had not suffered any injuries in Resident D's Accident/Incident Notification Record. It therefore found this charge proved.

Charge 3 c iii

c) Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

iii) Daily Handover Report

This charge is found proved.

In considering this charge the panel had regard to the Daily Handover sheet dated 25 February 2022 completed by Mrs Thompson which states:

> *'Pushed to floor by* [Resident B] *(occipital parietal) no bump head recorded? An Rt forearm…'*

The panel heard that this form was found some months after the incident having been missing for some time, during the Home's investigation conducted by Witness 8.

The panel had regard to a photograph of the Daily Handover Report completed by Mrs Thompson 25 February 2022, taken by Witness 7. It recorded at 18:00 that Resident was B *'…pushed to floor by* [Resident B] *(occipital parietal) bump head…'*. Based on the evidence before it, the panel was of the view, on the balance of probabilities, that the word *'no'* was added to the record later by Mrs Thompson. The panel was satisfied that Mrs Thompson had therefore amended a Daily Handover Report, at some time after the incident, which inaccurately recorded (with the addition of the word *'no'*) that Resident D had not suffered any injuries. It therefore found this charge proved.

Charge 3c) iv)

3. Inaccurately recorded that Resident D had not suffered any injuries in Resident D's:

    iv) Falls Risk Assessment

This charge is found NOT proved.

In considering this charge, the panel had regard to the Witness 7's statement which states:

> *'49. The NMC provided me with a copy of the falls risk assessment for Resident D…The document suggests that Sue did not document Resident D's fall on the falls risk assessment. However, I can recall that there was another version of the falls risk assessment completed by Sue, confirming that Resident D had a fall but sustained no injuries. I do not have a copy of the document.'*

The panel was provided with the Falls risk assessment document provided to Witness 7 and noted that it was for the period 2020 - 2021, and therefore did not cover the date of this incident. The panel noted from this document that there was some inconsistency amongst staff as to whether or not staff would record a resident's injury after a fall on this particular form. However, without having sight of the actual form from the time of the injury (February 2022), the panel considered that it had insufficient evidence to corroborate Witness 7's assertion that Mrs Thompson had inaccurately recorded that Resident D had not suffered any injuries in Resident D's Falls Risk Assessment. It therefore found this charge not proved.

Charge 4

> Your actions in one or more of charges 3) c) i); 3) c) ii); 3) c) iii); and 3) c) iv) above were dishonest in that you falsified records as you sought to conceal that Resident D had suffered an injury/injuries after their fall

This charge is proved in relation to charges 3c) i), 3c) ii) and 3c) iii).

In considering this charge, the panel considered the evidence it had examined in relation to charges 3c) i), 3c) ii) and 3c) iii). In effect, all that evidence showed that Mrs

Thompson had initially recorded an injury and subsequently changed records to show no injury.

The panel was of the view that it was odd to record on the *'Daily Handover Report'* that there was *'no'* bump to a specific area of the head, namely the occipital parietal, when the original fall showed that there was a bump.

The panel also had regard to the evidence of the original *'the accident-incident notification record'*, with the recorded time of 17:55, which showed that Mrs Thompson had initially recorded that Resident D had suffered injuries, when the later version of the same form recorded no injuries.

The panel was satisfied from the evidence before it that Mrs Thomspon was aware of Resident D's injuries. It considered, on balance, that Mrs Thompson had retrospectively altered two of Resident D's records to say that they did not suffer any injuries, and that in doing so Mrs Thompson would have known that her actions were misleading.

The panel took into account the context that Mrs Thompson had difficult relationships with some of her colleagues and was struggling with [PRIVATE]. It considered the possibility that this could simply be confusion or sloppiness in her record keeping, in a home where record keeping systems appeared to have some deficiencies. However, in retrospectively altering two separate records so that they said the opposite of what she had originally recorded, the panel could only infer that she was deliberately seeking to cover up retrospectively the fact that she had not followed the correct procedures following the incident. The panel noted that Mrs Thompson had not been able to provide a satisfactory explanation at the interview conducted by Witness 8. The panel noted that the patients daily care record had not been altered retrospectively, but it considered that this could be explained by the chaotic nature of Mrs Thompson's actions when she was trying to cover up the injury. The panel was satisfied that Mrs Thompson's actions would be seen as dishonest by the standards of ordinary and decent people. It therefore found charge 4 proved in relation to charges 3c) i), 3c) ii) and 3c) iii).

Charge 5

5) On 1 March 2022, inaccurately informed Colleague Y that Resident D did not sustain any injuries after their fall.

This charge is found proved.

In considering this charge the panel had regard to Witness 2's witness statement which states:

'21. I was initially unable to locate the accident and incident form for Resident D, or the daily handover sheet. I spoke to Sue on 1 March 2022. I produce a copy of the meeting minutes…During the meeting, Sue confirmed that she had witnessed Resident D's fall as the fall happened in the corridor, near to doorway of the office where Sue was sat. Sue said that she assessed Resident D and found no injuries and therefore did not seek medical advice. Staff completed hourly observations for Resident D throughout the night.

…

25. 1 also asked Sue again whether Resident D had bumped their head on 25 February 2022. Sue said no and I then explained that [Witness 7] *had been informed by someone that Resident D had bumped their head. Sue believed that it was* [Witness 7's] *husband* [Person 10] *who had informed* [Witness 7] *and said that they were both trying to get her into trouble.'*

The panel noted that Witness 2 had stated Mrs Thompson had told him on two occasions that Resident D had not suffered an injury as a result of the fall.

The panel also had regard to Witness 2's interview notes with Mrs Thompson on 1 March 2023, which states:

'[Witness 2] *Another concern is about a fall, I've received no accident fall about it but it involved getting pushed or knocked by a resident and bumping her head?*

ST Yes, that will be when I was on, it was witnessed and there was no injury. Again this would be [Person 10] *interfering…*

[Witness 2] *You were going to put that in writing weren't you?*

ST I know but like I said, its always someone else not them

[Witness 2] *What happened because I have no form*

ST I was there, Person 10 wasn't. It was a witnessed fall with no injury

[Witness 2] *She's on blood thinners is she not?*

ST No she's on aspirin, aspirin is not anticoagulant

[Witness 2] *So where is the form?'*

The panel was satisfied from the interview notes recorded and Witness 2's evidence that Mrs Thompson had informed them that Resident D did not sustain an injury. It therefore found this charge proved.

Charge 6

6) Your actions in charge 5) above were dishonest in that you sought to conceal that Resident D had suffered an injury/injuries after their fall

This charge is found proved.

In considering this charge the panel first had regard to Mrs Thompson's state of mind at the time of the incident. It noted that Mrs Thompson had initially documented a head injury for Resident D but did not follow the correct protocol following the fall, and later went back to amend an entry on the daily handover report to say there had been *'no'* head injury. Mrs Thompson was asked on a number of occasions about Resident D's injury, and had several opportunities to explain what had happened, but was unable to do so. The panel was therefore of the view that Mrs Thompson attempted to conceal the head injury to avoid criticism of her failure to take appropriate action. The panel was satisfied that her intention was to deceive Witness 2 that Resident D did not sustain a head injury when they had.

The panel was also satisfied that Mrs Thompson's actions would be seen as dishonest by the standards or ordinary and decent people. It therefore found this charge proved.

Charge 7a)i)

7) On or around 2 April 2022:

a) Outside the scope of your practice, inserted an unprescribed size 12 catheter into Resident A without:
i) Any clinical justification

This charge is found NOT proved.

In considering this charge, the panel noted that it heard evidence that the night nurse handed over to Mrs Thompson the fact that Resident A had not been passing urine, and that during the day Resident A was only passing small amounts of urine. The panel had regard to the care plan review for Resident A and noted that Mrs Thompson had recorded the following clinical justification:

‘Continues to have urine output monitored. Very little passed even when on the toilet.
Catheter inserted to monitor output Overnight if she will tolerate it. Urine into catheter as soon as it was inserted’

The panel was satisfied that Mrs Thompson had recorded her clinical justification for inserting the catheter. Further, the panel was not provided with any evidence to suggest that this decision was outside the legitimate scope of her clinical judgment. It therefore found this charge not proved.

Charge 7a) ii)

ii) Seeking and/or recording advice from a GP

This charge is found NOT proved.

In considering this charge, the panel had regard to the evidence of Witness 7, which states:

‘54. If Resident A was in urine retention, Sue should not have taken another resident's catheter (regardless whether this was spare or left over) and inserted this into Resident A. If Sue was concerned about Resident A's urine output, she would have needed to complete an assessment. This would have included Sue confirming whether Resident A's stomach was swollen or tender (which would have suggested she was in urine retention). This assessment should have then been added to Resident A's elimination care plan. Once this was done, Sue should have contacted Resident A's GP. The GP could have then sent a district nurse out to the Gables to complete a bladder scan on Resident A, to determine whether she was in urine retention or not. If the GP surgery was not open, Sue should have called 111 for their

advice. There was nothing doc within Resident A's notes, including her multidisciplinary record notes, that suggested Sue had sought advice from her GP or another medical professional.'

The panel noted Witness 7's evidence that *'Sue should have contacted Resident A's GP'*. However, in considering the Home's catheterisation and catheter care policy the panel was satisfied that there was no requirement for a nurse to seek advice from a GP in every case.

The panel also had regard to the statement of Witness 2, which states:

'45. If Sue was concerned about Resident A's urine output, she should have spoken to me in the first instance to obtain my advice. This is what the other staff nurses would do if they had any concerns. I would have been able to ensure that the relevant documents were completed and that consent was obtained from the multi-disciplinary team or Resident A's GP and Resident A's [PRIVATE]*. Sue's job role did not permit her to make a decision to catheterise alone.'*

The panel again noted that Witness 2, the Home Manager, did not say that the GP's advice definitely needed to be sought in every case.

Having considered the evidence before it, in relation to this charge, the panel was not satisfied that there was an explicit requirement for Mrs Thompson to have contacted a GP prior to catheterising Resident A. It therefore found this charge not proved.

Charge 7a) iii)

iii) Seeking and/or recording advice from the Multi-Disciplinary Team

This charge is found proved.

In considering this charge, the panel had regard to the Home's catheterisation and catheter care policy which states:

> *'Catheterisation is an invasive procedure and will only be carried out after a risk assessment has been completed and it is considered appropriate for the clinical need of the person and in their best interests. These discussions will take place with the multidisciplinary team.'*

The panel was satisfied that it was clear from the policy that advice would need to be sought from a multidisciplinary team prior to catheterisation taking place.

In the minutes from a meeting held with Mrs Thompson on 10 May 2022, she was recorded to have said:

> *'…All through the day she did not pass urine over 12 hours had passed. I examined her she had discomfort and I put a size 12 catheter to release the water retention. I made a clinical judgement at the time. I know now to seek advice.'*

The panel inferred from Mrs Thompon's words *'I know now to seek advice'*, that she was tacitly accepting that she had not sought advice from the multidisciplinary team at the time of the incident.

The panel also had regard to the minutes of the meeting with Mrs Thompson on 19 April 2022, which states:

> '[Witness 2] *Do you know the policy around catheterisation?*
>
> *ST yes*

[Witness 2] *Did you consult anyone about your decision, doctor, nurse,* [PRIVATE]*?*

ST not at the time, I felt it needed to be done and it was an emergency decision I had to make.

[Witness 2] *Did you speak with myself or* [Person 11] *the Deputy about Catheterising*

ST No, it was the weekend.

[Witness 2] *Did you know you need a best interest decision making first?*

ST No

[Witness 2] *That it must include a multi-disciplinary team?*

ST No'

The panel noted that Mrs Thompson had stated that she knew the policy regarding catheterisation, but did not know that it must include a multi-disciplinary team. It was therefore satisfied, on the balance of probabilities, that Mrs Thompson did not seek advice from the multi-disciplinary team prior to catheterising Resident A. It accordingly found this charge proved.

Charge 7a) iv)

v) Seeking and/or recording consent and/or advice from Resident A's [PRIVATE]

This charge is found proved.

In considering this charge, the panel had regard to the Home's catheterisation and catheter care policy which states:

> *'The Person and* [PRIVATE] *must be included in the decision-making process. The presence of a catheter can have huge implications for body image, mobility, pain and comfort. Indwelling catheters are also known to increase the risk of urine infections. It is vital therefore they are only used when clinically necessary.'*

The panel was satisfied from the policy that Resident A's [PRIVATE] should have been consulted prior to Mrs Thompson catheterisation Resident A, and there was no evidence before the panel that Mrs Thompson had done this.

The panel also had regard to the statement of Witness 7, which states:

> *'55. In terms of Resident A's consent, there was nothing documented to suggest that Sue had Resident A's consent to insert the catheter. Nevertheless, Resident A had dementia and could not retain information or make an informed decision. She had poor short term memory, which is why she was asking to go to the toilet all of the time as she would forget that she had just been. NICE clinical guidelines on 'decision making and mental capacity' (published 11 August 2020) confirmed that when a person lacks capacity to make a decision, all actions and decisions taken by practitioners must be in the person's best interests. This principle covers healthcare decision making and actions. The person must be placed at the heart of the decision-making process and supported to be involved in the decision- making process as far as possible. Wherever possible this means finding out about the person's past and present wishes, feelings, values and beliefs that would have influenced the decision if the person had capacity. It also means using information included in care plans and advance care plans, consulting with*

the person's [PRIVATE]*, carers and advocates and seeking to establish the person's wishes, preferences and values. There was no evidence that Sue did this.'*

The panel noted Witness 7's explanation regarding the best interests policy, which included consulting with a resident's [PRIVATE] prior to catheterisation. It then went on to consider the minutes of the meeting with Mrs Thompson on 19 April 2022 and noted that when Mrs Thompson was asked *'Did you know you need a best interest decision making first'* Mrs Thompson responded *'No'*. The panel was satisfied on the balance of probabilities, from Mrs Thompson's response, that she did not consult within Resident A's [PRIVATE] prior to catheterising Resident A. It therefore found this charge proved.

Charge 7a) v)

v) Seeking and/or recording advice from the Manager/Deputy Manager

This charge is found NOT proved.

In considering this charge, the panel had regard to the Home's catheterisation and catheter care policy and noted that there was no requirement contained within the policy for a manager to be consulted prior to catheterisation.

The panel had regard to the evidence of Witness 7 who stated that a GP must be consulted. It also had regard to the evidence of Witness 2, the Home Manager, who stated that a manager should have been consulted. The panel noted that it was only Witness 2 who had intimated that the manager should have been consulted.

In absence of the policy stating that advice from the manager or deputy manager should have been sought prior to catheterisation, the panel was not satisfied that there was a requirement to do so. It therefore found this charge not proved.

Charge 7a) vi)

vi) Monitoring and/or recording a fluid output chart

This charge is found proved in so far as it relates to recording.

In considering this charge the panel had regard to the statement of Witness 7 which states:

> *'53. … Sue did not document Resident A's actual amount of urine output anywhere and did not complete any urine output charts. Therefore I am unsure on how much urine Resident A actually passed on 2 April 2022. Sue did document within Resident A's daily record of care notes at 14:40 pm that she was passing small amounts of urine.'*

The panel noted that Witness 7 had stated that Mrs Thompson did not complete a urine output chart.

The panel also considered the statement of Witness 2, which states;

> *'38. …Sue said that she made a clinical judgement after monitoring Resident A's urine output and felt that inserting the catheter was necessary as Resident A was struggling to pass urine. The Gables have been unable to locate any of the fluid output charts for Resident A or the handover sheets. However, at the time of the incident, Sue was unable to provide the fluid output charts and I was unable to find any evidence which confirmed Resident A's actual input or output that justified Sue's decision to catheterise.'*

The panel noted that Witness 2 had stated that Mrs Thompson was unable to provide the fluid output chart.

The panel had regard to Resident A's care plan review and noted that Mrs Thompson had recorded *'catheter inserted to monitor output overnight…'*. The panel was of the view that there was no evidence provided to suggest that the monitoring did not take place as stated in the contemporaneous notes recorded. However, the panel had regard to the absence of a fluid output chart and noted that there was evidence to suggest that even if it was being monitored, Resident A's fluid output was not being recorded. Accordingly, the panel found this charge proved in relation to recording only.

Charge 7b) i)

b) Whilst inserting the catheter into Resident A, did not:
i) Explained the procedure to Resident A

This charge is found NOT proved.

In considering this charge the panel had regard to the statement of Witness 6, which states:

'6. Me and Care Assistant [Witness 3]*… sat with Resident A whilst Sue inserted the catheter.* [Witness 3] *was sat on one side holding Resident A's hand, and I was sat on the other side. During the procedure, Resident A was hysterically crying and kicking her legs out at Sue. Resident A said "get it out" and "you are hurting me". I do not think that Resident A understood what was happening as Sue did not explain the procedure beforehand.* [Witness 3] *and I tried to calm Resident A down and explain what was happening, but because she was so distressed she did not understand. The procedure lasted around five to ten minutes.*'

The panel noted that Witness 6 stated that Mrs Thompson did not explain the procedure to Resident A. However, it had regard to Witness 3's statement which contradicted this and stated:

> *'5. I am unsure on whether Sue had Resident A's consent to insert the catheter, however she did explain the process to Resident A prior to inserting the catheter. During the insertion, Resident A was distressed and she appeared to be in pain. Resident A was shouting a lot. I sat on one side of Resident A and care assistant* [Witness 6] *sat on the other side. We were both holding Resident A's hand, trying to reassure her throughout the process. Sue did not reassure Resident A.'*

In oral evidence Witness 3 confirmed that Mrs Thompson had spoken to Resident A and explained what she was going to do. The panel noted that there was inconsistency between the evidence of the two witnesses who were present at the time of the procedure. It considered that the NMC had produced insufficient evidence for the panel to be able to conclude on the balance of probabilities that the procedure was not explained to Resident A. The panel accordingly found this charge not proved.

Charge 7b) ii)

> b) Whilst inserting the catheter into Resident A, did not:
>
> ii) Reassure Resident A

This charge is found proved.

In considering this charge the panel had regard to the statement of Witness 3 which states:

‘5. …During the insertion, Resident A was distressed and she appeared to be in pain. Resident A was shouting a lot. I sat on one side of Resident A and care assistant [Witness 6] *sat on the other side. We were both holding Resident A's hand, trying to reassure her throughout the process. Sue did not reassure Resident A.’*

The panel noted Witness 3’s evidence that Mrs Thompson did not reassure Resident A. Witness 3 also confirmed this during their oral evidence. The panel accepted Witness 3’s evidence. However, the panel had regard to the fact that Mrs Thompson was occupied with undertaking catheterisation and there were two healthcare assistants providing reassurance to Resident A. The panel therefore did not consider that there was sufficient evidence to demonstrate that it was necessary for Mrs Thompson to provide reassurance to Resident A at this point, and found this charge proved on a factual basis only.

Charge 7c)

c) Inaccurately informed Colleague X that you had obtained permission from a GP to catheterise Resident A.

This charge is found proved.

In considering this charge the panel had regard to the statement of Witness 6 which states:

‘5. …I challenged Sue and said that I did not think that the catheter was necessary anymore. Sue then told me that she had permission from a General Practitioner ("GP") to catheterise Resident A as she was not passing urine. I did not say anything else as I believed that Sue had permission from Resident A's GP to carry out the procedure.’

In oral evidence Witness 6 was asked if she was positive that Mrs Thompson had told her she had permission from the GP, and Witness 6 responded *"yes, there was nothing written, Sue just said she had permission".* The panel found Witness 6 to be a compelling witness in this regard, whose written evidence was consistent with her oral evidence. The panel therefore accepted Witness 6's evidence that Mrs Thompson had told her she had received permission from the GP.

The panel also had regard to minutes of the meeting with Mrs Thompson on 19 April 2022 and noted that when asked *'Did you consult anyone about your decision, doctor, nurse,* [PRIVATE]*?'* Mrs Thompson responded, *'not at the time, I felt it needed to be done and it was an emergency decision I had to make.'* The panel was satisfied that Mrs Thompson had not obtained permission from Resident A's GP to catheterise Resident A. Therefore, having accepted the evidence of Witness 6, the panel accordingly found that Mrs Thompson had inaccurately informed Witness 6 that she had obtained permission from a GP to catheterise Resident A. It therefore found this charge proved.

Charge 8

8. Your actions in charge 7) c) above were dishonest in that you sought to misrepresent that you had obtained permission from a GP to carry out the procedure.

This charge is found proved.

In considering Mrs Thompson's state of mind at the time of the incident, the panel had regard to the interview notes and noted that Mrs Thompson had stated at the time that she had made a clinical decision to catheterise Resident A. The panel was of the view that this was an indication that Mrs Thompson recognised that she did not seek advice from the GP as she should have but had made her own clinical decision. Having found

that Mrs Thompson informed Witness 6 that she had obtained permission from a GP to catheterise Resident A when challenged by Witness 6 and knowing that she had not obtained permission from a GP, the panel was satisfied that they only reasonable inference it could draw was that Mrs Thompson was being dishonest by doing so. It was also satisfied that by the standards of ordinary and decent people, Mrs Thompson's actions would be considered dishonest. It therefore found this charge proved.

Charge 9

9. On 12 April 2022 applied a new buprenorphine patch to Resident H, without removing the old buprenorphine patch.

This charge is found proved.

In considering this charge, the panel had regard to a photograph of Resident H with two visible buprenorphine patches on their back. The panel also had regard to the controlled drug book which showed that Mrs Thompson had administered the patch on 12 April 2022 and on the previous occasion on 5 April 2022.

The panel also had regard to the oral evidence of Witness 7 who stated that she had seen there were 2 patches on Resident H, and that the old patch had not been removed, and that she had taken a photograph to show that Resident H had two patches.

The panel also had regard to the management of medications policy, which states:

'Ensure the old patch is removed before applying a new one…'

The panel was satisfied from the evidence before it that there was a requirement for the old patch to be removed before a new one was applied, and that Mrs Thompson had not done this. It accordingly found this charge proved.

Charge 10

10) Between 19 May 2022 and 20 June 2022,

a) After informing Dr V of Resident B's adverse reaction to a memantine 10mg prescription, incorrectly completed an order sheet for more memantine

This charge is found proved.

In considering this charge, the panel first had regard to the statement of Dr. V, which states:

'6. On 19 May 2022, I spoke to Sue over the telephone. Sue told me that Resident B had an adverse reaction to the memantine. Sue said that the memantine had increased Resident B's agitation, distress, and verbal aggression. I therefore asked Sue to discontinue the memantine medication and update Resident B's records accordingly.

7. Following the telephone call with Sue, I sent a letter to Resident B's GP and the Gables Care Home on 19 May 2022. I produce a copy of the letter…Within the letter, I asked that the 10mg of memantine for Resident B was stopped and records updated accordingly due to the adverse reaction Resident B had experienced. To be clear, the letter was not sent directly to Sue but was emailed and posted to the Gables Care Home Manager, as is our usual practice.'

The panel noted that there was a clear instruction from the doctor, on 19 May 2022, to discontinue the medication.

The panel next considered the order sheet for Resident B and noted that Memantine tablets had been requested for a period of 28 days for the period 28 May 2022 – 24 June 2022. The panel also noted that there was no signature attached to the request. However, it had regard to the evidence of Witness 7 which states:

> *'8. I returned to work on 22 June 2022. I told care assistant* [Witness 5] *that I did not think that Sue had requested a medication review for Resident B as the nurses diary note had not been ticked as actioned.* [Witness 5] *said that she knew that Sue had spoken to the Intensive Community Liaison Service ("ICLS").* [Witness 5] *said that she had taken a call from* [Dr V], *who was unhappy about the fact that Sue had requested more memantine for Resident B when she had asked for this to be discontinued on 19 May 2022. I produce a copy of the order sheet for the period between 28 May 2022 and 24 June 22 (that was completed by Sue)…'*

The panel had no reason to not accept Witness 7's evidence that Mrs Thompson had put in the request for the medication. It was of the view that the writing was consistent with Mrs Thompson's handwriting, and further noted from Resident B's Electronic Medication Administration Record ("eMAR") chart that Mrs Thompson was still administering Memantine to Resident B after 19 May 2022, despite having been told by the doctor to discontinue the medication. The panel was therefore satisfied on the balance of probabilities that Mrs Thompson was the nurse who incorrectly completed an order sheet for more memantine. It therefore found this charge proved.

Charge 10b)i)

b) Failed to appropriately discontinue Resident B's memantine 10mg prescription:

i. As instructed by Dr V

This charge is found NOT proved.

The panel was of the view that this charge should have been included in the stem of charge 10b as there was no allegation as to what Mrs Thompson had or had not done. The details of the alleged failures were set out in the particulars at 10 b ii and iii, and as worded, the words at 10 b i appear to add nothing as a separate allegation. The panel therefore found this charge not proved.

Charge 10b) ii)

ii. By updating the electronic medication administration system

This charge is found proved.

In considering this charge the panel had regard to the statement of Witness 7, which states:

> *'10. At the time, the nurses were not aware of* [Dr V] *instructions as Sue had not discontinued Resident B's memantine prescription on the electronic medication administration system, or updated Resident B's care notes to confirm that it had been discontinued. Therefore, the staff continued to administer the memantine to Resident B during the period between 19 May 2022 and 21 June 2022.'*

The panel had regard to Resident B's eMar chart and noted that there was nothing recorded to show that Memantine had been discontinued. *The panel did however note that on 19 May 2022, Mrs Thompson had written in Resident B's multidisciplinary record to note that the doctor would be sending an email to discontinue Memantine.* She had therefore, made a record of the doctor's instructions. However, the panel was satisfied

that Mrs Thompson did not update the electronic medication administration system and therefore found this charge proved.

Charge 10b) iii)

iii. By updating Resident B's care plan

This charge is found NOT proved.

In considering this charge, the panel had regard to the statement of Witness 2 which states:

> *'8. In July 2022 I completed an investigation into an allegation made against Sue. On 22 June 2022 Tracey informed me that the Memantine for* [Resident B] *should have been discontinued on 19 May 2022. The message was received by Sue on 19 May 2022 and written in the care plan and diary. The Memantine had been omitted on 19 May 2022. However, no written confirmation was received from the GP. The Memantine was therefore administered by the agency nurse and subsequent staff for the following approximate five weeks.'*

The panel noted that Witness 2 had stated that Mrs Thompson had written the confirmation of the discontinuation in the *'care plan and diary'.*

The panel next had regard to Mrs Thompsons diary note in respect of Resident B on 19 May 2022, which states:

> *'…Resident B's Awaiting for call back.*
> *STOP MEMANTIN'*

It also had regard to the entry in the multi-disciplinary record referred to in 10b)ii) above. It was clear to the panel that Mrs Thompson had made a relevant entry in the diary

notes. However, with regard to a record being made in the care plan, the panel had not been provided with a copy of any document described as the care plan. Given that the panel had other evidence of Mrs Thompson documenting the discontinuation of the medication elsewhere, and that Witness 2 had given positive evidence that she had recorded it in the care plan, the panel found this charge not proved on the balance of probabilities.

Charge 10c)

c) On one or more occasion, incorrectly administered discontinued memantine 10mg to Resident B.

This charge is found proved.

In considering this charge the panel had regard to Resident B's eMAR chart for the period 1 May – 22 June 2022 and noted that Mrs Thompson had on 25, 28 and 29 May, administered memantine to Resident B despite being informed on 19 May 2022 that the medication was to be discontinued.

The panel also had regard to Mrs Thompson explanation given contained in the minutes of meeting on 11 July 2022, which states:

"[Witness 2] *Morning Sue, can you tell me what happened about* [Resident B] *memantine medication?*

ST It's been stopped

[Witness 2] *Can you explain when it got stopped and why?*

ST Yes it was the other week, the Dr sent confirmation over it's already been stopped

[Witness 2] *What about in May I've seen in the care plan and notes it should have been stopped in May*

ST The Dr only did it verbally I omitted it then and handed it over, I was then off

[Witness 2] *What about when you returned?*

ST It was still prescribed and there was still no confirmation of it being stopped

[Witness 2] *When did you notice that?*

ST When I came back from my days off and that's when I called the Dr to get it in writing to stop.

[Witness 2] *What is the usual process for receiving instructions verbally*

ST To get it in writing or email like the doctor did

[Witness 2] *Did this happen?*

ST No not until I came back to work, no one else chased it or followed it up so I wasn't the only one to blame.'

The panel found, on the balance of probabilities, that Mrs Thompson had incorrectly administered Memantine to Resident B on three occasions after receiving the doctor's instruction to discontinue that medication. However, it noted Mrs Thompson's reason for continuing with the medication; namely that the written follow up had not been received from the doctor.

The panel noted that Home's management of medication policy, which states:

'In respect of changes to prescriptions given over the telephone:

- *…It must be recorded in the residents care plan and in the multi-disciplinary notes. The procedure for changing an instruction on the eMAR system must be followed.*
- *This must be followed up immediately by email from the prescriber before any changes can be implemented.*
- *The change must be made promptly on the eMAR system…'*

The panel was of the view that until written confirmation had been received from the doctor, Mrs Thompson did not have a duty to discontinue the medication. In the circumstances, the panel considered it debatable whether Mrs Thompson's reasons for continuing to administer the medication for three days in the week after the instruction was given, after she came back from leave could be said to be *"incorrect"* in the circumstances. It therefore found this charge proved only as a matter of fact.

Charge 11a) and b)

11) Did not administer 2 tablets of memantine 10mg at 08:00 as prescribed to Resident I on:

a) 29 June 2022

b) 30 June 2022.

These charges are found proved.

In considering these charges the panel had regard to Witness 7's statement, which states:

‘40. On 29 and 30 June 2022 Sue gave Resident I an underdose of her tolterodine and memantine medication (Sue documented on the eMAR…that she administered one tablet to Resident I when two should have been given). This would have meant that Resident I did not receive the full therapeutic benefits of the medications which could have effected their levels of confusion and urinary output. However, I did not personally notice any harm or difference to Resident I.’

The panel had regard to Resident I’s eMAR charts for the period 28 June 2022 – 13 August 2022 and noted that the instruction/prescription recorded for Memantine 10mg tablets was '*take two tablets once a day in the morning’.* The panel noted that Mrs Thompson’s was recorded on the eMAR chart as only having given Resident I one tablet on both 29 and 30 June 2022. However, the panel noted that other nurses at the Home had also only given 1 tablet to Resident I on different dates. Moreover, it noted that this was an underdose, rather than a total omission of medication.

The panel was satisfied from the testimony of Witness 7 and the eMAR charts, that Resident I had only been given 1 tablet by Mrs Thompson, and therefore found these charges proved on a factual basis only.

Charge 12

12) Did not administer 2 tablets of tolterodine 1mg at 08:00 as prescribed to Resident I on:

a) 29 June 2022

b) 30 June 2022.

These charges are found proved.

In considering these charges, the panel had regard to the eMAR chart for Resident I and noted that the instruction for tolterodine was *'take two tablets twice a day'*. On 29 and 30 June 2022, the contemporaneous record showed that Mrs Thompson had only given Resident I one tablet in the morning. Again, the panel noted that there were other occasions by other staff where only one tablet had been given to Resident I, and that this was an underdose rather than a total omission of medication.

The was satisfied from the contemporaneous medical records, that Mrs Thompson had only given one tablet of tolterodine to Resident I. It therefore found these charges proved on a factual basis only.

Charge 13

13) In or around July 2022 did not follow Resident F's care plan, in that you inappropriately instructed Colleague W to shower Resident F alone.

This charge is found proved.

In considering this charge the panel had regard to the consistent oral and written statement of Witness 4 which states:

4. I cannot recall the date of this incident. I believe that the incident occurred in July 2022. I was in the office when Sue asked me and care assistant [Witness 3] *to shower Resident F. I then left the office to get the personal protective equipment for me and* [Witness 3]*. When I returned to the office and asked* [Witness 3] *to help me shower Resident F, Sue said words to the effect of "no, shower him on your own".*

5. *Resident F could sometimes be violent and aggressive. I had read and seen Resident F's care plan, which said that due to his behaviour two members of staff were required to assist Resident F with personal care. This included when showering him…'*

The panel also heard oral evidence from Witness 4 which it found was consistent with her written statement and Resident F's care plan which states:

> *'Due to* [Resident F's] *behaviour and non compliance two staff will assist him to have a shower at least twice a week.'*

The panel also noted that Witness 4 had stated in the meeting minutes on 22 August 2022 that '[Mrs Thompson] *asked me to shower Resident F. He swears, punches, could fall. So, I got PPE for 2 people and ST said no, you can do it on your own. I didn't think that was right.'*

The panel was satisfied that it was clear from Resident F's care plan that two people were required to shower Resident F. It also accepted the consistent evidence of Witness 4 contained in her witness statement, oral evidence and minutes of meetings, that Mrs Thompson had told her to shower Resident F on her own. Accordingly, the panel found this charge proved based on the evidence before it.

Charge 14a) and b)

14) On or around 1 July 2022:

a) Discontinued Resident B's 15mg mirtazapine prescription, without adequately explaining the reason and/or clinical justification

b) Increased Resident B's mirtazapine prescription to 30mg without adequately explaining the reason and/or clinical justification.

These charges are found NOT proved.

In considering these charges, the panel first had regard to a letter from the GP dated 6 May 2022, which states:

> *'…28 days supply Mirtazapine 15mg at night (14) then to increase to 30mg at night, Memantine 10mg daily in the morning (to commence a week after Mirtazapine) - to be sent to Lloyds Pharmacy Linthorpe Road for delivery to care home'*

The panel was satisfied that there was a clear instruction from Resident B's GP to increase the dose 30mg at night.

The panel noted from Resident B's eMAR chart for July 2022 that Mrs Thompson discontinued giving Resident B 15mg Mirtazapine in the night, but at the same time started giving Resident B 30mg Mirtazapine at night. The panel considered that Witness 7, who identified the alleged omission, may have overlooked the increase dose and been mistaken in their evidence.

The panel also had regard to Resident B's medication list for 1 June to 30 September 2022 and noted the instruction on the prescription from the GP which

states: *'Take ONE (15mg) at NIGHT for 14 days then take two (30mg) at night for a further 14 days….'* The panel noted that the GP's instructions had been put into Resident B's medication list. It was therefore satisfied that there was a clinical justification for Mrs Thompson's actions in respect of charges 14a) and b), and that Mrs Thompson had acted in accordance with the GP's instructions. Accordingly, the panel did not find these charges proved.

Charges 15a) and b)

15) Incorrectly administered double the quantity of tolterodine 2mg tablets to Resident I on:
    a) 18 July 2022
    b) 19 July 2022

These charges are found proved.

In considering these charges the panel had regard to Resident I's eMAR charts for the period 28 June 2022 – 13 August 2022 and noted that the instruction on the chart was for one Tolterodine tablet to be taken *'twice a day'*, and that Mrs Thompson had recorded that she had given two tablets at 08:00 on both 18 and 19 July 2022. The panel was therefore satisfied from the contemporaneous evidence before it that Mrs Thompson had incorrectly administered a double quantity of tolterodine 2mg tables on these dates. Accordingly, it found these charges proved. The panel noted however, that another nurse had made the same mistake at 20:00 on both days.

Charge 16a)

16) On 29 July 2022 after being alerted that Resident G was non-responsive,
    a) On one or more occasion shook Resident G, using excessive force

This charge is found proved.

In considering this charge the panel had regard to the statement of Witness 5, which states:

‘5. Sue was in the corridor. I told Sue that Resident G would not wake up and did not seem right. Sue then entered the room and walked over to Resident G. Sue stroked Resident G's hand and face, however Resident G did not respond. Sue raised the bed and placed both of her hands onto Resident G's shoulders. Sue shook Resident G at least three or four times and shouted "Resident G , Resident G , Resident G ,,. [sic] *Resident G did wake, however she was not very alert and did not seem herself.*

6. *When Sue shook Resident G, her head jolted from side to side. It was like she had no control over her head at the time. The NMC asked me whether Sue used a lot of force when shaking Resident G. On a scale between one and ten, with one being very gentle and ten being very hard, I would describe it as a seven or eight. I had never seen anyone use force like that before when handling a resident.’*

The panel also had regard to Witness 5’s account given in the fact-finding meeting on 17 August 2022, which states:

‘SH: On the Friday (confirmed 29.7.20220, I walked into [Resident G]*’ room with her lunch and it was like she wasn’t there. I touched her face, rubbed her ear but no response. I went into the corridor and Sue Thompson was there. I asked her to come and look at* [Resident G]*. Sue Thompson went in, lifted* [Resident G]*’s head up, got hold of her shoulders and shook her. I was taken aback.* [Resident G] *sort of woke. Sue Thompson then said “there you go, give her (*[Resident G’s]*) lunch”.* [Resident G] *didn’t eat anything; she just was sitting there. After, I left and went to the office and said to Person 12 about it. On my return to shift I was told that* [Resident G] *was in hospital, she had had* [sic] *a seizure. I found out about her passing when I saw a card from* [PRIVATE]*. Maybe it was her time. I wanted to say something to Sue Thompson when she’d shaken* [Resident G]*, but didn’t.*

LS: On a scale of 1 to 10, one being very gently, 10 being very hard, how hard did Sue Thompson shake [Resident G]*?*

SH: About a 7 or 8. She did it about 5 or 6 times. [Resident G]*'s head was bouncing about all over the place. It was horrible, like a child being shaken. It really upset me.'*

The panel was of the view that Witness 5's written statement, oral evidence and notes from 17 August 2022 were consistent, and that Witness 5 appeared quite distressed by what she had witnessed. In oral evidence Witness 8 stated that she would not shake someone like that.

The panel also considered the statement of Witness 4 which states:

'9. There was an incident which occurred, involving Resident G having a seizure. I cannot recall the date of the incident. At the time of the incident, I was cleaning the corridor and Resident G's room door was ajar. I heard Sue shout Resident G's name three times. I then saw care assistant [Witness 5] *leave the room looking distressed. I did not witness anything further.'*

The panel noted that Witness 4 had seen Witness 8 leaving Resident G's room in distress following the incident.

The panel also had regard to Mrs Thompson's interview on 22 August 2022, which states:

'ST – … Care assistant came to me as she couldn't wake difficult to speak to as she is deaf. I went in and looked at her in bed. I shook her a bit to wake her. We've always had to do that
[Witness 8] *– Be more specific when you say you shook her a bit ST – On her arms (indicates a hand on each shoulder)*
[Witness 8] *– On a scale of 1 to 10 how hard would you say you shook her – 1 being so gently that she would barely feel it and 10 being extremely hard? ST – 2*

[Witness 8] – *Were you saying anything to her whilst you were shaking her?*
ST – Calling her name
[Witness 8] – *Was she saying anything? Were her eyes open?*
ST – No they were closed'

The panel noted that Mrs Thompson had stated that she shook Resident G on a scale at level 2, whereas Witness 5 had stated it was at a level of 7 and 8. The panel was of the view that it was unlikely that Witness 5 would have been distressed if a patient had been shaken at level 2. The panel preferred the evidence of Witness 5, noting that it was consistent with her contemporaneous record, they had gone to speak to someone else about it, and Witness 4 had seen Witness 5 leave the room in distress. The panel was therefore satisfied, on the balance of probabilities, that Mrs Thompson had shaken Resident G with excessive force. It therefore found this charge proved.

Charge 16b)

16) On 29 July 2022 after being alerted that Resident G was non-responsive,
b) Did not undertake/record any observations of Resident G

This charge is found proved.

In considering this charge the panel had regard to Witness 5's interview notes on 17 August 2022, which states:

'[Witness 8]*: Did you see Sue Thompson do any other observations? Like her blood pressure, pulse, look in her eyes, or any other obs?*

[Witness 5]: *No, she just left the room and said about giving* [Resident G] *her lunch. I thought she would call 999 not shake her. There were no obs taken. At the weekend, I spoke to* [Witness 7] *and said to her – is it ok to do this? Referring to the shaking.* [Witness 7] *said no and I got upset. Person 12 won't say anything as he doesn't like to get anyone into trouble. He wasn't there, but I told him about it.*

[Witness 8]*: Did Sue Thompson tell you or your colleagues to conduct extra checks on* [Resident G]*?*

[Witness 5]*: No, but we did anyway. We kept popping in to see her. She wasn't right.*

[Witness 8]*: To your knowledge, did Sue Thompson go back to* [Resident G] *and check on her at any point?*

[Witness 5]*: No'*

The panel took note of Witness 5's evidence that Mrs Thompson did not undertake any observations of Resident G.

The panel next considered Mrs Thompson's account contained in the interview notes of 22 August 2022, which states:

'[Witness 8] – *So after you had finished shaking her, what did you do then?*
ST – I left the room
[Witness 8] – *anything else?*
ST – I can't recall
[Witness 8] – *Did you go in to her room at any time after and check on her?*
ST – I went in half an hour later and did obs. PG, Oxygen, pulse
[Witness 8] – *And where is that recorded?*
ST – I don't know if I wrote it down
[Witness 8] – *Why?*
ST – I have no reason
[Witness 8] – *Where would you normally write down observations?*
ST – In my notebook, on handover.
[Witness 8] – *not in her Care Plan?*
ST – I can't recall.'

The panel noted Mrs Thompson's evidence, that she had gone back to do observations on Resident G half an hour later but she did not know if she had written it down.

The panel next considered the daily record of care for Resident G and noted that Mrs Thompson had recorded at 16:30 that Resident G *'…has been very sleepy today. Looks very frail. Small portions at meals remains slow to accept. No indication of pain but she continues to be monitored. For review by GP next week…'*

The panel noted from the daily record of care that Mrs Thompson had made a note of Resident G's conditions at 16:30 and that Resident G would need to continue to be monitored. The panel was also satisfied that Mrs Thompson had handed over the need for continued monitoring to the night nurse as the night nurse's entries reflected that Resident G was checked hourly. However, despite Mrs Thompson checking on Resident G at 16:30, the panel noted that there was no separate documentation of Resident G's vital signs. It therefore found this charge proved.

Charge 16c)i), c)i)i and c)iii)

16) On 29 July 2022 after being alerted that Resident G was non-responsive,
    c) Did not appropriately escalate Resident G's non-responsive state, in that you did not:
        i) Lightly pinch Resident G's ear
        ii) Place your hands on Resident G's shoulder
        iii) Call an ambulance for Resident G.

These charges are found NOT proved.

In circumstances where Resident G had woken up in response to being shaken, and where staff had been instructed to monitor Resident G, there was no evidence before the panel to suggest that lightly pinching Resident G's ear, placing hands on Resident G's shoulder, or calling an ambulance for Resident G was either necessary or appropriate.

The panel had regard to the National Early Warning Score ("NEWS") 2 Escalation sheet and was satisfied that there was no evidence of a requirement for Mrs Thompson to have carried out these steps as Resident G was responsive from having been shaken by Mrs Thompson. The panel therefore found these charges not proved.

Charge 17a)

17. On 10 August 2022 after Resident B had suffered a fall:
    a) Did not attend to Resident B in a timely manner

This charge is found NOT proved.

In considering this charge, the panel had regard to the statement of Witness 1, which states:

> *'5. Resident B was laid on the floor.* [Witness 1] *and* [Witness 3] *were holding her head and shoulders up from behind. She was positioned at an angle with her back to* [Witness 1] *and* [Witness 3]*. Deputy Manager* [Person 11] *then arrived.* [Person 11] *had been working on a different unit downstairs.* [Person 11] *had managed to attend Resident B before Sue did. Sue was working on the upper floor, the same unit as Resident B's fall. I saw Sue leave the bathroom, she strolled down the corridor in no hurry at all as if there was no emergency. Sue took her time and she was the last one to attend Resident B.'*

The panel noted that it was Witness 1's evidence that Mrs Thompson *'strolled down the corridor in no hurry at all*'. However, the panel had regard to the investigation notes on 22 August 2022 with Witness 1, which states:

> *'*[Witness 1]- *I was in Person 15's office and heard a scream. Went onto the unit. Res B was on the floor screaming.* [Witness 6] *and* [Witness 3] *were with her.* [Witness 3] *couldn't turn off the alarm.* [Person 11] *came up and the Sue Thompson came out of the toilet. She didn't rush and she was wiping*

her face. Res B was still screaming. ST went down onto her knees and started lifting Res B leg'

The panel noted that Witness 1's evidence was the basis for this allegation and that they had seen Mrs Thompson coming out of the toilet and wiping her face. In the panel's view, Witness 1's evidence contained unfair criticism of Mrs Thompson, apparently based on her observations with regard to her speed, gait, fitness or [PRIVATE].

The panel also noted that Mrs Thompson was not the only person working at the Home who could have assisted Resident B, and that Mrs Thompson arrived as soon as she could. It therefore found this charge not proved.

Charge 17b) i) and b)ii)

b) On one or more occasion inappropriately:
   i. Moved Resident B's right leg up and/or down and/or backwards
      and/or forward
   ii. Bent Resident B's right leg

These charges are found proved.

In considering these charges the panel had regard to the statement of Witness 1, which states:

'6. I am unsure on whether Resident B was hurt, however she seemed to be as she was screaming the whole time. Resident B did not verbally communicate that she was hurt but I am unsure on whether she was able to verbally communicate. Sue and [Person 11] *were trying to talk to Resident B but she continued screaming. Sue then started to move Resident B's right leg up and down. Sue then bent Resident B's right leg, so that her knee pointed upwards. Sue then straightened Resident B's leg back out and repeated the action once*

more. During this time, [Person 11] *held Resident B's other leg flat and Resident B was screaming.'*

The panel noted that it was Witness 1's evidence that Mrs Thompson had *'started to move Resident B's leg up and down*'. The panel also noted that this was corroborated by Witness 6 and Witness 3 who respectively stated:

'9. Sue attended Resident B. Deputy Manager [Person 11] *also attended. Me and* [Person 11] *rested Resident B against the wall so that Sue could examine Resident B. Sue then examined Resident B's legs. Sue placed one of her hands under Resident B's calf and the other hand on the back of Resident B's ankle. Sue then pulled Resident B's leg so that it straightened. After this, she pushed Resident B's leg towards her chest so that her knee bent and then pulled it back down so that it was straight again. Sue did this three or four times, pulling Resident B's leg backwards and forwards. At this point, Resident B was screaming out in pain. Resident B did not speak any words, she just screamed and cried. Sue's response to this was "she is being dramatic".'*

And

'8. Shortly after, Sue attended Resident B. Deputy Manager [Person 11] *and* [Witness 6] *also attended. Resident B continued to scream in pain. Resident B had her legs bent towards her chest, so that her knees were facing upwards. Sue then examined Resident B. In doing so, Sue grabbed the heel of Resident B's foot and straightened her leg. This caused Resident B to scream out in pain.* [Person 11] *then asked whether Resident B was okay and Sue responded "yeah, she's just a drama queen". Resident B did not respond to this and carried on screaming.'*

The panel saw and heard evidence from three witnesses who each attested to having seen Mrs Thompson move Resident B's right leg, as described in charge 17 b, and Resident B cry out in pain as a result.

The panel also had regard to Mrs Thompson's comments from the investigation meeting on 22 August 2022, which states:

> *'*[Witness 8] – *Staff heard Res B screaming and responded to the emergency, alongside yourself. Can you tell me what you did when you got to Resident B*
>
> *ST – Whilst she was on the floor, I was trying to examine her. She was laid on her side. I moved her onto her back and she screamed more. Her arm, leg and head movements were fine.*
>
> [Witness 8] – *What examinations did you do?*
>
> *ST – Her arms and back. Both her legs were bent. She would let me examine the right leg but not the left. She couldn't straighten them.*
>
> [Witness LS] – *Did you try to straighten them?*
>
> *ST – Yes.'*

The panel was satisfied from the investigation notes that Mrs Thompson had admitted to examining Resident B's right leg and straightening it. In conjunction with the evidence from the three witnesses, the panel was satisfied, on the balance of probabilities, that Mrs Thomas had moved Resident B's right leg up and/or down/or backwards and/or forward and bent Resident B's right leg.

The panel also had regard to the Home's care after an accident or fall policy, which states:

> *'<u>Action to be taken where an injury is apparent or suspected.</u>*
> *When the Person is conscious:*
> • *Determine the site of the injury by verbal enquiry and gentle physical examination.*

- *If there is evidence of/or suspected bony injury, make the Person as comfortable as possible without moving the injured area…'*

The panel was satisfied that the policy explained what should have been done, and found Mrs Thompson's actions, in moving Resident B's right leg and bending it, inappropriate. It therefore found these charges proved.

Charge 17c)

c) Inappropriately lifted and/or moved Resident B from the floor into a wheelchair, in that you did not use a hoist

This charge is found proved.

In considering this charge, the panel had regard to the statements of Witness 3, Witness 6 and Witness 1, which respectively state:

Witness 3

'9. I went to turn the emergency buzzer off and saw the domestic and the administrator enter the corridor. When I came back, Resident B was standing with Sue on one side and [Person 11] *on the other side. Both were holding Resident B's hands. Beth was stood behind with a wheelchair and Resident B was put into the wheelchair and taken back to her room. I then finished assisting the resident I was with prior to Resident B's fall.'*

Witness 6

'10. Resident B was unable to get up or move. Sue told me to get a wheelchair, which I did. Sue and [Person 11] *then pulled Resident B up by her elbows and put her into the wheelchair. Resident B continued to cry and scream and also said that she had hit her head.* [Witness 3] *tried to check Resident B's head for signs of injury. Sue did not acknowledge or check Resident B's head and wheeled Resident B back to her room.'*

Witness 1

‘7. At some point when Resident B was screaming, Sue said words to the effect of "stop being a drama queen" or "she is being a drama queen". [Witness 3] *went to turn the emergency buzzer off and then Sue and* [Person 11] *decided to pull Resident B up from the floor. Sue stood on one side of Resident B and* [Person 11] *stood on the other side. They each had one of their hands on Resident B's elbow and the other hand on Resident B's hand. When Sue and* [Person 11] *pulled Resident B up from the floor, she screamed the whole time. Resident B was then taken back to her room.’*

The panel noted that all three witnesses had attested to seeing Mrs Thompson pulling Resident B up or holding her up.

The panel also had regard to the investigation interview notes with Mrs Thompson on 22 August 2022, which states:

‘[Witness 8] – *Where did you move her from and to and how did you move her?*
ST – 2 of us transferred her. We lifted her off the floor
[Witness 8] – *Who are “we”?*
ST – [Person 11]. *We both lifted her off the floor.*
[Witness LS] – *Why would you do that?*
ST – I know, I know what you’re getting at.
[Witness 8] – *What do you know and what am I getting at?*
ST – You’re going to say I didn’t follow procedure and I should have used a hoist?
[Witness 8] – *Did you use the correct procedure? Could she stand?*
ST – On her right leg, but not her left leg.
[Witness 8] – *What other staff members were there?*
ST – I can’t recall. [Person 11] *was there and possibly* [Witness 6] *and* [Witness 3]
[Witness 8] – *So you and* [Person 11] *picked her up and put her in the wheelchair. Then what?*
ST – She was transferred onto the bed’

The panel noted from the investigation interview notes that Mrs Thompson had admitted to lifting Resident B up from off the floor, and that she did not follow the correct procedure as she did not use a hoist. It was therefore satisfied from Mrs Thompson's acceptance, and the corroborating evidence of the three witnesses, that she had inappropriately lifted or moved Resident B from the floor into a wheelchair without using a hoist.

The panel also had regard to the Home's care after an accident or fall policy, which states:

> *'Action to be taken where an injury is apparent or suspected.*
>
> *When the Person is conscious:*
>
> - *…*
> - *If there is evidence of/or suspected bony injury, make the Person as comfortable as possible without moving the injured area….'*

The panel was satisfied from the policy that it was inappropriate for Mrs Thompson to move Resident B at all, all the more so in the way that she had, by not using a hoist. It therefore found this charge proved.

Charges 17d) i) and ii)

> d) Spoke to and/or about Resident B using words to the effect:
> i. '*Stop being dramatic/a drama queen'*
> ii. '*She is being a drama queen'*

These charges are found proved.

In considering these charges the panel had regard to the statements of previously quoted in charges 17b) and c) above.

The panel had regard to the fact that all three witnesses had been present and noted that all three witnesses gave evidence that Mrs Thompson said words to the effect of those alleged in charges 17d) i) and ii). The panel was satisfied on the balance of probabilities that, although the witnesses recalled a slightly different version of the wording, that words to this effect had been said by Mrs Thompson. It accordingly found these charges proved.

Charge 17e)

e) Did not assess Resident B for any head injuries

This charge is found proved.

In considering this charge, the panel had regard to the statement of Witness 6, which states:

'10. Resident B was unable to get up or move. Sue told me to get a wheelchair, which I did. Sue and [Person 11] *then pulled Resident B up by her elbows and put her into the wheelchair. Resident B continued to cry and scream and also said that she had hit her head.* [Witness 3] *tried to check Resident B's head for signs of injury. Sue did not acknowledge or check Resident B's head and wheeled Resident B back to her room.'*

The panel noted Witness 6's evidence that Mrs Thompson did not acknowledge or check Resident B's head. The panel found Witness B to be a credible witness, whose written statement, was consistent with their oral evidence and evidence given at the local investigation stage. The panel therefore accepted the evidence of Witness 6 and found this charge proved on the balance of probabilities. The panel did however notice that this allegation was not put to Mrs Thompson at the local investigation stage.

Charge 17f) i) and ii)

f) Did not appropriately seek:

i) Medical advice and/or attention and/or 111 Services for Resident B

ii) An ambulance for Resident B.

These charges are found proved.

In considering these charges, the panel had regard to the Home's care after an accident or fall policy, which states:

> *'Action to be taken where an injury is apparent or suspected.*
> *When the Person is conscious:*
> *…*
> *• Delegate staff member to summon the emergency services using the 999 system…'*

The panel was satisfied that the policy set out a duty to seek medical assistance when there is a suspected injury. In circumstances where on, Mrs Thompson's own account, Resident B could not straighten their legs and would not let Mrs Thompson examine her left leg, and where other witnesses described Resident B screaming with pain, the panel was satisfied that Mrs Thompson should have suspected an injury and should have taken the steps set out in the policy. It therefore found this charge proved.

Charge 18

18) On an unknown date inappropriately asked Colleague Z, a House Keeper to watch an unlocked and/or unattended medication trolley.

This charge is found NOT proved.

In considering this charge, the panel had regard to the statement of Witness 1 which states:

> *'10. … There was an occasion when Sue left the medication trolley in the corridor. I do not recall the date. The emergency buzzer had gone off whilst Sue was doing something with the medication trolley. Sue then*

stopped what she was doing and left the medication trolley in the corridor and asked me to keep an eye on it for her. I am unsure whether the medication trolley was locked, or whether there was any medication on it. However, it was not my job to watch the medication trolley.'

The panel noted Witness 1 assertion that it was not their job to watch the medication trolley. However, having considered the Home's management of medication policy, the panel noted that there was nothing contained within the policy which said a member of staff could not leave the medication trolley with another member of staff in circumstances where they were called away urgently. There was no evidence that Witness 1 was asked to do anything more than stay with the trolley and keep an eye on it. It therefore did not find that asking Witness 1 was inappropriate. Furthermore, there was no evidence before the panel to show that the medication trolley was unlocked, as Witness 1 could not say whether or not it was unlocked, or that it had been left unattended, as it was left with Witness 1. Accordingly, the panel did not find this charge proved.

Charge 19a)

19) On 10 August 2022,
    a) Left a bottle of liquid paracetamol in Resident E's bedroom unattended

This charge is found NOT proved.

In considering this charge the panel first had regard to the statement of Witness 6 which states:

'14. After the ambulance had arrived for Resident B, I went to Resident E's room to give them their lunch. Resident E's toilet door was open and on the shelf was a bottle of liquid paracetamol. I do not recall how many millilitres the bottle measured, but it was a large bottle. Sue was the nurse on shift for that day and she would have been the only staff member responsible for handling and administering medications including paracetamol.'

The panel also had regard to the interview notes with Witness 6 on 17 August 2022, which states:

> *'*[Witness 8]*: Some allegations have been made about a nurse. They are quite serious allegations. In some incidents, I have been told you were witness to them. One is that you saw a bottle of liquid paracetamol left in a resident's room?*
>
> [Witness 6]*: Yes. I went in* [Resident E's] *bedroom and noticed there was a bottle of paracetamol in the bathroom.* [Witness 2] *was stood in the corridor so I took it to him and he took it and went to see Sue Thompson.'*

The panel noted that Witness 6 had stated in her witness statement and during her interview that she had seen a bottle of liquid paracetamol left unattended in Resident E's bathroom.

However, the panel noted that Witness 6's evidence was contradicted by the evidence of Witness 2, who stated:

> *'49. …On 10 August 2022, Sue was completing the medication round and was due to administer liquid paracetamol to Resident E. Sue went into Resident E's room with the liquid paracetamol and was accompanied by care assistant* [Witness 6]*.*
>
> *50. Whilst in Resident E's room, the emergency buzzer went off. Sue was responsible for responding to the emergency buzzer. Sue handed the liquid paracetamol bottle to* [Witness 6] *and then left the room. When I entered the corridor, I saw* [Witness 6] *standing outside of Resident E's door and Sue was running up the corridor.* [Witness 6] *had the liquid paracetamol bottle in her hand and she passed this to me.* [Witness 6] *said that Sue had left the liquid paracetamol bottle in Resident E's room whilst she responded to the emergency buzzer.*

51. *I spoke to Sue and* [Witness 6] *after the incident, I do not recall the dates. They both confirmed the version of the events that I have described above. Sue said that she handed the liquid paracetamol bottle directly to* [Witness 6] *and* [Witness 6] *confirmed this. I also saw* [Witness 6] *with the liquid paracetamol bottle in her hand.*

52. *It was not ideal for Sue to leave the liquid paracetamol bottle with* [Witness 6]*, however Sue did not leave the medication unattended. Sue's priority was responding to the emergency buzzer and she needed to get to the emergency as quickly as possible. There was no harm caused to Resident E. I took the liquid paracetamol bottle from* [Witness 6] *shortly after Sue had handed this to her. The risk of harm in leaving a liquid paracetamol bottle unattended is that the resident could consume the medication.'*

The panel noted that according to Witness 2, both Witness 6 and Mrs Thompson had confirmed to him that Mrs Thompson handed the bottle to Witness 6. It also noted that Witness 2 had stated that the bottle was never left unattended.

The panel could not be satisfied what the correct version of events was, as Witness 2 had stated that Witness 6 had confirmed what he had relayed. The panel noted that the account Witness 6 gave to Witness 2 at the time of the incident and shortly afterwards was inconsistent with her evidence to the panel. The evidence in support of this allegation was contradictory and the panel could not be satisfied on the balance of probabilities that the account in Witness 6's witness statement for this hearing was accurate. The panel therefore could not be satisfied on the crucial issue of whether or not the medication was left unattended. It therefore found this charge not proved.

Charge 19b)

b) Left medication unattended in a corridor

This charge is found NOT proved.

In considering this charge the panel had regard to the statement of Witness 3, which states:

> *'12. On 10 August 2022, the emergency buzzer went off. I was in the corridor and saw Sue leave the medication trolley in the corridor to respond to the emergency buzzer. The medication trolley was unlocked at the time. I believe that there were medications on the trolley, however I do not know for sure. I cannot recall which medications would have been on the trolley as I was not involved in administration.'*

The panel noted that it was Witness 3's evidence that she could not be sure whether there were *'medications on the trolley'.*

The panel also considered the statement of Witness 6, which states:

> *'16. On 10 August 2022, I saw the medication trolley unattended in the corridor, just outside of the office door. Sue was the nurse on shift. The medication trolley was open, there was no medication on top of the trolley but there was access to medication as it was left unlocked. Sue was nowhere to be seen so I shouted her name and did not receive a response. To be clear, I did not see any of the residents take or consume any of the medication that would have been contained within the trolley. As soon as I saw the trolley in the corridor, I pushed it into the office and put the lock on the office door.'*

The panel noted Witness 6's evidence that there was no medication on top of the trolley, there would have been access to medication, and indicated that there would have been medication inside of the trolley.

The panel also had regard to the statement of Witness 7, which states:

> *'68. Within my email…I also raised concerns that Sue left the medication trolley unattended in the corridor. This was reported to me* [Witness 6] *and care assistant* [Witness 3]*.* [Witness 6] *and* [Witness 3] *said that*

Sue was in the process of potting residents medication when the emergency buzzer went off. Sue allegedly left the pots of medication on top of the trolley and left the trolley wide open whilst she went and responded to the emergency buzzer. I do not recall the date of the incident.'

However, the panel noted that Witness 7's evidence was indirect hearsay based on what had been reported to her by Witness 3 and Witness 6.

The panel noted that while there was evidence of a medication trolley being left in the corridor, there was no direct evidence of medication being left unattended in a corridor. It found that the NMC's evidence in support of this charge was too vague and contradictory to make out the charge. It therefore found this charge not proved.

Charge 19c)i) and c)ii)

c) Left a medication trolley in a corridor:
    i) Unattended
    ii) Unlocked.

These charges are found prove

In considering these charges the panel had regard to the statement of Witness 3 and Witness 6, which respectively state:

’12. On 10 August 2022, the emergency buzzer went off. I was in the corridor and saw Sue leave the medication trolley in the corridor to respond to the emergency buzzer. The medication trolley was unlocked at the time. I believe that there were medications on the trolley, however I do not know for sure. I cannot recall which medications would have been on the trolley as I was not involved in administration.

13. Any of the residents could have walked past the trolley and grabbed the medication. Sue was the only person who would have had the keys to the trolley. [Witness 6] *was also present so she moved the trolley to the office and then locked the door so that the medication was kept safe. When other nurses in the home would respond to an emergency, they would usually lock the trolley before attending the emergency.’*

Witness 6:

’16. On 10 August 2022, I saw the medication trolley unattended in the corridor, just outside of the office door. Sue was the nurse on shift. The medication trolley was open, there was no medication on top of the trolley but there was access to medication as it was left unlocked. Sue was nowhere to be seen so I shouted her name and did not receive a response. To be clear, I did not see any of the residents take or consume any of the medication that would have been contained within the trolley. As soon as I saw the trolley in the

corridor, I pushed it into the office and put the lock on the office door.'

The panel noted that Witness 3 had stated that she had seen Mrs Thompson leave the trolley, and Witness 6 had identified Mrs Thompson on the shift. Furthermore, both witnesses had stated that the trolley was left unattended and unlocked.

The panel also had regard to the fact-finding interview with Mrs Thompson on 31 August 2022, which states:

> '[Witness 3] *stated that during an emergency, Susan Thompson had left the medication trolley "wide open" in the corridor. Susan Thompson states she "cannot recall" doing this, but accepts it is possible.'*

The panel took into account that Mrs Thompson had accepted that it was possible that she could have left the medication trolley unattended and unlocked. It heard no evidence which undermined the witnesses accounts, both of which confirmed the medicine trolley was left unattended and unlocked. The panel was satisfied from the evidence before it that Mrs Thomson was the nurse who had left the medicine trolley unattended and unlocked. It therefore found these charges proved.

Charge 20

> 20) On one or more occasion on unknown dates administered lorazepam to Resident D, without clinical justification.

This charge is found NOT proved.

In considering this charge the panel had regard to the statement of Witness 5 which states:

> *'17. I had concerns that Sue would over administer lorazepam medication to Resident D. To be clear, Resident D was prescribed lorazepam. However it was only required to be given when needed. Resident D suffers from dementia so she is loud and vocal. At times, she can be challenging to manage and care for. However, Sue would give Resident D lorazepam when her behaviour was not presenting as challenging to keep her quiet.'*

The panel noted that it was Witness 5's position that Mrs Thompson was administering lorazepam to Resident D when Witness 5 felt it was not necessary. However, the panel noted from resident D's eMAR records that the lorazepam was to be given as and when required, using a nurse's clinical judgement.

The panel also had regard to Witness 2's statement, which states:

> *'53. The only concerns that were raised to me about Sue administering lorazepam when it was not clinically necessary to do so, were in relation to Resident D. Resident D was prescribed 1mg of lorazepam, 0.5 mg to be given up to twice per day as required for agitation and distress. Resident D often became agitated and restless. I produce a copy of Resident D's care plan and risk assessment…'*

The panel had regard to Witness 2's evidence that they had reviewed the medication for Resident D and that Mrs Thompson had not administered more than 1mg, which was within the parameters of the prescription. In Witness 2's view, there was a difference of opinion on the approach between Witness 5 and Mrs Thompson with regard to administering Lorazepam, which was a matter of clinical judgement. The panel heard no evidence which undermined Witness 2's conclusion.

The panel also had regard to Resident D's medication and treatment administration records, and noted that Mrs Thompson had recorded in the notes her reasons for administering Lorazepam to Resident D. The panel could not therefore be satisfied on the evidence that Mrs Thompson had administered lorazepam to Resident D, without clinical justification. It therefore found this charge not proved.

Charge 21

21) On an unknown date, left medication unattended on Resident I's bedside table.

This charge is found NOT proved.

In considering this charge, the panel had regard to the witness statement of Witness 7, which states:

'67. I raised numerous concerns to [Witness 2] *via email on 15 August 2022. I produce a copy of the email…Within the email, I mentioned that there was a bottle of medication left unattended on a resident's bedside table. This involved*

Resident I. However, I cannot recall the date of the incident or which medication was left on her bedside table. Therefore, I am unable to comment on the clinical risks associated with this concern.'

The panel noted the indirect evidence of Witness 7. It further noted that the email referred to in the statement made no reference to Resident I.

The panel considered that there was no direct evidence in support of this charge and the indirect evidence provided was very vague. It was of the view that there was insufficient evidence before it to support this charge. It therefore found this charge not proved.

Charge 22

22) On an unknown date took Resident L's insulin pen home.

This charge is found proved.

In considering this charge, the panel had regard to the statement of Witness 7 and Witness 5, which respectively state:

'There was also no insulin pen for Resident L (it transpired that Sue had taken it home with her). Resident L was prescribed insulin at 08:00 am but it was administered at 13:00 pm after staff went to Sue's house without success and contacted her next of kin who returned the insulin pen. There was no harm caused as I monitored the residents blood sugar levels every two hours and they remained at a safe level. However, there was the risk that the resident's blood sugar levels

could have spiked to a dangerous level which could have caused temporary discomfort; including feeling very thirsty, feeling sleepy and weak and having blurred vision. Very high blood sugar levels can also cause permanent injury to the peripheral nerves and eyes. Psychologically, any such discomfort would have been difficult for Resident L as she had severe learning disabilities and as a result we could not keep her apprised of the situation. Resident L also had to have her blood sugar levels tested several times instead of just the once which was not a nice experience for her.'

And

'25. 0n the same day, Sue took home a residents insulin pen. I cannot recall the name of the resident. However, one of the staff members had to attend Sue's home and retrieve the resident's insulin pen. I cannot recall the name of the staff member.'

The panel noted that both witnesses had given evidence that Mrs Thompson had gone home with Resident L's pen, and that someone had to attend Sue's home to retrieve it.

The panel had regard to Witness 5's evidence that Mrs Thompson [PRIVATE] at the time.

The panel accepted the evidence of both Witness 7 and Witness 5, noting that their oral evidence was consistent with their written statements and also supported each other's recall of events. The panel therefore found this charge proved. However, it acknowledged that on the day Mrs Thompson went home with the insulin pen she was reported to be [PRIVATE] and had been sent home early from her shift.

Charge 23

23) [PRIVATE]

f) [PRIVATE]
g) [PRIVATE]
h) [PRIVATE]
i) [PRIVATE]
j) [PRIVATE

These charges are found proved.

In considering these charges the panel had regard to the statements of Witness 1, Witness 3, Witness 2, Witness 4, Witness 5, Witness 7 and Person 1, which respectively state:

Witness 1

'11. [PRIVATE]*.'*

Witness 3

'14. [PRIVATE]'.

Witness 2

'[PRIVATE]*.'*

Witness 4

‘5. [PRIVATE].

6. [PRIVATE]’

Witness 5

‘23. [PRIVATE]*.’*

Witness 7

‘87. [PRIVATE]*.*

88. … [PRIVATE]

89. [PRIVATE]*.’*

Person 1

7. [PRIVATE]*.’*

The panel noted that there were several witnesses who had reported that they had seen Mrs Thompson [PRIVATE]. The panel also took into consideration that one of the witnesses was [PRIVATE] of a resident, who had felt the need to report her concern for the safety of [PRIVATE].

In oral evidence the witnesses all confirmed, and the panel accepted that, whilst working at the Home, Mrs Thompson sometimes displayed strange behaviour. In oral evidence some of the witnesses also gave evidence that Mrs Thompson [PRIVATE]. These concerns seemed to be long standing and to have occurred at times throughout the period Mrs Thompson had worked with the various witness.

The panel noted that there had been concerns expressed on some occasions that some of Mrs Thompson's behaviours may have been the result of [PRIVATE]. The panel noted that none of the witnesses [PRIVATE], and that at no point did any of the witnesses provide evidence of Mrs Thompson [PRIVATE]. There was insufficient evidence for the panel to be able to make any finding as to the cause of the behaviours described. However, those behaviours, and evidence from various witnesses about Mrs Thompson reporting episodes of [PRIVATE], were sufficient for the panel to be able to infer that there were some days when Mrs Thompson was [PRIVATE] whilst at work.

Moreover, it appeared from the evidence referred to above that some of those days of [PRIVATE] coincided with days when clinical incidents referred to in other charges took place. It therefore appeared that at times Mrs Thompson's [PRIVATE] on her clinical practice. On at least one occasion, Mrs Thompson acknowledged in interview that she may have come back to work too soon after a period [PRIVATE]. The incidents described in the charges in this case include clinical errors and errors of judgement which had the potential to cause harm to residents. On the balance of probabilities, the panel therefore found that on one or more occasions Mrs Thompson attended work when, for reasons of [PRIVATE], she was unfit to practise safely. It therefore found charge 23 proved in its entirety.

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 Thompson'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 ability to practise kindly, safely and professionally.

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 Thompson'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.'*

Mr Radley provided the panel with written and oral submissions. He referred the panel to *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin). Mr Radley 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.

Mr Radley submitted that based on the actions on the facts proven, there are question marks over Mrs Thompson's practice and behaviour:

> *'The actions reported and found proven are failings directly related to the care of Residents/ Patients and the management of patients/clients who are vulnerable in life through age and health.*
>
> *In addition, her relations with other staff is clearly lacking professional understanding and bearing in mind charge 7c where she lied to colleague Witness 6 regarding GP approval.*
>
> *The actions proven against the Registrants* [sic] *are not simply breaches of a local disciplinary policy or minor concerns, they are matters at the heart of and fundamental to the professional's practice, for example;*
>
> a. *Integrity based on the proven charges of dishonesty (Dishonesty charges – 4, 6 and 8)*
>
> b. *Medications management and safety'*

Mr Radley invited the panel, in determining seriousness, to consider the NMC guidance (FtP-3) and provided the following written submissions:

> *'The NMC say these are serious concerns at the heart of a caring profession.*
>
> *a. compassion - the assessment of Resident B's injuries*
>
> *b. Drama queen – language being used to a patient*
>
> *They can be described as serious professional misconduct because these issues relate to the nurses, role as a registered professional (A senior Nurse in a care home setting) and the impact on their area of practice, such as Dishonesty/inadequate record keeping which could affect patient care and the nursing teams of the individual resident, the lack of proper cooperation with the Governing body.*
>
> *Considering Seriousness: - the panel will be aware that seriousness is an important concept which informs various stages of our regulatory processes. The public's trust and confidence in all nurses, demonstrating the behaviour found by the Panel here must, we assert, amount to serious professional misconduct.*
>
> *a. The public expect honest practice from their nurses*
>
> *b. There is a lack of candour*
>
> *Contextual factors: - When considering seriousness of the misconduct, you must take into account of evidence of any relevant contextual factors.*

It may be that some consideration is given to the, somewhat unusual behaviour exhibited by 'SJT'? (Judgement pages 89 et seq). Regrettably there is no evidence to help the Panel with what in fact the problems were E.G.

a. [PRIVATE]

It is a fact that this took place during COVID with the effect that agency staff could not be appointed. Witnesses, [Witness 2/Colleague Y] *and* [Witness 7] *confirmed this to be the case.*

The workload was manageable albeit obviously busy.'

Mr Radley identified the specific relevant standards of the Code within his written submissions where he submitted that Mrs Thompson's actions amounted to misconduct.

Mr Radley provided the following written submissions:

'The Panel will in the case of 'SJT', no doubt, pay particularly attention to;

- *The period of time that the misconduct took place over,*
- *The potential serious outcome of the misconduct (E.g. – vulnerable elderly patients [patient B's fall])*
- *The lack of professionalism in the behaviour towards other staff E.G* [Resident] *G care assistant* [Witness 5]
- *The failure to follow up incidents and displaying an uncaring and laissez-faire attitude towards her patients*

- *The Lack of engagement with staff effectively*
- *The lack of legitimate documentation, notes and rational for the decisions.*

These factors can have a serious effect on patient trust and confidence in the Nursing profession, especially in the case of the vulnerable patients being dealt with here. This, we say, underpins the need to identify this behaviour as serious misconduct in the case of the Registrant'

Submissions on impairment

Mr Radley 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. The panel had regard to the NMC guidance which states, *'the question that will help decide whether a professional's fitness to practise is impaired is: Can the nurse, midwife, or nursing associate practise safely, kindly and professionally'.* 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).

Mr Radley provided written submissions and referred the panel to the four factors set out by Dame Janet Smith in her fifth report to the Shipman inquiry:

'Do our findings of fact in respect of the [nurse'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 professions 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 professions; and/or*

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

Mr Radley submitted that all four limbs of *Grant* are engaged. He submitted:

'A decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that's relevant is considered. It is dependent on the individual circumstances surrounding each concern found by the panel.

The panel will no doubt ask themselves if any part of the CODE has been breached or is liable to be breached in the future. Any breach would be considered alongside other relevant factors.

The NMC refer the panel to the earlier concerns on the breaches of the CODE contained within the Misconduct representations.

The NMC say that the [breaches] *of the Code involves breaching a fundamental tenet of the profession and the Panel would be entitled to conclude that a finding of impairment is required in the case of 'SJT'.*

The finding of impairment, the NMC say, is required to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour (Yeong v GMC [2009] EWHC 1923 (Admin) [Hamer para 37.09].

The Fitness to Practise Panel will consider the context in which things have happened. Here the panel will be asked to consider, amongst many other aspects.

- *Any factors relating to the professional existing at the time of the charges. We have not been told of any by the Registrant. The Panel note the comments of the witnesses*
- *The professional's working environment and culture. It was COVID and agency staff could not be employed (*[Witness 7]*)*
- *The lack of cooperation with the Governing Body.*
- *The threatening manner to other staff*

The NMC say that these features, and any others within the case, do substantially adversely affected the professional's ability to practice professionally and as a consequence the professional will not be able to demonstrate that they are currently able to practise kindly, safely and professionally.

The third area of context is the learning, insight and steps the professional has taken to strengthen their practice. Here the professional has provided no evidence or involvement, in the process and no engagement in the hearing. She has not provided;

a. *Reflective piece*

b. *Learning to address the charges*

c. *Witness support*

d. [PRIVATE]

e. *Portfolio evidence of training*

f. *No evidence of risks being addressed*

The Registrant entered no plea so was taken to have denied the allegations causing the witnesses to attend to give evidence.

Whether it is likely that the conduct will be repeated is a concern for the NMC. This will impact on the professional's ability to practise kindly, safely, and professionally, resulting in the NMC, suggest a finding of impairment.

The consequences of the professional's conduct risked the patients trust and confidence and is very serious especially in areas of catheterisation, dishonesty etc

For these reasons the NMC say that the Registrant's fitness to practice is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *R (on the Application of Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin), *Nandi v General Medical Council*, and *Calheam v General Medical Council.*

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 Mrs Thompson's actions amounted to breaches of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 Treat people with kindness, respect and compassion.*
> *1.2 Make sure you deliver the fundamentals of care effectively.*
> *1.5 Respect and uphold people's human rights.*
>
> ***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.*

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

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

4 Act in the best interests of people at all times

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 Maintain the knowledge and skills you need for safe and effective practice.

8 Work co-operatively

To achieve this, you must:

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

8.2 Maintain effective communication with colleagues.

8.5 Work with colleagues to preserve the safety of those receiving care.

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

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

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 Take all steps to keep medicines stored securely.

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

To achieve this, you must:

19.4 Take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 Keep to and uphold the standards and values set out in the Code.

20.2 Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered each of the proven charges (or, where appropriate, groups of charges or sub-charges) in turn and reached the following findings:

Charge 1(a)

The panel had regard to its earlier finding that, although the facts alleged in the charge were technically proved, there was no requirement in the circumstances for Mrs Thompson to record the fall. This was because there was insufficient evidence for the panel to be satisfied that Mrs Thompson was made aware of the fall on the day it happened. The panel therefore considered that the matters found proved in relation to this charge were not sufficient to amount to misconduct.

Charge 1(b)

For the same reasons as set out in relation to charge 1(a), the panel considered that Mrs Thompson's actions in not seeking appropriate medical advice and/or attention were not sufficient to amount to misconduct in the circumstances.

Charge 1(c)

For the same reasons as set out in relation to charge 1(a), the panel considered that Mrs Thompson's actions in not escalating Resident C's injuries and/or mobility in a timely manner were not sufficient to amount to misconduct in the circumstances.

Charge 2(a)

The panel had regard to its earlier findings. It noted that Mrs Thompson had left medication unattended in a Resident's room, and that she had later acknowledged that she was aware that she should not have done this. However, the medication appears to have been left for only a short period of time while Mrs Thompson went out to collect an additional medication which was required for the Resident. Resident C's [PRIVATE] was present for at least some of that time.

The panel considered that this was an isolated incident of poor medications management practice which, on its own, did not represent a sufficiently serious departure from expected standards to amount to misconduct.

Charge 3(a)

The panel bore in mind that Mrs Thompson had originally identified a bump to Resident D's head after her fall. The Home's policy therefore required her to seek medical advice and/or attention and/or an ambulance. The panel considered that having identified an injury, the omissions in charge 3(a) amounted to a failure to follow clear policy following a fall, and a significant departure from required standards. The panel concluded that this was a sufficiently serious departure to amount to misconduct in the circumstances.

Charge 3(b)

The fact that Resident D was on anticoagulant medication was a potentially significant factor in assessing risk after she had a fall and sustained a bump to the head. The panel noted that it appeared from what Mrs Thompson said at the time of the incident that she did not know that aspirin was classed as an anticoagulant. However, the panel considered that this was basic knowledge and that Mrs Thomas should have known or made herself aware if she was unsure. The panel considered that this represented a sufficiently serious departure from required standards to amount to misconduct.

Charges 3(c) (i), (ii), (iii) and 4

The panel considered these charges together because they were inextricably linked facets of the same wrongdoing, and the dishonesty was a significantly aggravating feature of the inaccurate recording. It bore in mind that it had found charge 3(c)(iv) not proved.

The panel noted that Mrs Thompson had completed three different documents which inaccurately represented whether or not Resident D had suffered an injury in the fall. In two of those cases, she had gone back and amended or rewritten the original documents so that they said the opposite of what she had first recorded. The panel was mindful that inaccurate documentation has the potential to impact on subsequent care and is therefore always potentially serious. In this case, however, it was compounded by the fact that the panel has found that Mrs Thompson's actions were deliberate and dishonest, and that she had deliberately altered documents which had originally recorded the presence of a bump to the head to say, inaccurately, that there was no injury.

The panel was mindful that it had found at the previous stage that it was likely that the reason Mrs Thompson acted as she did was because, after being spoken to about the incident by Witness 2, she did not want to get into trouble for failing to take appropriate steps after the accident and was therefore seeking to conceal that there had been an injury.

The panel noted its earlier findings that Mrs Thompson appeared to [PRIVATE] at the time, and that inference was supported by the [PRIVATE] her actions at the time, including her failure to amend the entry in the resident's daily care record, which still showed that there was an injury. The panel considered that her actions may have stemmed from poor judgment and chaotic decision-making. However dishonest clinical record-keeping with the intent of concealing her own failure to follow procedure was nevertheless a serious departure from standards, with the potential to cause harm in terms of ongoing care. The panel considered that this was a sufficiently serious departure to amount to misconduct.

Charges 5 and 6

For the same reason as for charges 3(c) and 4, the panel considered these charges together. The wrongdoing in charges 5 and 6 were very similar to the previous pair of charges, in that they involved Mrs Thompson deliberately and dishonestly providing colleagues (in this case the Home Manager Witness 2) with inaccurate and dishonest information about whether or not Resident D had sustained injuries in her fall, in order to conceal the fact of the injury so that she would not be criticised for failing to take inappropriate action in response to the fall. Again, the panel considered that this was a sufficiently serious departure from standards to amount to misconduct.

Charge 7(a) (ii) and (iii)

In relation to this charge, the panel noted that it had found sub-charges (i), (ii) and (v) not proved and sub-charge (vi) proved in respect of recording only. It was mindful that it had found that there was clinical justification for Mrs Thompson's decision to insert a catheter and that this was within the scope of her legitimate clinical judgment and practice as a nurse.

The proven allegations in relation to charges 7(a)(iii) and (iv) amounted to a failure to follow appropriate *'best interests decision-making'* procedure by not seeking advice and/or consent from the Multi-disciplinary Team and/or from Resident A or [PRIVATE] prior to inserting the catheter. The panel considered that the requirements set out in the policy were clear and were there in order to protect vulnerable residents from any harm or distress associated with clinical interventions such as this one.

Although the decision to insert a catheter was within the scope of Mrs Thompson's clinical judgment, she was still required to consult in accordance with the policy before she went

ahead with the procedure and failed to do so. The panel considered that this was a significant departure from what was required of her and resulted in an incident which caused distress to the resident. While Mrs Thompson may well have been seeking to help the patient, she had gone about it in the wrong way, and the panel considered that in the circumstances her actions and omissions were sufficiently serious to amount to misconduct.

Charge 7(a)(vi)

This sub-charge related to not completing a fluid output chart to provide a formal record of any monitoring of output. The panel noted its finding at the previous stage that there was no evidence to suggest that the output was not in fact monitored, simply that the outcome was not recorded. The panel considered that this could be regarded as an isolated oversight on the part of Mrs Thompson which, taken on its own, was not sufficiently serious to amount to misconduct.

Charge 7(b)(ii)

The panel noted that sub-charge (b)(i) was not proved. The sub charge which was proved related to Mrs Thompson not providing reassurance to Resident A during the procedure to insert the catheter. The panel was mindful of its finding that Mrs Thompson was occupied with undertaking the catheterisation and that there were two healthcare assistants present who were providing reassurance to Resident A. It had found the charge proved on a purely factual or technical basis. In the circumstances, the panel did not consider that this matter represented a sufficiently serious departure from standards to amount to misconduct.

Charge 7(c) and 8

The panel noted its earlier finding that Mrs Thompson had not sought or obtained permission from Resident A's GP prior to the catheterisation but had inaccurately informed Colleague X/Witness 6 that she had that permission. The panel had concluded that Mrs Thompson's actions were dishonest because she knew she did not have permission. As with the earlier dishonesty charges, the panel considered that the dishonesty finding was so intrinsically linked with the finding of an inaccurate assertion that it was appropriate to consider these charges together, with the dishonesty found proved in charge 8 being an aggravating feature of the misrepresentation in charge 7(c).
The panel considered that Mrs Thompson's actions, in deliberately stating that the GP had given permission for the procedure, had the purpose and effect of making a junior colleague think that it was appropriate to continue with the catheterisation, when in doing so Mrs Thompson was in breach of the Home's policy. The panel considered that this represented a serious departure from required standards and was sufficiently serious to amount to misconduct.

Charge 9

The panel noted that the failure to remove the old buprenorphine patch before applying the new one was a breach of the Home's medications management policy. However Resident H did not suffer any ill-effects, and the evidence before the panel was that the patch required replacement after being in place for a certain period, because it would lose its efficacy after that time. Whilst it was not good practice to leave it in place as it was a failure to adhere to policy, the panel did not consider that it represented sufficiently poor

practice to represent a significant departure from required standards. The panel concluded that this charge did not amount to misconduct in the circumstances.

Charge 10

The panel considered that charge 10, taken as a whole, represented different facets of the same incident. The panel's findings in respect of each separate sub-charge are set out below. However, it noted that various mitigating features applied in relation to the entire incident. Mrs Thompson had acted appropriately by contacting the doctor to seek a change of prescription when Resident B had an adverse reaction. She had obtained a verbal instruction to discontinue the medication and had recorded that instruction in a number of places, including Resident B's care plan and multidisciplinary record. She also omitted the medication that day and the following day. Again, that was appropriate. What Mrs Thomas failed to do, which was required by the Home's Management of Medication Policy, was to update the eMAR system pending receipt of the GP's written instruction. That is the failing found proved in relation to charge 10(b)(ii).

It appears that it was that failure which may have contributed to subsequent failures found proved in relation to charge 10(a) and 10(c). It appears that there was a delay in the GP's written instruction reaching the Home, or that when it arrived it was not actioned (potentially by other people: there is no clear evidence about when it arrived or who received it). Mrs Thompson had a few days of leave, and on her return, found that the instructions had still not been received, so continued to administer the medication on three occasions the following week (10(c)). She also incorrectly completed an order sheet for further supplies of the medication (10(a)).

Charge 10(a)

The panel noted that the policy is clear that changes to prescriptions cannot be implemented until the written instruction from the prescriber is received. In the circumstances set out above, the panel considered it understandable that, having been on leave in the intervening period, Mrs Thompson had overlooked the instruction on her return from leave and inadvertently ordered more of the medication. It appeared that nobody else had taken appropriate steps to follow up the matter with the GP in her absence. In the circumstances, the panel considered that this departure from required standards appeared to be an isolated lapse which was not sufficiently serious to be characterised as misconduct.

Charge 10(b)

Similarly, and for similar reasons, the panel considered that although, technically, Mrs Thompson should have updated the eMAR system, it was understandable that she had not done so pending receipt of the written instruction from the GP which she had understood would be sent. She had made notes of the verbal instruction elsewhere which it appears nobody else had followed up. Again, the panel did not consider that this failure could be characterised as sufficiently serious to amount to misconduct in the circumstances.

Charge 10(c)

The panel noted its earlier finding that it was debatable whether Mrs Thompson's actions in administering the medication on the three further occasions could be said to be

"incorrect" in the circumstances, and that it had found charge 10(c) proved only as a matter of fact. For similar reasons as in relation to charges 10(a) and 10(b), the panel found that Mrs Thompson's actions in relation to this charge did not represent a sufficiently serious departure from standards to amount to misconduct.

Charges 11(a) and (b)

The panel noted that these charges involved an inadvertent underdose of medication to a single resident on two consecutive shifts, and that it was a mistake which had been made by other nurses at the Home on other occasions. The medication was not omitted altogether. The panel was mindful that it found the charges proved on a purely factual basis. It considered that these medication errors were not sufficiently serious to amount to misconduct in the circumstances.

Charges 12(a) and (b)

The panel noted that these charges involved an inadvertent underdose of medication to a single resident on two consecutive shifts, on the same dates, for the same resident and on the same medication round as those for charge 11. Again, the panel noted that it was a mistake which had been made by other nurses at the Home on other occasions. The medication was not omitted altogether. The panel was mindful that it found the charges proved on a purely factual basis. Again, it considered that these medication errors were not sufficiently serious to amount to misconduct in the circumstances.

Charge 13

This was a single incident of instructing a care assistant colleague to shower a resident alone. The instruction to have two carers was included in this resident's care plan because of violent and aggressive behaviour which the resident sometimes displayed towards people providing care. In these circumstances, Mrs Thompson's instruction had the potential to put both Colleague W/Witness 4 and Resident F at risk of harm. It was a breach of policy and a significant departure from required standards. The panel considered that Mrs Thompson's actions in relation to this charge were sufficiently serious to amount to misconduct.

Charge 15(a) and (b)

These charges involved an accidental overdose of a single medication to a single resident during the medication round on two consecutive shifts. The panel had regard to its finding that another nurse had made the same mistake during the evening medication round on both days. The panel noted that the medication in question was to help regulate urinary output and there was no evidence that the inadvertent overdose would have risked causing any significant harm. It considered that, whilst not representing good medication administration practice, these isolated medication errors were not sufficiently serious to amount to misconduct in the circumstances.

Charge 16(a)

The real mischief of this charge, in the view of the panel was 16(a). When she was alerted to the fact that Resident G was not responsive, the appropriate steps to take would be those set out in the Home's policy and listed in charge 16(c) (which was found not

proved). Instead, Mrs Thompson shook Resident G using a degree of force which was excessive in the circumstances, after which the resident responded.

The panel considered that Mrs Thompson's actions in this charge represented a serious departure from required standards. It noted that a junior colleague who was present had been distressed by the incident and had been noted to leave the room looking distressed. Resident G was an elderly and vulnerable resident and Mrs Thompson had used excessive force to rouse her, which did not respect her dignity or represent kind or compassionate treatment. The panel considered that this represented a sufficiently serious departure from standards to amount to misconduct.

Charge 16(b)

The panel had regard to its earlier finding that after rousing Resident G, Mrs Thompson then also failed to undertake or record any observations of Resident G. This was a serious omission in circumstances where a vulnerable resident had been found non-responsive. The Home's policy, and basic good nursing practice, required Mrs Thompson to make and keep a formal record of observations of the resident's condition to monitor any signs of deterioration in her health or condition. The panel considered that this represented a sufficiently serious departure from required standards to amount to misconduct.

Charge 17

The panel considered that the proven charges 17(b), (c), (d), (e) and (f) all represented different facets of a failure to take appropriate steps when attending a resident who had fallen. All of them occurred in a context where Resident B was screaming with pain

throughout Mrs Thompson's interventions following the fall. On Mrs Thompson's own account after the incident Resident B would not allow her to examine her left leg at all. Other accounts record that Resident B was complaining of a bump to the head and was unable to bear weight on her left leg. The panel considered each of the proven sub charges in turn.

Charge 17(b)

The panel noted its earlier finding that Mrs Thompson manipulated Resident B's leg inappropriately. Whilst her intention may have been to conduct an examination, her actions were in breach of policy and she appears to have ignored the presentation and reaction of the resident to her interventions. It appears that her actions were causing the resident further pain and distress. The panel considered that this represented a serious departure from expected standards and was sufficiently serious to amount to misconduct.

Charge 17(c)

Mrs Thompson then, with a colleague, lifted Resident B into a chair without using a hoist. It was clear from the Home's policy that it was inappropriate to try to move Resident B at all in the circumstances, still less without the assistance of a hoist (which was required by the resident's care plan). Mrs Thompson's actions were again in breach of policy and she appears to have ignored the resident's screams of pain. The panel considered that this represented a sufficiently serious departure from required standards to amount to misconduct.

Charge 17(d)

The panel considered that by using words to the effect of those found proved in charge 17(d)(i) and/or (ii), Mrs Thompson was dismissive of Resident B's screams of pain. Her use of those words was not kind, appropriate or professional, and failed to respect the resident's dignity. The panel considered that this amounted to a sufficiently serious departure from required standards to amount to misconduct.

Charge 17(e)

Given that Resident B had had a fall and was complaining of a bump to the head, the panel considered that Mrs Thompson should, as a matter of both policy and common sense, assessed the resident's head for injuries. Her failure to do so put a vulnerable resident at risk of harm from unobserved and undocumented head injuries. The panel considered that this represented a sufficiently serious departure from required standards to amount to misconduct in the circumstances.

Charge 17(f)

The panel was mindful of its finding at the previous stage that:

> '*In circumstances where, on Mrs Thompson's own account, Resident B could not straighten her legs and would not let Mrs Thompson examine her left leg, and where (on the account of other witnesses present) Resident B was screaming in pain and complaining of a bump to her head, the panel was satisfied that Mrs Thompson should have suspected an injury…'*

In circumstances where she suspected, or should have suspected, the presence of an injury, the Home's policy was clear that she was required to seek medical advice and/or attention, and/or call 111 services and/or an ambulance. Again, the failure to do so, put Resident B at risk of harm from unobserved and undocumented injuries. The panel considered that this was a sufficiently serious departure from required standards to amount to misconduct.

Charge 19(c)

This incident involved a single incident of leaving a medication trolley unattended and unlocked in the corridor when Mrs Thompson was called away during her medication round. The panel noted that because the trolley was both unattended and unlocked, there was a risk that vulnerable residents, some of whom may not have had capacity, may have had access to medication which could cause them harm. The panel considered that this represented a sufficiently serious departure from good medications management practice that it amounted to misconduct.

Charge 22

The panel was mindful of its finding that on the day when Mrs Thompson inadvertently went home with Resident L's insulin pen, she was reported [PRIVATE] and was sent home. The pen was subsequently retrieved from her home. The panel heard no evidence to suggest that this was anything other than inadvertence or oversight on the part of Mrs Thompson. In the context of [PRIVATE] on this isolated occasion, the panel considered that her actions could not be characterised as being sufficiently serious to amount to misconduct.

Charge 23

The panel was mindful of its findings that there appeared to be numerous occasions when Mrs Thompson reported [PRIVATE] or displayed behaviours (itemised at sub-charges 23(a) to (e)) which her colleagues considered *"strange"* and which led them to believe that she [PRIVATE]. On at least one occasion she accepted that she had returned too soon from [PRIVATE]. The panel was mindful that it found that on one or more occasions, days when Mrs Thompson appeared to be [PRIVATE] seemed to have coincided with clinical incidents referred to in these charges, with potential consequences for patient harm.

The panel considered very carefully whether and to what extent Mrs Thompson could be criticised for her conduct in relation to this charge. Although no medical evidence was placed before the panel, it noted that Mrs Thompson clearly appears, according to numerous witnesses, to have had [PRIVATE] issues, which do not appear to have been well-managed. That could not be fairly described as being her fault, neither was there any evidence to suggest that she was not taking appropriate steps to address or manage [PRIVATE]. The panel was concerned that, without having any evidence about the nature of [PRIVATE], it was difficult to assess the extent to which she could reasonably be expected to have insight into them or their potential impact on her ability to practise safely.

The panel further noted that there was some evidence to suggest that Mrs Thompson may have felt under pressure to continue to come to work. Many of the incidents in this case took place during a period in which restrictions were in place as a result of the COVID-19 pandemic, and there was evidence that the Home had not been able to secure agency staff to cover shifts when members of permanent staff were on sick leave. Witness 2 said

that Mrs Thompson made it clear that she did not want to let him down, and evidence from Witness 7 suggested that Witness 2 may have expressed some reluctance to address concerns raised with him about [PRIVATE].

Nevertheless, the panel noted that Mrs Thompson told colleagues on a number of occasions over a significant period of time that she was [PRIVATE]. She accepted during the Home's investigation that on at least one occasion she had returned too soon from [PRIVATE]. It appears that she had some awareness that she was [PRIVATE], and the panel considered that she should have considered whether [PRIVATE] were impacting on her judgment and decision-making to an extent where they presented a risk of harm to residents in her care, as they appear to have done on one or more occasions.
The panel's view was that, had Mrs Thompson considered the issue, she would have realised that, on some occasions, she was not fit to practise safely. The panel therefore concluded that, although [PRIVATE] were a significantly mitigating feature of this case, Mrs Thompson's actions, in attending work when she was not fit to practise safely on one or more occasions, did represent a significantly serious departure from required standards that they amounted to misconduct.

Charges 2, 11, 12 and 15 viewed cumulatively

Finally, the panel noted that there were several proven charges in relation to medication management and/or administration errors which it had found individually to be insufficiently serious to amount to misconduct. It next considered those charges cumulatively to consider whether or not, taken together, they represented a pattern which crossed the threshold of misconduct.

The panel noted that charge 2 was of a different character to 11, 12 and 15, in that it related to management of medications rather than medication administration errors. In relation to charges 11 and 12, the panel noted that these took place over a period of 2 days in June 2022, and related to errors by underdosing a single patient with two different medications on the medication rounds on those two consecutive days. Charge 15 related to an erroneous overdose of medication to a single patient on two medication rounds on consecutive days in July 2022.

The panel considered that these incidents, viewed cumulatively, represented a handful of medication administration errors on a handful of days within a relatively short period of time. In respect of each of the medications in question, the panel had noted exactly the same mistakes being made in respect of the same medications and residents by other nurses at around the same time. Mrs Thompson's errors did not appear to form a pattern of wider medication administration errors or poor medication practice over a protracted period. The panel did not consider that, even viewed cumulatively, these incidents were sufficiently serious to meet the threshold of misconduct.

Summary of the panel's conclusions in relation to misconduct

The panel found that the following proven charges did NOT amount to misconduct:

Charges 1(a) (in its entirety), 1(b) (in its entirety), 1(c), 2(a), 7(a)(vi), 7(b)(ii), 9, 10(a), 10(b)(ii), 10(c), 11 (in its entirety), 12 (in its entirety), 14 (in its entirety), 15 (in its entirety), 22.

The panel found that the matters found proved in respect of each of the following charges fell seriously short of the conduct and standards expected of a nurse and each amounted, individually, to misconduct:

Charges 3(a) (in its entirety), 3(b), 3(c) and 4 (taken together), 5 and 6 (taken together), 7(a)(iii) and (iv) (taken together), 7(c) and 8 (taken together), 13, 16(a), 16(b), 17(b) (in its entirety), 17(c), 17(d), 17(e), 17(f) (in its entirety), 19(c) (in its entirety) and 23 (in its entirety).

The panel then went on to consider whether Mrs Thompson's fitness to practise is currently impaired by reasons of the matters which it found amounted to misconduct. It considered that the misconduct it had found proved could be summarised as follows:

- Failure to take appropriate action following a fall in respect of Residents D (February 2022) and B (August 2022).
- Incorrect entry in clinical records (February 2022).
- Failure to take appropriate steps prior to catheterisation in respect of Resident A (April 2022) and in response to Resident G being unresponsive (July 2022).
- Three instances of dishonest clinical record-keeping and/or dishonest oral misrepresentations in respect of Residents D (February 2022) and A (April 2022) in order to conceal from colleagues a failure to follow appropriate procedures.
- Inappropriate instruction in breach of care plan for Resident F (July 2022).
- Inappropriate force in respect of Resident G (July 2022).
- Inappropriate manipulation in respect of Resident B (August 2022).
- Poor medication management practice on a single occasion (August 2022).

- Attending work whilst unfit to practise safely (one or more occasion, unknown dates).

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel found all limbs of *Grant* engaged in respect of the past. In addressing limb a) Mrs Thompson's actions placed residents at unwarranted risk of harm. On some occasions**,** Residents were caused actual physical and emotional harm. Further, in relation to limb b), the panel took the view that given the seriousness of some of the charges found proved, Mrs Thompson's actions brought the profession into disrepute. A member of the public and her fellow colleagues would have been appalled to learn that Mrs Thompson called residents under her care a *'drama queen'* and caused them physical and emotional pain. In addressing limb c) the panel found that Mrs Thompson breached the fundamental tenets of the nursing profession in that she failed to provide basic nursing care and failed to respect residents' dignity. Lastly, in addressing limb d), the panel found that Mrs Thompson has acted dishonestly.

The panel went on to consider whether Mrs Thompson was liable in the future to place patients at risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession and act dishonestly. The panel determined that in the absence of any information from Mrs Thompson to demonstrate her insight, remorse and remediation, there was a risk of repetition and the limbs of Grant are therefore also engaged in respect of the future.

The panel considered the principles derived from *Cohen*:

- Whether the concern is easily remediable;
- Whether it has in fact been remedied; and
- Whether it is highly unlikely to be repeated.

In considering whether the concern is easily remediable, the panel took into account the nature and seriousness of the charges found proved. It noted that some of the charges found proved are directly linked to Mrs Thompson's clinical practice, and therefore are in theory capable of being remedied. In terms of the dishonesty element, the panel acknowledged that dishonesty is always a serious matter and may be difficult to put right. However, the panel took the view that the dishonesty in Mrs Thompson's case is towards the lower end of the spectrum in that she appears to have panicked and acted spontaneously in an attempt to conceal her errors. It seems that she may also have been suffering from [PRIVATE] matters which affected her decision making and her judgment. However, whilst the panel found that Mrs Thompson's [PRIVATE] are likely to have had an impact in her judgment and decision making, there is not enough information to say how much of the impact it has had and no information to show that she has taken steps to address those [PRIVATE] issues.

The panel next considered whether the misconduct in this case has been remedied. The panel considered the responses from Mrs Thompson during the initial local investigation and noted that she was given opportunities to address the matters put before her. At that stage she demonstrated only very limited insight or remorse, and the panel had no evidence of subsequent reflection, insight or remorse.

The panel went on to consider whether Mrs Thompson's actions are highly unlikely to be repeated. The panel is of the view that there is a risk of repetition given that there is insufficient evidence to indicate that Mrs Thompson has taken steps to address the misconduct in this case or to strengthen her practice. 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 on wider public interest grounds. It noted that the proven charges and misconduct identified in this case are serious and include dishonesty. It considered that a fully informed member of the public would be appalled, and that public confidence in the nursing profession would be undermined, if a finding of impairment was not made

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Thompson off the register. The effect of this order is that the NMC register will show that Mrs Thompson has been struck-off the register.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley informed the panel that in the Notice of Hearing, dated 12 December 2024, the NMC advised Mrs Thompson that it would seek the imposition of a striking off order if it found Mrs Thompson's fitness to practise currently impaired.

Mr Radley provided the panel with oral and written submissions. He invited the panel to impose a striking off order. In terms of proportionality, he provided the panel with the aggravating features of this case:

> *'The representations on aggravating factors based on the misconduct findings are;*
>
> 1. *Registered nurses occupy a position of privilege and trust in service. They must maintain professional standards and provide professional service.*
> 2. *The Nurse has displayed a lack of insight into her failings*
> 3. *The impact on the profession is high. The Public would not expect a Nurse to be practicing based on the misconduct.*
> 4. *The four limbs of the Grant test are engaged*
> 5. *Patients/Residents were placed in unwarranted risk of harm/ physical distress (nurse calling a patient a drama queen)*

6. *Breaching fundamental tenets of the Nursing profession*

7. *Lack of understanding of the seriousness of her actions – manipulation of the patient with a fractured hip, impact on the care of a falls patient (dishonestly covering up her actions)!*

8. *Lack of any or relevant up to date training/ references/ reflection or evidence understanding the mischief*

9. *Public interest and public protection are engaged*

10. *Dishonesty on three occasions – Our serious sanctions guidance is clear when it comes to dishonesty of this kind. Considering sanctions for serious cases - The Nursing and Midwifery Council*

11. *"Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore, allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register."*

12. *The aggravating factors here include a direct risk to people in care, a pattern of dishonesty (three occasions), the dishonesty is linked directly to the registrant's clinical practice and there appears to be a deliberate breach of the duty of candour.*

13. *The panel are directed to FTP SAN – 2.*

14. *Would a nurse practicing with the Registrant be able to trust/rely upon the work of her fellow professional.'*

In addressing the mitigating features, Mr Radley submitted:

> *Mitigating features*
>
> *The mitigating features are;*

1. *No previous regulatory or disciplinary findings (as expected)*
2. *Thankfully no direct lasting patient harm*
3. *Age and experience'*

Mr Radley submitted that the most appropriate sanction in this case is a striking off order due to the following:

> *'Striking off:*

- *lack of insight*
- *Dishonesty – Serious Regulatory concern see above.*
- *Poor comments made in front of other staff and patients*
- *Lack of acceptance of the wrong.*
- *Misconduct directly related to patient care'*

Decision and reasons on sanction

Having found Mrs Thompson'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:

- Conduct which caused vulnerable residents actual harm and placed other vulnerable residents at risk of harm.
- Dishonesty took place on more than one occasion.
- Lack of insight into failings.
- Lack of evidence of remorse.

The panel also took into account the following mitigating features:

- On one or more occasions, days when Mrs Thompson appeared to be [PRIVATE] seemed to have coincided with clinical incidents referred to in these charges.
- The incidents took place during COVID-19.
- Evidence with the manager that she was generally a good nurse.

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 Mrs Thompson’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 Thompson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel 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 Thompson's registration would be a sufficient and appropriate response. The panel noted that some of the charges found proved in this case could be addressed by way of conditions of practice as it relates to Mrs Thompson's clinical practice. Furthermore, the panel found that the dishonesty in this case is at the lower end of spectrum. However, given Mrs Thompson's lack of engagement, the panel could not be assured that she would engage with conditions of practice if this was imposed. The panel concluded that the placing of conditions on Mrs Thompson'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 Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*

The panel took into account that on one or more occasions, days when Mrs Thompson appeared to be [PRIVATE] seemed to have coincided with clinical incidents referred to in these charges, with potential consequences for patient harm. Whilst the panel acknowledges that [PRIVATE] may have affected her decision making at the time of the charges found proved, the panel found that her behaviour towards Resident D and G were a serious breach of the fundamental tenets of the profession and is fundamentally incompatible with Mrs Thompson remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Thompson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Thompson's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Thompson in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Thompson's own interests until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that based on the substantive order made by the panel today and the risk identified, he invited the panel to impose an interim suspension order to cover the period of appeal.

Mr Radley submitted that an interim suspension order is necessary on the grounds of public protection and the wider public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the nature and 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 on the grounds of public protection and the wider public interest for the same reasons as the

substantive sanction imposed. The panel also considered that an interim order would cover the period of appeal in the event that Mrs Thompson wishes to make an appeal.

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

That concludes this determination.