Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Meeting
Wednesday, 8 April 2026

Virtual Meeting

Name of Registrant:	**Maria Charito Estrella Poblete**	
NMC PIN:	03G0273O	
Part(s) of the register:	Sub part 1 RN1 Registered Nurse – Adult 04 July 2003	
Relevant Location:	Ards and North Down Borough Council	
Type of case:	Misconduct	
Panel members:	Derek McFaull Katharine Rudd Joanne Morgan	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Oliver Wise	
Hearings Coordinator:	Samara Baboolal	
Order being reviewed:	Conditions of practice order (12 months)	
Fitness to practise:	Impaired	
Outcome:	**Striking-Off order to come into effect on 6 May 2026 in accordance with Article 30(1)**	

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Mrs Poblete's registered email address by secure email on 12 February 2026.

The panel took into account that the Notice of Meeting provided details of the review that the review meeting would be held no sooner than 23 March 2026 and inviting Mrs Poblete to provide any written evidence seven days before this date.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Poblete has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) (the Rules).

Decision and reasons on review of the current order

The panel decided to replace the conditions of practice order with a striking-off order. This order will come into effect at the end of 6 May 2026 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the first review of a substantive conditions of practice order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 2 April 2025.

The current order is due to expire at the end of 6 May 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

> '***Charge 1***

"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:

Did not conduct appropriate reviews and/or ensure that ongoing assessments were undertaken following documentation of a sacral wound in May 2022, as was your responsibility as Deputy Sister."

This charge is found proved.

In reaching its decision the panel took into account contemporaneous documents, such as a written statement from Witness 2 which refers to damage found on Resident A's sacrum/buttocks, care plan 7, the initial wound assessment and the care plan evaluation sheet.

The panel noted that the care plan evaluation sheet shows that on the 5, 7, 9, 11, 13 and 15 May 2022 there are entries in respect of the sacral wound. However, there is no evidence of further entries in this document until 2 October 2022, at which stage treatment is documented as being undertaken on sacral wounds.

From the written and oral evidence from Witness 1 the panel found that there was no ongoing assessment of the wound between 18 May and 1 October 2022. The panel did not find evidence of a closing assessment to state that the wound had healed, nor any ongoing assessments. Given that the entries contained in the repositioning charts show ongoing sacral issues, specifically on four occasions on 12, 15, 18 and 23 July 2022, it expected that would be a review and ongoing assessment within those findings and this has not been documented or presented to the panel. The panel would have expected to see evidence of ongoing assessments of the wound given the finding of a severe sacral wound within the repositioning chart. As the Deputy Sister Ms Poblete should have been aware of the entries in the repositioning charts and ensured appropriate reviews and ongoing assessments were being undertaken, and acted accordingly.

The panel noted that in early September 2022 fellow nurses documented Resident A's sacral wounds on two occasions. However, again there was no ongoing assessment by any staff member, nor any documented review of the wounds. As

Deputy Sister, as previously outlined, it was Ms Poblete's responsibility to conduct the assessments herself or to ensure that a member of staff had done so.

The panel therefore determined that, on the balance of probabilities, charge 1 is found proved.

Charge 2

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Did not ensure that between 18 May 2022 and 1 October 2022 their wound assessment and/or care plan paperwork was updated, as was your responsibility as Deputy Sister."*

This charge is found proved.

In reaching its decision the panel took into account contemporaneous documentation and the evidence before it, in particular, Care Plan 7, the ongoing wound assessment form, the care plan evaluation sheet and the repositioning charts.

The panel found that the initial wound assessment was documented on 3 May 2022 and the last entry in care plan 7 and the care plan evaluation sheet was on 15 May 2022. There were no further entries on these documents after this point. However, during this period the daily repositioning chart documents wounds on Resident A's buttocks and included entries of 'bottom bleeding' during July 2022. On 6 September 2022 'breaks on bottom' were recorded and on 24 September 2022 and a nurse noted '2 breaks' on the bottom in the daily progress sheets. Witness 1 told the panel that these entries in the repositioning charts and progress sheets should have led to further updates of the care plan paperwork and wound assessments.

The repositioning charts contain a number of entries, particularly during July and September, which reveals that members of the health care staff discovered 'breaks on the bottom', bleeding and two sacral wounds.

In light of this, the panel found that in her role as Deputy Sister, Ms Poblete should have carried out the wound assessments and updated both the wound assessments and care plans, or she should have ensured that they were done by another member of staff. The panel had evidence that these tasks were not completed.

The panel therefore determined that, on the balance of probabilities, charge 2 is found proved.

Charge 3

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Did not ensure that a Braden score was completed in July and/or August and/or September 2022, as was your responsibility as Deputy Sister."*

This charge is found proved.

In reaching its decision, the panel took into account the contemporaneous documentation of the Braden score form for Resident A and oral evidence from Witness 1 that this score should have been completed at least monthly. The panel noted the Braden score form contained entries in November 2021, December 2021, January 2022, February 2022, March 2022, May 2022 and 18 June 2022. The next entry was 2 October 2022. This is a clear break in the record between 18 June and 2 October 2022.

Witness 1 stated that it was particularly important that this score should have been undertaken and recorded on at least a monthly basis, given the history of Resident A and their vulnerabilities.

The panel established that the Braden score was not completed as per policy. As the Deputy Sister for the first floor where Resident A was a long term resident, it was Ms Poblete's responsibility to complete the Braden score, or ensure that

another member of staff had done so. The panel found that this duty had not been discharged.

The panel therefore determined that, on the balance of probabilities, charge 3 is found proved.

Charge 4

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Did not ensure that the MUST score was completed between 19 June 2022 and 1 October 2022, as was your responsibility as Deputy Sister."*

This charge is NOT found proved.

In reaching this decision the panel took into account the hearsay evidence from Witness 2.

The panel acknowledged that Witness 2's written evidence stated that the MUST score was completed on 18 June 2022 and that this was not recorded again until 2 October 2022. The panel recognised that this was hearsay evidence that could not be cross examined. However, it also has sight of contemporaneous evidence from the tissue viability wound assessment/ review form within Witness 1's documentary evidence, in which a MUST score was recorded on 30 August 2022. This document was co-signed by Ms Poblete. This reveals a clear contradiction between this contemporaneous documentary evidence and the witnesses written statement. Due to this clear conflict within the evidence provided by Witness 2, and no other evidence being presented by the NMC on this matter, the panel was not satisfied that the NMC had discharged the burden on it of proving this charge to the required standard.

The panel therefore determined, that on the balance of probabilities, charge 4 is found not proved.

Charge 5

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Prior to 2 October 2022, did not appropriately escalate and/or seek advice regarding their pressure ulcers, as was your responsibility as Deputy Sister."*

This charge is found proved.

In reaching its decision the panel took into account the Trust Guidelines for Referrals to Clinical Nurse Facilitator for Tissue Viability Support (TVN), the orally affirmed evidence from Witness 1, Resident A's patient records and the staff rota.

The panel considered the evidence before it and accepted that the pressure ulcers documented on 2 October 2022 was considered a serious wound as it was escalated to Witness 1 whilst they were on annual leave. The panel was also provided with a picture of the wound and contemporaneous documents containing detailed assessments. It is clear from the evidence that the wound was escalated to Witness 1 and that this instigated immediate action including a range of treatments and subsequent referrals to external specialists. The concern was also reported to a safeguarding team.

The panel also noted the TVN referral guidelines which clearly outlines that a referral should be made to tissue viability support if the wounds were not responding to appropriate treatment after four weeks of appropriate treatment. The panel accepted that Ms Poblete should have been aware of these guidelines.

The evidence before the panel indicated that prior to the discovery of the wound on 2 October 2022, it should have been clear to Ms Poblete that the wound required escalation as the sacral wounds were described by Witness 1 as 'the most concerning as they should have been reported and treated'. The witness told the panel that in her professional opinion 'the wounds had been present for a considerable period of time and they were not acute' and at the very least should have been escalated to senior staff within the home, prior to such deterioration.

The panel accepted that entries in Resident A's patient records alone should have sparked an escalation of the concerns. The panel noted that by 2 October 2022 there is no evidence of a referral to either senior members of staff or the tissue viability nurse.

The panel also had sight of the staff rota and acknowledged that Ms Poblete was working 3-5 days per week in September so should have been aware of and ensured the escalation of this concern regarding Resident A, especially given that the repositioning chart documents issues with wounds in May, July and September.

The panel found that as Deputy Sister it was Ms Poblete's responsibility to ensure that she or another member of staff escalated the concerns or sought advice on the wounds clearly documented within the sacral area.

In light of this the panel therefore determined, on the balance of probabilities, charge 5 is found proved.'

The original panel determined the following with regard to impairment:

'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 Ms Poblete's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Poblete's actions amounted to breaches of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered misconduct in relation to each individual charge found proved.

In relation to Charge 1, the panel was of the view that to carry out appropriate reviews and ongoing assessments of a sacral wound is a basic nursing function. This is even more relevant as Resident A was an elderly, frail, vulnerable and a high risk resident who was chair bound and doubly incontinent with a documented history of pressure damage. The panel noted Resident A's diagnosis of dementia made it 'difficult for him to express his thoughts and feelings and wishes regarding his care needs'. The medical concern regarding the sacral area had been documented as an ongoing problem that continued over a period five months. The panel found that as the Deputy Sister Ms Poblete had multiple opportunities for oversight of Resident A's care and failed to act on these opportunities to address the issues. For example, she failed to ensure that monthly reviews of Resident A's care plan 7 (damage to buttocks) were undertaken and the paperwork updated. The result of not performing these basic elements of her role as the Deputy Sister resulted in serious harm to Resident A. The panel is of the view that the failings in this case on the part of Ms Poblete go beyond mere inadvertence or incompetence and are so serious they are properly characterised as misconduct.

In its consideration of Charge 2, the panel considered that the wound assessments and patient care plans are core paperwork, especially in the context of caring for an

elderly and frail patient in a nursing home, with a history of skin issues. These basic tasks were clearly not performed and if they had been, a different plan of care would have been implemented. The required assessments and care plans were not completed over a protracted period of time and when there was a duty on Ms Poblete, as the Deputy Sister, to ensure that they were. The panel finds that this amounts to serious misconduct.

The panel next considered misconduct in relation to Charge 3 and it found that the Braden score test was an important but simple and basic pressure ulcer risk assessment tool that should have been carried out on all residents. This was a dedicated single form completed on a monthly basis and a straightforward and basic review of documentation would have indicated that this was not being undertaken. As Deputy Sister Ms Poblete had oversight and was responsible for checking this and she did not. Given that Resident A had a history of skin problems, a monthly Braden score would have highlighted concerns and put him on a pathway of care for this issue, subsequently preventing the harm to him. The panel finds that this amounts to serious misconduct.

In relation to Charge 5, the panel was of the view that the consequence of not carrying out the assessments meant that Ms Poblete failed to escalate the concern. In her role as the Deputy Sister in charge of the floor that Resident A resided on, Ms Poblete neglected to escalate the concern to senior management at the home, or to follow the clear guidance in relation to escalating the concern to the Tissue Viability Nurse. She did not do this or ensure that another member of staff had done so.

The panel found that Ms Poblete's actions both individually and as a whole did fall seriously short of the conduct and standards expected of the Deputy Sister, and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Poblete'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. 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

The panel finds that Resident A suffered actual harm as a result of Ms Poblete's misconduct. The panel noted that the actual harm to Resident A was over a period of time, and the severity of the wounds should not have got to the stage that they did. It considered that Ms Poblete's lack of action and supervision of the staff on the first floor of the home, and her neglecting to complete the appropriate records, or ensure that they were treated, directly caused harm to Resident A. The panel made reference to the safeguarding report which states that 'pressure damage could have been prevented'. Consequently, the panel finds that the wounds were preventable. Ms Poblete's conduct in neglecting to conduct basic assessments, complete basic records and to escalate concerns in accordance with the relevant guidelines or to, in her role as Deputy Sister, ensure that another member of staff had done so, resulted in harm to Resident A.

In its consideration of the second limb of the Grant test, the panel finds that patients and their families need to be able to trust nurses. Within her role as Deputy Sister within a nursing home, there is an expectation from residents and their family members that someone within her position as Deputy Sister had oversight for overall patient care and safety. Her departure from this could potentially make others hesitant to put family members into the care of nurses.

As such, the panel finds that Ms Poblete's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

After finding that all three limbs of Grant are engaged the panel made reference to Cohen [2008] EWHC 581.

Regarding insight, the panel had no evidence before it to indicate that Ms Poblete has demonstrated remorse for her actions, acknowledged how her actions put patients at risk of harm, or how she would handle the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being remediated, as they are clinical management functions. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Poblete has taken steps to strengthen her practice. The panel noted that there is nothing before it to suggest that she has undertaken any training courses. There is also no evidence of any remorse being shown in a reflective statement despite the fact that she received the hearing papers months prior to the commencement of this hearing.

The panel is of the view that there is a risk of repetition based on the lack of evidence from her to suggest that she would not repeat the conduct that led to these regulatory concerns. 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 because a member of the public knowing the details of this case may be concerned if Ms Poblete was allowed to continue to practice without restriction.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case as the panel made

particular reference to a statement made by Resident's A's relative who stated that 'it should not have happened that's their job and they get paid a lot of money to look after him'. Any member of the public would expect that, given the facts found proved, this conduct should be marked to protect the public and ensure public confidence in the profession. Therefore, the panel also finds Ms Poblete's fitness to practise impaired on the grounds of public protection.

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

The original panel determined the following with regard to sanction:

'Having found Ms Poblete'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 Sanctions Guidance (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:

- *The conduct that led to these regulatory concerns resulted in actual harm to Resident A and put them at risk of further harm.*
- *Lack of any evidence of insight into failings*
- *Lack of any evidence of reflection and remediation*

The panel also took into account the following features which, although not mitigation, are contextually relevant:

- *There were other professionals, senior to Ms Poblete within the Home, who should have also been aware of the ongoing issues regarding the care being provided to Resident A and her failure to fulfil her role as the Deputy Sister.*
- *Ms Poblete was the Deputy Sister in a Home that was described as 'failing' by the Home Manager.*

- *The corporate takeover and the increase in occupancy/staff in the Home during the relevant period.*

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 Ms Poblete'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 Ms Poblete's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the failings identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Poblete's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. In considering the SG the panel considered that the following aspects applied in this case:

- *The panel had not found that there were harmful deep-seated personality or attitudinal problems;*
- *There are identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *There is no evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel has been informed that Ms Poblete is not currently working in clinical practice, however, should she wish to return to nursing, appropriate safeguards will afford her the opportunity to strengthen her practice, whilst protecting the public.

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

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of Ms Poblete's case because it would be punitive and not give Ms Poblete the opportunity to strengthen her practice. The panel considered it important to give Ms Poblete the chance to return to nursing, with the failings which the panel has found proved addressed, should she wish to do so.
Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will adequately protect the public and mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a Registered Nurse.

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

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

1. *You must only work for a single substantive employer or, when working as a bank or agency nurse, you must be allocated to a*

single place of work for a minimum of 3 months duration where there is a consistency of supervision.

2. *You must not be the nurse in charge of any shift.*

3. *You must have monthly meetings with your supervisor, line manager or mentor to discuss and document your clinical practice in relation to:*
   - a) *Assessment of prevention and management of pressure ulcers.*
   - b) *Escalation of deteriorating residents.*
   - c) *Communication skills with fellow staff and patients*
   - d) *Effective care planning and updating of paperwork, including reviews/assessments*

4. *You must provide a report to the NMC prior to any review from your supervisor, line manager or mentor relating to:*
   - a) *Assessment of prevention and management of pressure ulcers*
   - b) *Escalation of deteriorating residents*
   - c) *Communication skills with fellow staff and patients*
   - d) *Effective care planning and updating of paperwork, including reviews/assessments*

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

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

7. *You must immediately give a copy of these conditions to:*
    a) *Any organisation or person you work for.*
    b) *Any agency you apply to or are registered with for work.*
    c) *Any employers you apply to for work (at the time of application).*
    d) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

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

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

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- *Your attendance at a future hearing*
- *Testimonials from a line manager or supervisor at your place of employment*
- *Evidence of strengthening of your practice in the areas highlighted*
- *A reflective statement'*

Decision and reasons on current impairment

The panel has considered carefully whether Mrs Poblete's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel had regard to all of the documentation before it, including the NMC bundle.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mrs Poblete's fitness to practise remains impaired.

The panel took into account that Mrs Poblete has not engaged with the NMC in over a year, and has not engaged with the hearing process. There is no new information provided

by Mrs Poblete since the initial substantive hearing in 2025 to suggest that she has taken steps to remediate the concerns. There is no information before the panel to support that Mrs Poblete has strengthened her practice since the substantive hearing, she has not provided any reflections or evidence of insight, and there is nothing before the panel to support that the risk of harm and risk of repetition has been mitigated in any way.

In light of this, the panel determined that Mrs Poblete is liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mrs Poblete's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mrs Poblete fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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 Poblete'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, but the Committee wants to mark that what*

happened was unacceptable and must not happen again.' The panel considered that Mrs Poblete's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on Mrs Poblete's registration would still be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account that there is no information to support that Mrs Poblete has been complying with her conditions of practice, working to mitigate the concerns raised and her impairment, and working in a healthcare setting or as a registered nurse.

The panel also took into account that Mrs Poblete has not attended this hearing, provided testimonials from a line manager or supervisor at her place of employment, demonstrated evidence of strengthening of practice, and has not provided a reflective statement. This information, as well as Mrs Poblete's future engagement, was requested by the original panel in order to assist today's reviewing panel.

In light of the above, the panel considered that any conditions of practice order would not be workable and would serve no useful purpose.

The panel next considered imposing a suspension order. The panel noted that Mrs Poblete has not engaged with her regulator and these proceedings, and has not provided evidence of remorse for her misconduct, taken steps to strengthen her practice, and has not provided evidence of further insight into her failings. In these circumstances the panel determined that a period of suspension would not serve any useful purpose. The panel determined that the continuation of restrictions on Mrs Poblete's practice would not be in the public interest given the continued lack of engagement from her. Registrants cannot remain on restrictions indefinitely, and the panel determined that it was necessary to take action to prevent Mrs Poblete from practising in the future and concluded that the only sanction that would adequately protect the public and serve the public interest was a striking-off order. The panel therefore directs the registrar to strike Mrs Poblete's name off the register.

This striking-off order will take effect upon the expiry of the current conditions of practice order, namely the end of 6 May 2026 in accordance with Article 30(1).

This will be confirmed to Mrs Poblete in writing.

That concludes this determination.