Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

24 & 25 March 2022

Virtual Hearing

Name of registrant:	Miss Ruth Pugh	
NMC PIN:	98D1061O	
Part(s) of the register:	RN3 (1998)	
Area of registered address:	Isle of Man	
Type of case:	Misconduct	
Panel members:	John Penhale Richard Lyne Caroline Taylor	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Gillian Hawken	
Hearings Coordinator:	Leigham Malcolm	
Facts proved by admission:	Charges 1, 2, 3, 4, 5a, 5b, 6 & 7	
Fitness to practise:	Impaired	
Sanction:	**Striking-off order**	
Interim order:	**Interim suspension order (18 months)**	

Decision and reasons on service of Notice of Meeting

The Nursing and Midwifery Council (NMC) must provide 28 days' notice of any substantive meeting unless a shorter period of notice is accepted by a registrant.

The panel was informed that the notice of this meeting had been sent to Miss Pugh's registered email address on 10 March 2022. 28 days had not passed since the notice of this meeting was sent to Miss Pugh. The panel was referred to an email from Miss Pugh to the NMC dated 4 March 2022 in which she stated:

"I have no issue with accepting short notice after you have given me notice."

The panel took into account that the Notice of Meeting provided details of the charge faced by Miss Pugh, as well as the time-frame during which the meeting would be held, and set out the options available to the panel in terms of sanction if it finds Miss Pugh's fitness to practise to be currently impaired. The panel also took account of Miss Pugh's email dated 4 March 2022 in which she accepts 'short notice'.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Pugh has been served with effective notice of this meeting.

The panel was also satisfied that it was appropriate to proceed to consider this matter at a hearing. The panel noted that the NMC had sent information to Miss Pugh detailing the differences between a hearing and a meeting and the information before the panel was that Miss Pugh had requested a meeting. The panel had no reason to believe that referring this matter to a hearing would result in Miss Pugh's attendance.

Details of charge

That you, a registered nurse:

1) On an unknown date in May 2018, used inappropriate force by placing your hand over Resident A's mouth.

2) On an unknown date in 2018, used inappropriate force by pushing Resident B's lower jaw upwards causing Resident B to bite her tongue.

3) On an unknown date in 2018, inappropriately force-fed Resident C.

4) On an unknown date in August 2018, were physically abusive to Resident D by holding his arms and shaking him back and forwards.

5) On 27 August 2018, used inappropriate force on Resident E by;

a) Pulling her forcibly by the wrists and;

b) Pulling her forcibly by the arm.

6) On 16 March 2019, inappropriately and excessively restrained Resident F by using physical force to grip and hold her arms thereby causing bruising.

7) On 16 March 2019, spoke unkindly and with an unnecessarily raised voice to Resident F.

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

Rule 19

At the outset of the meeting, the legal assessor raised the issue that within the information before the panel there was reference to Miss Pugh's health. Although this substantive meeting is not open to the public, it was proposed that any reference to Miss Pugh's health within the written determination produced be marked as private pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the circumstances of this case the panel decided to mark any information relating to Miss Pugh's health as private in accordance with Rule 19 of the Rules.

Background

The NMC received two referrals, one on 20 October 2018 and another on 5 April 2019, in relation to Miss Pugh's nursing practice. Both referrals related to Miss Pugh's nursing practice whilst employed as Clinical Lead Nurse at Castle View Nursing Home (the Home).

The Home investigated a number of incidents which occurred in 2018. A disciplinary hearing was subsequently held on 20 September 2018 at which Miss Pugh was issued with a final written warning and a comprehensive action plan which included mandatory training and actions [Private]. Despite this management intervention and further support and training in relation to professional development, and to assist Miss Pugh in carrying out best practice in dementia care and managing Vulnerable Adults, further incidents of a similar nature occurred which led to Miss Pugh being suspended on 18 March 2019. On 4 April 2019 the Home held a second disciplinary hearing at which Miss Pugh was dismissed from her post.

The referrals to the NMC alleged that Miss Pugh physically and verbally abused vulnerable residents, used inapropriate langague towards residents, and used inapropriate manual handling techniques between August 2018 and March 2019, as set out in the charges.

Decision and reasons on facts

At the outset of the meeting, the panel had regard to the completed Case Management Form (CMF) dated 10 April 2021 returned to the NMC by Miss Pugh. Within the CMF Miss Pugh indicated that she admitted to each of the Charges, namely Charges 1, 2, 3, 4, 5a, 5b, 6 & 7.

The panel considered Miss Pugh's admissions to be clear and unequivocal. The panel therefore finds Charges 1, 2, 3, 4, 5a, 5b, 6 & 7 proved in their entirety, both on the uncontested NMC evidence and by way of Miss Pugh's full admissions in accordance with Rule 24(5).

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Miss Pugh's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Pugh's fitness to practise is currently impaired as a result of that misconduct.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.' The panel was mindful that in his judgment Lord Clyde emphasised that the misconduct must be serious.

The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code") in making its decision. The panel was of the view that Miss Pugh's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the following sections of the Code:

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

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

2.3 encourage and empower people to share decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment, and

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

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
4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel bore in mind that nurses have a responsibility to provide safe and effective care to vulnerable patients. The six residents in this matter, Residents A – F, were elderly and particularly vulnerable patients and Miss Pugh's conduct resulted in actual patient harm to some of them. Although it may not have been intentional, her conduct was rough and resulted in more than one resident suffering bruising. Further, the information before the panel indicated a pattern of behaviour which involved inappropriate and excessive force, behaviour which was also witnessed by colleagues.

The panel was in no doubt that both individually and collectively, the charges amounted to serious misconduct. The panel determined that Miss Pugh's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

The panel accepted the advice of the legal assessor which included reference to *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

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.

The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) …*

The panel found that patients were caused physical and emotional harm as a result of Miss Pugh’s misconduct. Miss Pugh’s misconduct breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel took account of the information provided by Miss Pugh’s in relation to [Private] along with her statement [Private]. The panel bore in mind that Miss Pugh has admitted to the charges and taken responsibility for her conduct. However, it considered her insight to be limited [Private], as opposed to the impact of her actions on the six residents in her care and on the colleagues that she was meant to be leading. The panel did not identify any understanding demonstrated by Miss Pugh of the impact of her actions on the wider public and the reputation of the nursing profession. Further, nor did the panel identify any remorse within Miss Pugh’s reflection.

[Private]. Nor did the panel have any information to suggest that Miss Pugh has undertaken any attempts at remediation since the Home created an action plan in response to the incidents in 2018.

The charges found proved, individually and collectively, amounted to serious misconduct. Miss Pugh's misconduct fell seriously short of the standards expected of a registered nurse. The panel reached the view that there is a risk of repetition based on Miss Pugh's limited insight, lack of remediation, and [Private]. 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 are 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 given the seriousness of the misconduct and the patient harm caused. The panel was in no doubt that Miss Pugh's actions towards elderly and particularly vulnerable dementia patients would undermine public confidence in the profession and would damage its reputation. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Pugh's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Pugh'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 Miss Pugh off the register. The effect of this order is that the NMC register will show that Miss Pugh 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.

Decision and reasons on sanction

Having found Miss Pugh'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 was made aware that as the result of regulatory proceedings brought by the NMC in 2017, Miss Pugh had received a caution order for a period of four years. The panel had sight of that determination and, noting the nature of the regulatory concerns in that case, identified no features similar to this case before it today. It therefore determined not to regard the caution order Miss Pugh received in 2017 as an aggravating feature in this case.

The panel took into account the following aggravating features:

- Miss Pugh's misconduct put patients at risk of harm and resulted in actual patient harm;
- The patients in Miss Pugh's care were particularly vulnerable dementia patients;
- The misconduct was repeated despite the Home putting an action plan in place, indicative of a pattern of behaviour;
- Miss Pugh abused her position of trust, especially in light of her position as Clinical Lead Nurse;

- Miss Pugh's limited insight.

The panel also took into account the following mitigating features:

- Miss Pugh's early admissions;
- [Private].

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Pugh's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Pugh'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 Miss Pugh's registration would be a sufficient and appropriate response. The panel noted that the action plan put in place by the Home had failed to address Miss Pugh's conduct. Further, the panel had no information as to whether or not Miss Pugh is currently employed as a nurse or what her future intentions are. The panel could not be satisfied that any conditions imposed would sufficiently address the risks identified. Further, the panel concluded that the placing of conditions on Miss Pugh's registration would not adequately address the seriousness of this case, keep patients safe, and would not address the serious public interest concerns. Accordingly, the panel determined that a conditions of practice order would not be the appropriate or proportionate sanction.

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.*

Miss Pugh's misconduct was not a single incident. There was evidence before the panel of a concerning attitude on Miss Pugh's part, particularly in light of the fact that the misconduct was repeated over several months and in relation to six patients in her care in her position as Clinical Lead Nurse. Although the misconduct was identified and management intervention and further support and training in relation to professional development was put in place, specifically to assist Miss Pugh in carrying out best practice in dementia care and managing Vulnerable Adults, her inappropriate behaviour and excessive force used towards patients was repeated.

The panel took into account that the SG indicates key considerations in relation to suspension:

"Key things to weigh up before imposing this order include:

- *whether the seriousness of the case require temporary removal from the register?*
- *will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?"*

In the circumstances of the case, the panel was not satisfied that a suspension order would adequately address the public interest.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel has identified only limited insight from Miss Pugh by way of her admissions, but she has not demonstrated any understanding of the seriousness of her actions and their potential effect on those in her care, her colleagues and public confidence in the profession. The panel was of the view that the serious breaches of the fundamental tenets of the profession evidenced by Miss Pugh's actions would be considered so serious by members of the public that it may be incompatible with ongoing registration. In these circumstances, the panel was not satisfied that a period of suspension would satisfy the public interest or uphold public confidence in the profession or the NMC. Balancing all of these factors, 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?*

Miss Pugh'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 Miss Pugh'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.

Miss Pugh has demonstrated limited insight; limited insight which focused solely on [Private]. The misconduct was repeated over several months and caused actual harm to vulnerable patients, despite the Home putting an action plan in place to support Miss Pugh. The panel was of the view that Miss Pugh has not provided sufficient evidence of insight or remediation to alleviate the panel's grave concerns that these incidents were attitudinal in nature and risk happening again.

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 matters it identified, in particular the effect of Miss Pugh'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.

In making this decision, the panel carefully considered the NMC's sanction bid, a nine month suspension order. However, the panel considered that a nine month suspension order would not be proportionate in the circumstances of this case and would not sufficiently address the public interest given the seriousness of the misconduct.

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.

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 Miss Pugh's own interest until the striking-off sanction takes effect.

The panel took account of the representations made by the NMC and accepted the advice of the legal assessor.

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

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

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

That concludes this determination.

This will be confirmed to Miss Pugh in writing.