Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 December 2023 – Friday, 15 December 2023

Virtual Hearing

Name of Registrant:	Delia Newman
NMC PIN	86Y2047E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 19 February 1990
Relevant Location:	Lincolnshire
Type of case:	Misconduct
Panel members:	Sarah Lowe (Chair, Lay member) Richard Curtin (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Tim Bradbury
Hearings Coordinator:	Hamizah Sukiman
Nursing and Midwifery Council:	Represented by Louise Cockburn, Case Presenter
Mrs Newman:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 1i, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2j and 2k
Facts not proved:	Charges 1g, 1h, 2a and 2i
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Newman was not in attendance and that the Notice of Hearing letter had been sent to Mrs Newman's registered email address by secure email on 6 November 2023.

Ms Cockburn, 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Newman'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 Newman 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 Newman

The panel next considered whether it should proceed in the absence of Mrs Newman. It had regard to Rule 21 and heard the submissions of Ms Cockburn who invited the panel to continue in the absence of Mrs Newman. She submitted that Mrs Newman had voluntarily absented herself.

Ms Cockburn referred the panel to the email from Mrs Newman, dated 23 August 2023, which confirmed that Mrs Newman was content for the hearing to proceed in her absence. She submitted that Mrs Newman has not returned a Case Management Form (CMF), and she has maintained her position that she does not wish to engage with these proceedings. Ms Cockburn submitted that Mrs Newman

has not requested an adjournment, and there is nothing to suggest that an adjournment to secure her attendance at a later date. She further submitted that it is in the interest of justice for the expeditious disposal of this matter.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Newman. In reaching this decision, the panel has considered the submissions of Ms Cockburn and the advice of the legal assessor. It regarded the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Newman has informed the NMC that she is content for the hearing to proceed in her absence;
- No application for an adjournment has been made by Mrs Newman;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence, with two others who are due to attend; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Newman in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will

not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Newman'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 Newman. The panel will draw no adverse inference from Mrs Newman's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse, while employed at Abbey Nursing Home ("the Home");

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    a. Did not complete an Incident Report;
    b. Did not complete a Wound Care Plan;
    c. Did not update Patient A's Skin Integrity Need Care Plan;
    d. Did not complete a Waterlow Assessment;
    e. Did not adequately complete a Body Map to include any or all of the following information:
        i. what changes were observed to Patient A's body;
        ii. a description of the Wound;
        iii. the reason for the dressing.
    f. Did not update Patient A's Daily Notes;
    g. Did not inform Patient A's next of kin;
    h. Did not conduct a short multi-disciplinary team meeting known as a Safety Huddle;
    i. Did not record the Wound and your observations in the Handover Booklet;

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:

a. Did not include any or all of the following information on the Incident Form:
    i. what position Patient B was found in;
    ii. the type of examination you carried out on Patient B;
    iii. whether Patient B was able to move his limbs normally;
    iv. whether Patient B was able to stand;
    v. whether Patient B had any signs of pain;
b. Did not complete a Wound Care Plan;
c. Did not update the Falls Risk Assessment;
d. Did not complete the Actions within the Falls Checklist;
e. Did not update Patient B's Mobility Care Plan;
f. Did not complete a Body Map;
g. Did not take a picture of any injuries sustained by Patient B as a result of the Fall;
h. Did not record observations consisting of pulse and/or blood pressure and/or the reaction of Patient B's pupils to light;
i. Did not contact Patient B's next of kin;
j. Did not conduct a short multi-disciplinary team meeting known as a Safety Huddle;
k. Did not record the Fall and your observations in the Handover Booklet;

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

Background

Mrs Newman was admitted to the NMC register in 1990 and has had no previous regulatory concern against her.

The charges arose out of events on the nightshift of 8 to 9 July 2020, whilst Mrs Newman was employed as a registered nurse at the Home. The Home has 87 beds and provides primary healthcare needs to residents. The nightshift spans from 19:00

hours to 07:00 hours the next morning. At 20:00, Mrs Newman completed a routine supervision session with Witness 2, who was the Deputy Manager at the time. Witness 2 informed Mrs Newman that she had not been keeping care plans and risk assessments for those in her care up to date. Mrs Newman agreed, during the supervision, to complete the care planning and risk assessments, and set a target date to complete those for a month from then. This was recorded in the supervision record.

On 9 July 2020, it is alleged that Mrs Newman had inspected a wound and taken a photo of the wound on Patient A. Patient A is an elderly resident who is frail and bedbound. As a result, Patient A's skin integrity is monitored regularly. It is further alleged that Mrs Newman had cleaned and dressed the wound but had not adequately completed the relevant nursing documentation, which included an incident report, wound care plan, an updated skin integrity plan and Waterlow assessment. It is further alleged that Mrs Newman had not contacted Patient A's next of kin, her GP or a tissue viability nurse. Patient A later developed a stage 3 pressure ulcer, which was subsequently reported to safeguarding, the Tissue Viability Nurse, the GP and next of kin.

It is further alleged that, just before midnight on 8 July 2023, Patient B had suffered a fall, but Mrs Newman did not complete an adequate risk assessment, update the care plan, complete the falls log and falls checklist, and failed to compete a body map for the injury. Patient B has vascular dementia and diabetes and was prone to falling.

It is further alleged that Mrs Newman did not adequately handover the nursing care of Patient A and Patient B.

With regard to Patient A, Mrs Newman's position is that she informed Witness 3 regarding the wound during the oral handover on the morning of 9 July 2023. She maintained she inspected, cleaned and dressed the wound appropriately, and completed body map as necessary. However, in the time between 06:00 hours and 07:00 hours, she did not have the time to update care plans. With regard to Patient B, Ms Cockburn outlined that Mrs Newman makes reference to Patient B's difficult

behaviour, which prevented her from completing the necessary observations in the time period.

Mrs Newman stopped working for the Priory Group on 13 September 2020.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Cockburn, on behalf of the NMC, to amend the wording of charge 2(h).

The proposed amendment was to substitute 'Patient A' to 'Patient B'. Ms Cockburn submitted that this is a typographical error, and the entirety of Charge 2 refers to Patient B. She submitted that the proposed amendment would correct this typographical error and accurately reflect the evidence.

The original charge is as follows:

'That you, a registered nurse, while employed at Abbey Nursing Home ("the Home");

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    h. Did not record observations consisting of pulse and/or blood pressure and/or the reaction of Patient A's pupils to light'

The proposed amendment is as follows:

'That you, a registered nurse, while employed at Abbey Nursing Home ("the Home");

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:

h. Did not record observations consisting of pulse and/or blood pressure and/or the reaction of ~~Patient A's~~ **Patient B's** pupils to light'

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 Newman and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to correct the typographical error and correctly reflect the evidence.

Decision and reasons on application to admit telephone evidence

The panel heard an application made by Ms Cockburn under Rule 31 and Rule 23(1)(d) to allow Witness 2 to give their evidence over the telephone. [PRIVATE]. Ms Cockburn informed the panel that she had given Witness 2 time to familiarise herself with her witness statements and exhibits before Witness 2 appears before the panel. She invited the panel to allow Witness 2 to give evidence via the telephone, as to allow Witness 2 to give evidence whilst providing her with the reasonable adjustments she needs.

In the preparation of this hearing, the NMC had indicated to Mrs Newman in the Case Management Form, that it was the NMC's intention for Witness 2 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 2, Mrs Newman made the decision not to attend this hearing. On this basis Ms Cockburn advanced the argument that there was no lack of fairness to Mrs Newman in allowing Witness 1 to give evidence over the telephone.

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

The panel considered that Mrs Newman has absented herself and is not in a position to express a view on the application. The panel further considered that the NMC is content for Witness 2 to give evidence over the telephone, in light of her

circumstances. The panel determined that any prejudice to Mrs Newman can be balanced through questions, if necessary.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Witness 2 to give evidence over the telephone but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

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

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

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: CQC-registered Deputy Home Manager at the Home (at the time of the incident)
- Witness 2: Clinical Lead at the Home (at the time of the incident)

- Witness 3: Registered nurse at the Home (at the time of the incident)

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 both the NMC and Mrs Newman.

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

Charge 1a)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    a. Did not complete an Incident Report

This charge is found proved.

In reaching this decision, the panel recognised there is a discrepancy between the dates, as Mrs Newman's statement, dated 21 August 2020, in which she stated she was informed of the Wound on 9 July and saw the Wound on the morning of 10 July. However, the panel considered the photograph of the Wound taken by Mrs Newman, which was dated 9 July 2020, as well as Mrs Newman's Record of Observations which were dated 9 July 2020. The panel was satisfied that the dates reflect those on the charge, rather than Mrs Newman's statement. The panel concluded the contemporaneous documents provided by Mrs Newman supports this finding.

The panel concluded that there was a duty for Mrs Newman to complete an Incident Report. The panel considered the Home's policy, entitled 'Incident Management, Reporting and Investigation', which detailed Mrs Newman's obligation to complete an Incident Report for all incidents and near misses. Consequently, as the Wound is an incident, an Incident Report should have been completed. However, the panel also considered oral evidence from Witness 3, which indicated that Patient A was admitted with a pressure ulcer already present, alongside the Home's 'Wound

Management' policy (wound care policy). The panel noted that the wound care policy required an incident report to be completed upon admission, with a new incident report if the wound progresses or becomes a Category 3 or 4 wound. The panel further considered the photographs, and Witness 2's inability in her evidence to definitively stage the Wound.

The panel further considered that the Wound was serious enough to prompt Mrs Newman into taking a photograph of it as well as record it in the Record of Observations, yet Mrs Newman failed to complete an Incident Report when she should have done so. Consequently, the panel found this charge proved on the balance of probabilities.

Charge 1b)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    b. Did not complete a Wound Care Plan

This charge is found proved.

In reaching this decision, the panel took into account the Home's wound care policy, witness evidence from Witness 3 as well as Mrs Newman's own admission in the interview, dated 13 August 2020. The panel considered that Witness 3 made clear that a Wound Care Plan is completed to ensure patients receive the appropriate treatment. In the absence of a Wound Care Plan and with Mrs Newman's admission in the interview that she did not complete a Wound Care Plan, the panel found this charge proved.

Charge 1c)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    c. Did not update Patient A's Skin Integrity Need Care Plan;

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence from Witness 1 and Witness 2. The panel noted that it did not have sight of Patient A's Skin Integrity Need Care Plan. However, the panel concluded that both Witness 1 and Witness 2 confirmed the need for the care plan, with Witness 2 outlining it as a part of a greater risk assessment taken together with the Waterlow Assessment. The panel is content that there was a need to complete this care plan and determined that Mrs Newman did not complete this care plan, as claimed by Witness 1. Consequently, this charge is found proved.

Charge 1d)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    d. Did not complete a Waterlow Assessment;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2, which details the Waterlow Assessment and the Wound Care Plan as parts of a greater risk assessment, and that Mrs Newman had not completed one. The panel also considered the Home's wound care policy, which sets out the requirement to complete a Waterlow Assessment. The panel further considered that the absence of the Waterlow Assessment was inferred in Mrs Newman's interview, dated 13 August 2020. In the absence of a Waterlow Assessment, the panel found this charge proved.

Charge 1e)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    e. Did not adequately complete a Body Map to include any or all of the following information:
        i. what changes were observed to Patient A's body;
        ii. a description of the Wound;
        iii. the reason for the dressing.

This charge is found proved.

In reaching this decision, the panel took into account the Body Mapping Record as well as Witness 2's oral evidence. The panel noted that Mrs Newman did have a body map for Patient A, but it determined that the information specified in this charge were not documented. The panel considered oral evidence from Witness 2 and the prompt questions asked on the Body Mapping Record and concluded that the Body Map made for Patient A only detailed the location of the Wound. The Body Map had insufficient information on the Wound, and consequently, this charge is found proved.

Charge 1f)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    f. Did not update Patient A's Daily Notes Assessment;

This charge is found proved.

In reaching this decision, the panel considered Patient A's Daily Progress Notes. The panel considered Mrs Newman's entry at 0400 hours on 9 July 2023, which reported 'settled and slept well. No new concerns'. Based on the photograph and Record of Observation, the panel concluded this entry does not update or adequately reflect

the state of Wound at the time of the entry, which constituted a concern. The panel found this charge proved.

Charge 1g)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    g. Did not inform Patient A's next of kin;

This charge is found NOT proved.

In reaching this decision, the panel considered the Home's 'Resident Records and Care Planning for Older People Services' policy, which outlined an obligation for Mrs Newman to communicate incidents that impacts Patient A's care to Patient A's next of kin. The panel also considered Witness 3's oral evidence, which confirmed that informing the next of kin may be passed on to the day-shift nurse unless the incident was serious. The panel determined that the incident was not serious enough to warrant an immediate contacting of Patient A's next of kin, as Patient A did not require hospital treatment, and was known to be at risk of pressure damage. The panel noted that Mrs Newman should have taken steps to facilitate the day-shift nurse to contact Patient A's next of kin, but the panel determined that there was no duty for Mrs Newman to inform the next of kin during the night shift. Consequently, this charge is found not proved.

Charge 1h)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    h. Did not conduct a short multi-disciplinary team meeting known as a Safety Huddle;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Home's 'Prevention of Falls Strategy', with specific regard to the procedures outlined within 'Following a Fall', the Home's handover policy entitled 'Colleague Meetings, Handovers and General Communications' (handover policy) as well as witness evidence from Witnesses 1 and 2. The panel considered that the policy makes clear that a Safety Huddle should be multi-disciplinary, and conducted at 1400 hours. The panel also considered evidence from Witness 1, who confirmed that a Safety Huddle could be conducted at any time outside of this specified time. The panel further considered evidence from Witness 2, who informed the panel that this was common practice and taught both in the induction training and at university.

The panel determined that Mrs Newman's training records would indicate she completed the Home Induction Training in 2018. However, the policy clearly outlined that a Safety Huddle should be multi-disciplinary and at a specific time in the day to ensure multi-faceted care can be provided to patients. The panel determined that this could not be effectively held during a night shift, and the policy does not require it to be held.

The panel found this charge not proved.

Charge 1i)

1. On the night shift of 8-9 July 2020, failed to adequately document the care you gave to Patient A's pressure ulcer ("the Wound") in that you:
    i. Did not record the Wound and your observations in the Handover Booklet;

This charge is found proved.

In reaching this decision, the panel took into account the Home's handover policy, Patient A's handover notes, dated 9 July 2023, oral evidence from Witness 3, Mrs Newman's statement, dated 13 August 2020, as well as the NMC Code of Conduct. The panel considered that both the NMC Code of Conduct and the Home's policy required Mrs Newman to keep clear records of the Wound in the handover notes.

Furthermore, although Witness 3 could not recall whether there was a verbal handover from Mrs Newman, she confirmed that finding and treating a wound is important, and had it been communicated, it is her normal practice to record that information in the handover notes. The panel considered, on balance, a verbal handover did not occur, and that in addition, Patient A's handover notes stated 'settled', which did not accurately reflect Mrs Newman's findings regarding the Wound. Consequently, this charge is found proved.

Charge 2a)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    a. Did not include any or all of the following information on the Incident Form:
        i. what position Patient B was found in;
        ii. the type of examination you carried out on Patient B;
        iii. whether Patient B was able to move his limbs normally;
        iv. whether Patient B was able to stand;
        v. whether Patient B had any signs of pain;

This charge is found NOT proved.

In reaching this decision, the panel considered the Home's policy, entitled 'Essential Care Following a Fall' (fall policy) as well as its Standard Operating Procedure (SOP) on falls. The panel noted that there was ambiguity in whether Patient B suffered from a head injury, but it concluded that if there was not, then the SOP asks staff to complete a Body Map. The SOP does not detail a specific requirement to include information outlined in this charge in the Incident Report Form. The panel considered that the Incident Report Form consists of a section entitled 'Details of Incident' but makes no specific reference as to information which must be concluded.

The panel further considered Witness 2's acceptance that this requirement was found in normal practice in the Home, rather than a specific policy. The panel also

considered Witness 1's statement which details information she would include in an Incident Report Form, which includes the requirements listed in the charge. However, the panel determined that Witness 1 is a very experienced nurse with clear views on what should be included within an Incident Report Form. The panel concluded that an absence of details in which Witness 1 would have included does not constitute a failure to include information as required in the Incident Report Form. The panel determined that, without specific requirements, incident reports can include varying degrees of detail.

The panel determined there is insufficient link between the Home's fall policy, the SOP and the Incident Report Form to find this charge proved.

Charge 2b)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    b. Did not complete a Wound Care Plan;

This charge is found proved.

In reaching this decision, the panel considered Patient B's handover notes, dated 9 July 2020 and the Falls Log for the same day. The panel determined, based on these documents, that Patient B suffered two falls during the day and one in the evening. The two falls during the day were handed over, but the panel concluded no separate Wound Care Plan was written for the wound arising from the Fall, despite Mrs Newman noting that Patient B 'scrap[ed] his Rt elbow on the bed'.

As the Home's wound care policy requires Mrs Newman to complete a Wound Care Plan for every new wound, there was a clear duty for Mrs Newman to do so for the scrape sustained in the evening fall. In light of witness evidence confirming Mrs Newman failed to do so as well as the absence of a Wound Care Plan for this wound, the panel found this charge proved.

Charge 2c)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 (“the Fall”), in that you:
    c. Did not update the Falls Risk Assessment;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and exhibits from Witness 1, as well as her oral evidence. The panel considered that the Falls Risk Assessment document is a live document that is updated regularly as risks change. The panel determined that Patient B’s Falls Risk Assessment has been updated to account for the two falls which occurred during the day on 9 July 2023, but was not updated with the evening fall.

Consequently, the panel found this charge proved.

Charge 2d)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 (“the Fall”), in that you:
    d. Did not complete the Actions within the Falls Checklist;

This charge is found proved.

In reaching this decision, the panel considered Patient B’s ‘Checklist Following a Fall’ (the Checklist), dated 9 July 2020. The panel noted that Mrs Newman ticked several of the actions as completed. The panel gave specific regard to Mrs Newman ticking the tasks involving updating the care plan and risk assessment to reflect the fall as completed. Based on its finding for Charge 2c, the panel concluded that Mrs Newman had not updated the care plan and risk assessment yet marked it as complete. The panel also considered that Mrs Newman indicated in the checklist that

the fall has been documented on the handover information, despite the handover sheet containing no record of the evening fall, and only stated ‘Settled’ and ‘No concerns’.

Due to the reasons above, this charge is found proved.

Charge 2e)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 (“the Fall”), in that you:
    e. Did not update Patient B’s Mobility Care Plan;

This charge is found proved.

In reaching this decision, the panel considered Witness 1’s statement and exhibits. The panel determined that the Evaluation of Planned Care document for Patient B was not updated on 9 July 2023 to reflect the fall sustained by Patient B.

Consequently, the panel found this charge proved.

Charge 2f)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 (“the Fall”), in that you:
    f. Did not complete a Body Map;

This charge is found proved.

In reaching this decision, the panel took into account the falls SOP and determined that a Body Map must be completed when a patient sustained a fall. In the absence of a Body Map as well as Mrs Newman’s admission in her statement dated 21 August 2020, the panel was satisfied that this charge is proved.

Charge 2g)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    g. Did not take a picture of any injuries sustained by Patient B as a result of the Fall;

This charge is found proved.

In reaching this decision, the panel considered that the Home's wound policy, which required Mrs Newman to photograph any wound. The panel also considered witness evidence from Witness 1, who confirmed that no photograph of the injuries sustained by Patient B was taken. In the absence of such a photograph, the panel found this charge proved.

Charge 2h)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    h. Did not record observations consisting of pulse and/or blood pressure and/or the reaction of Patient B's pupils to light;

This charge is found proved.

In reaching this decision, the panel considered the 'Observation Record Following a Fall', dated 9 July 2020. The panel determined that Mrs Newman did not record any observation consisting of the information as outlined in the charge. The panel further considered Witness 1's oral evidence which confirmed that the pages missing from this exhibit, namely the flip side of the scanned pages, were also blank. This indicates that Patient B's observation record was not updated when the evening fall occurred.

The panel considered that Mrs Newman's statement made clear that the observations were not done due to Patient B's behaviour. However, the panel concluded, based on oral evidence from Witness 1, Mrs Newman could have made further attempts to complete the observations and administer medication to alleviate the behaviour if necessary.

Charge 2i)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    i. Did not contact Patient B's next of kin;

This charge is found NOT proved.

In reaching this decision, the panel considered the SOP for falls as well as oral evidence from both Witness 2 and 3 regarding Patient B's next of kin's contact preferences. The panel considered that the fall occurred in the late hours of the night, and Patient B frequently sustained falls. Based on the evidence from Witnesses 2 and 3, the panel determined that Patient B's next of kin's contact preferences was to be contacted immediately only for emergencies and serious incidents. As the procedure outlined in the SOP requires Mrs Newman to inform the next of kin when appropriate, the panel determined this charge not proved, as it would not be appropriate to contact Patient B's next of kin in the early hours of the morning, given the circumstances and nature of the fall.

Charge 2j)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    j. Did not conduct a short multi-disciplinary team meeting known as a Safety Huddle;

This charge is found proved.

In reaching this decision, the panel considered the Home's 'Prevention of Falls Strategy', with specific regard to the procedures outlined within 'Following a Fall', as well as Mrs Newman's admission in her statement. The panel determined that the procedure required Mrs Newman to conduct a Safety Huddle. In light of her admission that she did not do so, this charge is found proved.

Charge 2k)

2. On the night shift of 9-10 July 2020, failed to adequately document the care you provided to Patient B following a fall (which occurred on or around 23:30 on 9 July 2020 ("the Fall"), in that you:
    k. Did not record the Fall and your observations in the Handover Booklet;

This charge is found proved.

In reaching this decision, the panel took into account the Home's handover policy as well as the handover notes for Patient B, dated 9 July 2020. The panel determined that the handover policy required Mrs Newman to record the Fall and her observations, but the handover note stated 'settled' and 'no concerns'. The panel determined both these entries did not reflect Patient B's fall accurately. Consequently, this charge is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Newman'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 Newman's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Cockburn 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, with specific regard to the following:

'**1 Treat people as individuals and uphold their dignity**

To achieve this, you must:

1.2 Ensure the fundamentals of care are delivered effectively.

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 care is delivered effectively.

8 Work co-operatively

To achieve this, you must:

8.2 Maintain effective communication with colleagues

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

8.6 Share information to identify and reduce risk.

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

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

Ms Cockburn identified the specific, relevant standards where Mrs Newman's actions amounted to misconduct. She submitted that Mrs Newman was aware of the Home's policies and procedures and did not perform the responsibilities required of her. Ms Cockburn submitted that Witness 1 confirmed that there was a risk of harm as a result of Mrs Newman not following protocol, as vital information was not handed over whether verbally or in writing, medical records were not completed accurately and crucial observations of a vulnerable patient following a fall were not recorded.

Ms Cockburn further submitted that the panel has found that the registrant could have made further attempts to complete the observations and administer medication to alleviate the behaviour if necessary. In light of this finding, she submitted that the health and well-being of both patients was put at risk because of Mrs Newman's failure to act in accordance with policies and procedures.

Submissions on impairment

Ms Cockburn moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Cockburn submitted that Mrs Newman's fitness to practise is impaired, by way of her lack of insight and remorse. She submitted that the misconduct could be remedied but has not been and is likely to be repeated.

She submitted that Mrs Newman has not demonstrated an understanding of how her misconduct impacted Patient A and Patient B, and she has not accepted any responsibility. Ms Cockburn drew the panel's attention to Mrs Newman's statement, dated 21 August 2020, which referred to the investigation against her as a 'witch-hunt'. Ms Cockburn submitted that Mrs Newman has demonstrated limited insight over the three years since the incident, and there has been no evidence of safe or effective practice.

Ms Cockburn submitted there remains a risk to the health, safety and wellbeing of the public, and she invited the panel to find Mrs Newman's fitness to practise 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 and *R (Calhaem) General Medical Council* [2007] EWHC 2606 (Admin).

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 Newman's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Newman's actions amounted to a breach of the Code, as outlined in Ms Cockburn's submissions above.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. Furthermore, the panel considered the context surrounding the misconduct. The panel noted that Witness 1 gave evidence that the unit was not unusually busy at the time of the incident, but further noted that Mrs Newman claimed that it was busy. The panel also considered that Patient A was admitted with a pressure sore, pursuant to Witness 3's oral evidence, which brought into question as to how other members of staff did not notice the sore until Mrs Newman took a photograph of it on 9 July 2020, despite measures identified in Patient A's Care Plan, which included the need for an air mattress, repositioning and daily monitoring of Patient A's skin. However, whilst the panel accepts other factors may have contributed to the progressing of Patient A's Wound, the panel concluded that, at the relevant time, Mrs Newman was the nurse in charge of the care of both Patient A and Patient B. The panel determined that there was a risk of harm created due to her omissions and, in the case of Patient A, real harm has been caused, in part, by these omissions.

The panel found that Mrs Newman's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The panel determined, in the absence of a Wound Care Plan, there was no documentation to alert other members of staff to the Wound. The panel concluded, irrespective of potential systemic inadequacies at the Home, Mrs Newman did not do what she was responsible for with specific regard to the care of Patient A and Patient B.

The breaches of the Code are wide-ranging and significant, and the panel found this amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Newman'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* [2011] EWHC 927 (Admin) 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;'*

The panel finds that patients were put at risk and were caused physical harm as a result of Mrs Newman's misconduct. Mrs Newman's misconduct had breached the

Code, and consequently, the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Newman has not demonstrated any insight into the impact of her misconduct on patients, or what she would have done differently if this were to occur again. The panel considered Mrs Newman's email, dated 21 August 2020, which contested responsibility and assigned blame to the Home, and had no acceptance of her own role in that blame. The panel determined that Mrs Newman has not demonstrated insight or remorse, and is argumentative regarding her role in the greater failures surrounding the care of both Patient A and Patient B. There was no evidence before the panel of any steps taken by Mrs Newman to strengthen her practice.

The panel was satisfied that the misconduct in this case is entirely capable of being addressed and remediated. However, the panel considered that Mrs Newman has not engaged with the regulator since the incident. Consequently, the panel is unable to determine that Mrs Newman has demonstrated steps towards strengthening her practice. The panel also considered that Mrs Newman has demonstrated some attitudinal concerns with regard to her lack of engagement with the regulatory process, which suggests a lack of insight.

The panel considered that there is no evidence that Mrs Newman has previously had any relevant regulatory concern raised against her prior to this and the evidence would suggest she has enjoyed a long, unblemished career in nursing. However, the panel determined the aforementioned lack of insight and strengthening of practice carries a risk of repetition. 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 as a well-informed member of the public would be concerned a finding of impairment were not made in these circumstances. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Newman's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

Submissions on sanction

Ms Cockburn informed the panel the NMC seeks the imposition of a suspension order for a period of six months.

With regard to aggravating factors, Ms Cockburn submitted that Mrs Newman had put patients at a risk of harm. She further submitted that there is a pattern of incidents as there were concerns regarding Mrs Newman's documentation prior to the starting of the relevant shifts, albeit not regarding Patient A or Patient B. She further submitted that Mrs Newman was aware of the policies and knew where to access them. Ms Cockburn submitted, based on the panel's finding of misconduct and impairment, that Mrs Newman demonstrated no insight. She further submitted that there has been no indication that Mrs Newman has strengthened her practise and has failed to engage with the NMC.

[PRIVATE]

Ms Cockburn submitted that, based on the panel's findings, Mrs Newman demonstrates attitudinal concerns and is argumentative regarding her role in the failures in care for Patient A and B. She further submitted that, pursuant to the Sanctions Guidance (SG), a caution order would not be the appropriate order to impose, given the concerns surrounding patient safety. Whilst the concerns could be remedied, they have not been. In light of actual harm which came to Patient A as a result of Mrs Newman's misconduct, she invited the panel to not impose a caution order.

Ms Cockburn further submitted that Mrs Newman is currently not practicing as a nurse and has expressed an intention of not returning to nursing. She submitted that Mrs Newman's position on her future in nursing may change, but presently, a conditions of practice order would neither be appropriate nor workable in these circumstances, as she is not currently practicing and presently has no intention to do so in the future.

She further submitted that the misconduct is not incompatible with remaining on the register. Consequently, a striking-off order would be wholly disproportionate.

Ms Cockburn invited the panel to impose a suspension order for a period of six months. She submitted this would adequately address the public protection and public interest concern.

Decision and reasons on sanction

Having found Mrs Newman'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:

- Actual patient harm caused as a result of the misconduct;
- Both patients were vulnerable patients, who depended entirely on Mrs Newman and her leadership at the time of the shift;
- Lack of remorse and insight into her failings;
- Lack of engagement with the NMC.

The panel also took into account the following mitigating features:

- [PRIVATE];
- Facts proved amounted to two incidents on two separate evenings in relation to a single patient on each occasion, and to that extent, could be regarded as a relatively isolated set of incidents.

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given Mrs Newman's expressed intention of not returning to nursing, and that she is currently not practicing as a nurse. The panel also considered Mrs Newman's lack of engagement with the NMC process and concluded that it could not accurately assess Mrs Newman's willingness to engage and comply with the conditions, if she were practicing. The panel further considered that no workable conditions could be formed surrounding documentation, as it would be inappropriate to limit Mrs Newman's documentation responsibilities, but infeasible to require she would be supervised in doing so, given the nature of the Home and similar homes in which Mrs Newman would work. The panel considered this would require Mrs Newman to practise in a different environment, which she may need to retrain for. The panel is unable to conclude if Mrs Newman would be willing to undertake this retraining and change of environment.

Furthermore, the panel concluded that the placing of conditions on Mrs Newman's registration would not adequately address the public interest concerns.

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:

- *No evidence of harmful deep-seated personality or attitudinal problems; and*
- *No evidence of repetition of behaviour since the incident.*

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

considered that a suspension order would allow Mrs Newman time to remediate and reflect, as well as take steps towards returning to nursing, should she choose to. A suspension order also adequately addresses the public protection and public interest concerns. The panel noted Mrs Newman's attitudinal concerns, but concluded it was not deep-seated and consequently not inconsistent with the imposition of a suspension order.

The panel considered whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Newman's case to impose a striking-off order.

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

The panel noted the hardship such an order may cause Mrs Newman. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct, whilst also giving Mrs Newman the time she may need to remediate and strengthen her practice, should she choose to return to nursing.

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

Any future panel reviewing this case would be assisted by:

- Statement from Mrs Newman indicating her views on returning to nursing practice;
- A reflective piece;
- Documentation which demonstrates steps Mrs Newman has taken to strengthen her practice; and
- Testimonials from a line manager or supervisor that detail Mrs Newman's current nursing practices, if relevant.

This will be confirmed to Mrs Newman in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest until the suspension order 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 Ms Cockburn. She submitted that, should Mrs Newman appeal these findings, the substantive order would not be in place until that process has concluded. Consequently, an interim order would be necessary to cover the interim period, in light of Mrs Newman's impaired fitness to practise.

Ms Cockburn invited the panel to impose the same interim order which reflects that or the substantive order. She submitted that if the panel agreed with the NMC's submissions and it was minded to impose a suspension order, then it should impose an interim suspension order to reflect this. Conversely, if the panel sought to impose a conditions of practice order, then it should impose an interim conditions of practice order on the same terms.

Decision and reasons on interim order

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

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

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

That concludes this determination.