Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
09 May 2023- 10 May 2023
12 May 2023- 22 May 2023

Virtual Hearing

Name of Registrant:	Ruth Austin
NMC PIN	75U2196E
Part(s) of the register:	Sub Part 2 RN2 – Adult nurse (level 2) – 5 January 1977 Sub Part 1 RN1 – Adult nurse (level 1) – 25 September 1998
Relevant Location:	Somerset
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, Lay member) Rosalyn Mloyi (Registrant member) Shaun Donnellan (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Roshani Wanigasinghe
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Mrs Austin:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e(i), 1e (ii), 1f (i), 1f (ii), 1f (iv), 2a, 2b, 3b, 3e, 3f, 3g, 3h, 3i, 3j and 4.

Facts not proved:	Charges 1f (iii) and 3a.
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Austin was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 23 March 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing/that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Austin'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 Austin 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 Austin

The panel next considered whether it should proceed in the absence of Mrs Austin. It had regard to Rule 24 and heard the submissions of Mr Smalley who invited the panel to continue in the absence of Mrs Austin. He submitted that Mrs Austin had voluntarily absented herself.

Mr Smalley referred the panel to an email from Mrs Austin dated 3 April 2023 which stated:

“I give my permission for the hearing to go ahead.”

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Austin. In reaching this decision, the panel has considered the submissions of Mr Smalley, the emails from Mrs Austin, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Austin;
- Mrs Austin has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Six witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Austin in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her and she has sent her responses 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 Austin's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide live evidence or make live submissions on her own behalf.

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

Details of charge

That you, a registered nurse, working at the Dunkirk Memorial House:

1) Between 1 January 2016 and 15 August 2019

    a) On one or more occasions did not respond to an emergency bell in a timely fashion **[Charge found proved]**
    b) On one or more occasions failed to turn a resident as required **[Charge found proved]**
    c) On one or more occasions failed to provide incontinence care to residents **[Charge found proved]**
    d) On one or more occasions documented that you had completed a resident incontinence check when you had not done so **[Charge found proved]**
    e) On one or more occasions provided inadequate incontinence care in that:

i. Residents' underwear would not be pulled up properly **[Charge found proved]**

ii. Pads would not have been fitted correctly **[Charge found proved]**

f) Failed to conduct yourself professionally in respect of colleagues in that:

i. You failed to respect and/or reflect upon the contributions of colleagues in respect of your practice **[Charge found proved]**

ii. On one occasion lost your temper with a member of staff and slammed a cup of water onto a table **[Charge found proved]**

iii. You demonstrated favouritism when allocating work tasks **[Charge found NOT proved]**

iv. On one or more occasions you adopted an abrupt manner when dealing with colleagues **[Charge found proved]**

2) Between 1 January 2019 and 15 August 2019 in respect of a resident in room 25 who had suffered a fall and sustained injury

a) you failed to respond to an emergency bell **[Charge found proved]**

b) having been informed that the resident required help you did not attend in a timely manner **[Charge found proved]**

3) Between 1 March 2019 and 15 August 2019

a) Instructed Patient B to "piss in his pad" or words to that effect **[Charge found NOT proved]**

b) Failed to change the wet incontinence pad of Patient B **[Charge found proved]**

~~c) Regularly failed to change the wet incontinence pads of residents~~

~~d) Regularly documented that you had provided incontinence care when you had not done so~~

e) On one or more occasions did not answer residents' call bells or did not answer them in a timely fashion **[Charge found proved]**

f) On one or more occasions slept whilst on duty **[Charge found proved]**

g) On one or more occasions failed to reposition residents who needed to be turned **[Charge found proved]**
h) On one or more occasions documented that you had repositioned a resident when you had not done so **[Charge found proved]**
i) On one or more occasions failed to wash residents in the morning **[Charge found proved]**
j) Regularly failed to assist care assistants to provide personal care for residents when required **[Charge found proved]**

4) And your conduct as specified in charges 1 d) ~~and/or 3 d)~~ and/or 3 h) was dishonest in that you sought to give the impression to your colleagues and/or others that you had provided care to residents when you had not done so **[Charge found proved]**

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

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

At the outset of the hearing, Mr Smalley made a request that this case be held partly in private on the basis that proper exploration of Mrs Austin's case includes reference to **[PRIVATE]**. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to hold any references to **[PRIVATE]** in private, as and when such issues are raised in order to protect her privacy.

Decision and reasons on the consideration for further particularisation of the charges

Mr Smalley referred the panel to an earlier objection raised by Mrs Austin's previous representative at the Royal College of Nursing (RCN), that the "allegations against Mrs Austin are not particularised and does not meet the two-stage test of particularisation as seen in the case of *R. (Johnson and Maggs) v Professional Conduct Committee of the NMC* [2008]".

Mr Smalley submitted that as Mrs Austin is not represented, it would be fair and appropriate to bring this challenge by her previous representatives to the panel's attention notwithstanding their absence today.

Mr Smalley then provided the panel with information related to Rule 24 (2) of the Rules and referred to the case of *Hutchinson v General Dental Council* [2008] EWHC 2896 (Admin) and submitted that the current allegations are sufficiently particularised to allow Mrs Austin to understand and respond to. He submitted that Mrs Austin has in fact been able to provide responses to the charges in her bundle. He submitted that this case involves matters related to poor clinical practice which are set out within the charges. He said that a number of witnesses are due to provide evidence in respect of these charges and that they are unable to recall dates and times of those incidents. He submitted that as there were a number of alleged incidents, the dates are not material.

The panel accepted the advice of the legal assessor.

The panel considered the submissions of the case presenter and the written challenge from Mrs Austin's then representative. The panel also had regard to the documentation before it. It was of the view that there was in fact sufficient information within the current charges to enable Mrs Austin to respond. The panel noted that in fact she has already provided detailed responses to the charges without it being further particularised. The panel took into account the fact that the witnesses have said that they do not recall the

dates and times when the incidents occurred. The panel was content that the period of the dates identified are immaterial (not material averments) as advised by the legal assessor. However, the panel noted that if it, after hearing oral evidence, is of the view that the charges would need further particularisation, it would consider the matter afresh at that point.

Decision and reasons on application to amend charges

The panel heard an application made by Mr Smalley, on behalf of the NMC, to amend charges in relation to 3c, 3d and 4 in accordance with Rule 28.

He submitted that charges 3c and 3d were duplicates of the contents of charges 1c and 1d. He therefore invited the panel to delete charges 3c and 3d and delete the reference to charge 3d in charge 4.

Mr Smalley informed the panel that he requested that the Case Officer inform Mrs Austin about this application and invite any response. However, she has not responded.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such amendments, as applied for, were simply to correct a repetition of the charges. It bore in mind that Mrs Austin was made aware of this application. The panel was satisfied that there would be no prejudice to Ms Austin and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the deletion to charge 3c and 3d and to allow the amendment, as applied for, to charge 4 to ensure clarity and accuracy.

Background

The NMC received a referral from the Home manager at Dunkirk Kirk Memorial House (the

Home) following a whistleblowing letter received by them about another member of staff. During the investigation, concerns were raised about Mrs Austin's clinical care of residents at the Home. The Home is a 86 bedroom home split into 3 units of a residential unit, a nursing unit and a dementia unit.

The investigation at the Home revealed a number of concerns about Mrs Austin's practice, which are set out and described in the charges. Charges 1- 4 relate to poor clinical care of residents within the Home, poor interpersonal skills with colleagues, and in certain circumstances, dishonest record keeping.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Smalley on behalf of the NMC and Mrs Austin's written responses to the charges.

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

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, who worked at the Home at the time of the incidents:

- Ms 1: Health Care Assistant at Musgrove Park Hospital and Bank Care, Assistant at Dunkirk Memorial House;

- Ms 2: Registered nurse;
- Ms 3: Care Assistant at Abbeyfield Extra Care Home;
- Mr 4: Care Assistant at Dunkirk Memorial House;
- Ms 5: Deputy Manager at Dunkirk Memorial House;
- Ms 6: Home Manager at Dunkirk Memorial House.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel also had the advantage of the NMC identifying the witness evidence and Mrs Austin's responses to some of the charges.

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

Charge 1a

1) Between 1 January 2016 and 15 August 2019

a) On one or more occasions did not respond to an emergency bell in a timely fashion

This charge is found proved.

In reaching this decision, the panel took into account the Internal Investigation Meeting notes with Ms 6 and the evidence of Ms 1.

The panel noted that within the Internal Investigation Meeting notes at the Home dated 1 August 2019 with Ms 6, in answer to the question of *"Have any of the residents ever complained to you about their care of staff members"*, Ms 1 states:

> *"Room 25 after he had fallen. We pressed the emergency bell and waited and waited. I had to go and tell Ruth and she said ''ill be there in a minute' I went back to his room and apologised…She eventually came between 5 and 10 minutes later and looked at his arm. [sic]"*

The panel also bore in mind Ms 1's witness statement dated 7 June 2021 in which she said:

> *"The Registrant used to take ages to respond to emergency bells within the Home. She would never move fast. As a Nurse, the Registrant felt her only responsibility was to complete the medication round. It is all staff's responsibility to respond to emergency bells."*

The panel took into account Mrs Austin's responses in relation to this charge where she says that she did frequently answer call bells and that they would take it in turns in the Home.

The panel found that the main witness for this event is Ms 1, who was a Health Care Assistant at the Home at the relevant time. It found Ms 1 to be a reliable witness in respect of this charge. The panel was satisfied from the information before it that Ms 1 gave a clear account to Ms 6 during the meeting on 1 August 2019. Further, the panel bore in mind that Ms 1's oral evidence was consistent with her written evidence.

The panel was able to rely on this evidence as Ms 1 was tested during her oral evidence and therefore, the panel preferred the evidence of Ms 1 to Mrs Austin's responses. The panel therefore determined that between 1 January 2016 and 15 August 2019, on one or more occasions, Mrs Austin, did not respond to an emergency bell in a timely fashion.

The panel therefore found charge 1a proved.

Charge 1b

1) Between 1 January 2016 and 15 August 2019

b) On one or more occasions failed to turn a resident as required

This charge is found proved.

In reaching this decision, the panel took into account the Internal Investigation Meeting notes with Ms 6 and the evidence of Ms 1.

The panel noted Ms 1's witness statement dated 7 June 2021 in which she said:

> *"Some of the residents required regular turning in their sleep. On some occasions the Registrant said not to turn some residents who should have been turned because they looked peaceful. Two residents that come to mind are Patient C and Patient D."*

The panel also bore in mind Ms 1's oral evidence in which she explained that she could not remember who the patient was, C or D, but Mrs Austin had said they looked peaceful and that they should not turn them.

The panel took into consideration the Internal Investigation Meeting notes dated 1 August 2019 with Ms 6. It noted Ms 1's response to the question of *"have you ever felt that our resident should have their position changed more frequently"* where she replies:

> *"No not really. I think the more that you go in and disturbing them and their sleep. Unless they are really breaking down like …(no longer a resident) but not if skin is intact or at end of life. [sic]"*

The panel took into account Mrs Austin's responses in relation to this charge where she says that she and a carer paired up to check residents for turning and incontinence.

The panel was of the view that, in relation to this charge, the information it had received regarding Mrs Austin not wanting to turn a resident as they looked peaceful was not a justified explanation. The panel noted that Ms 1 is the main witness for this event, and it found her to be a credible and reliable witness in respect of this charge. The panel was satisfied from the information before it that between 1 January 2016 and 15 August 2019, Mrs Austin, on one or more occasions failed to turn a resident as required.

The panel therefore found charge 1b proved.

Charge 1c

1) Between 1 January 2016 and 15 August 2019

c) *On one or more occasions failed to provide incontinence care to residents*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1 and Ms 3.

The panel considered the witness statement of Ms 3 dated 14 May 2021, in which she wrote:

> *"I cannot remember the date of this incident, but I often had to provide incontinence care when the Registrant had failed. These events highlighted to me that the Registrant's standards of care were not good enough."*

The panel also bore in mind Ms 1's witness statement dated 7 June 2021 in which she said:

“The Registrant would sometimes fail to provide incontinence care to residents at the Home. I would know the Registrant had failed to provide the correct level of care because she would complete the checks too fast. During a round, all the staff in the nursing unit would help with incontinence checks. I would check the residents after the Registrant had, and find the Registrant had not completed the checks. Additionally, there were occasions when residents rang their bells for assistance, straight after the Registrant had seen them. The residents would do this because the Registrant had not provided incontinence care.

Each time a check was completed, it would be recorded in the residents care plan, by the staff member who performed the check. Sometimes the Registrant would record in the care plan that she has completed a check, when she had not completed a check.

When I would question the Registrant about not providing incontinence care, she would reply that the resident must have wet themselves in the short time between being checked by the Registrant and myself. I knew this was not the case because when I went to check a resident after the Registrant, their incontinence pad would be cold. If they had just wet themselves, it would be warm.

I am unable to recall any specific time frames or residents to which the Registrant did not provide incontinence care.”

Considering that Mrs Austin had said in her written response that it was possible that the residents had become incontinent soon after she had changed the incontinence pads and bedding on each visit, the panel explored this possibility with Ms 1 and Ms 3. They both explained the difference between a recently soiled pad which they said would be damp and warm and a one that had not been changed for a while which would be wet, cold and

heavy.

The panel was satisfied that both Ms 1 and Ms 3 provided clear explanations as to how they would know that an incontinence pad was not appropriately changed as described above. The panel bore in mind that their explanations were consistent with that of their witness statements and were corroborated with one another.

Given all the evidence above, the panel was satisfied that between 1 January 2016 and 15 August 2019, Mrs Austin, on one or more occasions failed to provide incontinence care to residents.

The panel therefore found charge 1c proved.

Charge 1d

1) Between 1 January 2016 and 15 August 2019

d) *On one or more occasions documented that you had completed a resident incontinence check when you had not done so*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1 and Ms 3.

The panel considered the witness statement of Ms 3 dated 14 May 2021, in which she wrote:

> *"When I started working at the Home, I was warned by the other Care Assistants that the Registrant frequently failed to provide incontinence care to the residents. I cannot remember the names of the Care Assistants who warned me. I was informed that the Registrant would often not change the incontinence pads of*

residents when were wet. This warning became apparent when I started working with the Registrant. I would often go into a resident's room after the Registrant had said she completed an incontinence pad check. I would discover their incontinence pad was wet and had not been changed. The Registrant would record that she had provided incontinence care when she had not. I know this because I would look at the records and then go and see the residents. The record did not match the condition of the residents incontinence pad. This happened on nearly every shift I completed with the Registrant. [sic]"

The panel also bore in mind Ms 1's witness statement dated 7 June 2021 in which she said:

"The Registrant would sometimes failed to provide incontinence care to residents at the Home. I would know the Registrant had failed to provide the correct level of care because she would complete the checks too fast. During a round, all the staff in the nursing unit would help with incontinence checks. I would check the residents after the Registrant had, and find the Registrant had not completed the checks. Additionally, there were occasions when residents rang their bells for assistance, straight after the Registrant had seen them. The residents would do this because the Registrant had not provided incontinence care.

Each time a check was completed, it would be recorded in the residents care plan, by the staff member who performed the check. Sometimes the Registrant would record in the care plan that she has completed a check, when she had not completed a check."

The panel was satisfied that both Ms 1 and Ms 3 provided evidence as to how they would know that an incontinence pad was not changed, contrary to what Mrs Austin had recorded. Although the panel noted that there were no care records brought before it to support this charge, it bore in mind that Ms 1 and Ms 3 were consistent in their oral

evidence and witness statements and their explanations corroborated with one another.

The panel further bore in mind that the investigation into this concerns occurred in the course of internal meetings which were not directed at Mrs Austin or not instigated by Mrs Austin's failures. The panel was therefore of the view that Ms 1 and Ms 3 would not have had a reason to fabricate their evidence. The panel found both witnesses to be credible and reliable in respect of this charge.

Given all the compelling evidence above, the panel was satisfied that between 1 January 2016 and 15 August 2019, Mrs Austin, on one or more occasions documented that she had completed a resident incontinence check when she had not done so.

The panel therefore found charge 1d proved.

Charge 1e (i)

1) Between 1 January 2016 and 15 August 2019

e) On one or more occasions provided inadequate incontinence care in that:

i. Residents' underwear would not be pulled up properly

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 4.

The panel had sight of Mr 4's witness statement dated 5 May 2021 in which he states:

> *"Sometimes the Registrant completed the incontinence checks on her own, when this happened I had concerns. I had concerns because the Registrant would not complete the checks to the standard I feel should be met. When completing the incontinence checks at 02:00, I would frequently find the checks completed at 22:00 by the Registrant were not to the high standard I would expect. I would see*

residents' underwear would not be pulled up properly or a pad would not be changed correctly so it had leaked. No particular residents come to mind. It was obvious that the Registrant was not completing the checks properly because she would complete them quickly. I know how long incontinence checks should take and the Registrant would complete them faster than this. This indicated to me that the checks were not being completed to the correct standard.

I raised my concerns about the standard of incontinence care being provided by the Registrant to Lead nurse, [Ms 2], at the end of the night shift on a couple of occasions. I do not remember the dates I raised these concerns."

The panel reminded itself of Mr 4's oral evidence in which he reiterated that the residents' underwear would often not be pulled up properly. In response to questions by the panel, Mr 4 stated it was possible for residents to have moved their underwear themselves. However, for the particular resident he was concerned about, they would not have been able to do so. The panel also bore in mind that Mr 4 was balanced in his oral evidence as he said that sometimes it can be difficult to pull up the underwear properly and that Mrs Austin's failings would not be on every occasion.

The panel found that the main witness for this event is Mr 4, who was a Health Care Assistant at the Home at the relevant time. It found Mr 4 to be a reliable witness in respect of this charge. The panel was satisfied from the information before it that Mr 4 gave a clear and consistent account in respect of this charge. Further, the panel was able to rely on this evidence as Mr 4 was tested during his oral evidence. It noted that Mr 4 had high standards of care and the panel was impressed by the standard of care that Mr 4 found to be acceptable.

Given all the evidence above, the panel determined that between 1 January 2016 and 15 August 2019, on one or more occasions, Mrs Austin, provided inadequate incontinence care in that the residents' underwear would not be pulled up properly.

The panel therefore found charge 1e (i) proved.

Charge 1e (ii)

1) Between 1 January 2016 and 15 August 2019

e) On one or more occasions provided inadequate incontinence care in that:

ii. Pads would not have been fitted correctly

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 4.

The panel had sight of Mr 4's witness statement dated 5 May 2021 in which he states:

> *"Sometimes the Registrant completed the incontinence checks on her own, when this happened I had concerns. I had concerns because the Registrant would not complete the checks to the standard I feel should be met. When completing the incontinence checks at 02:00, I would frequently find the checks completed at 22:00 by the Registrant were not to the high standard I would expect. I would see residents' underwear would not be pulled up properly or a pad would not be changed correctly so it had leaked. No particular residents come to mind. It was obvious that the Registrant was not completing the checks properly because she would complete them quickly. I know how long incontinence checks should take and the Registrant would complete them faster than this. This indicated to me that the checks were not being completed to the correct standard.*
>
> *I raised my concerns about the standard of incontinence care being provided by the Registrant to Lead nurse, [Ms 2], at the end of the night shift on a couple of occasions. I do not remember the dates I raised these concerns."*

The panel also bore in mind Mr 4's oral evidence in which he gave the panel a description of how to fit a pad correctly without it folding. The panel explored with Mr 4 what action he would take to ensure the pad was fitted properly. Mr 4 explained that pads would need to be flat, and it would be folded over sometimes without a carer realising. He further explained that he would roll residents over, align the pad with a residents' bottom and ensure they are fitted properly by carrying out the checks. He then amplified his evidence in that he noted this issue only occurred when Mrs Austin had carried out the incontinence care and not with other staff at the Home.

The panel found Mr 4's evidence to be clear and consistent. It determined that Mr 4 was a credible witness in relation to this charge and that it had no reason not to believe him. The panel was of the view that that there would be no reason for Mr 4 to make anything up or fabricate events.

Mrs Austin was silent in respect of this charge.

Given all the evidence above, the panel determined that between 1 January 2016 and 15 August 2019, on one or more occasions, Mrs Austin, provided inadequate incontinence care in that, pads would not have been fitted correctly.

The panel therefore found charge 1e (ii) proved.

Charge 1f (i)

1) Between 1 January 2016 and 15 August 2019

f) Failed to conduct yourself professionally in respect of colleagues in that:

i. You failed to respect and/or reflect upon the contributions of colleagues in respect of your practice

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 4, Ms 1 and Ms 5.

The panel first considered the witness statement of Mr 4 dated 5 May 2021, in which he wrote:

> *"The Registrant was very dismissive of comments about her practice. If the Registrant was on duty and you said something wrong, you would be sent upstairs to the resident unit. This created an atmosphere where Care Assistants felt they could not raise concerns about the Registrant's practice."*

The panel also reminded itself of Mr 4's oral evidence in which he said that if one were to point out an error to Mrs Austin, she would say "I know my job…". The panel further bore in mind that Mr 4 said that Mrs Austin was dismissive about comments regarding her practice. He told the panel that if he commented, for example, that Mrs Austin had not put the pad on properly, the next day he would be sent upstairs.

The panel further considered Ms 5's oral evidence in which she described Mrs Austin to be *"abrasive in manner",* particularly in relation to third parties.

The panel was also provided corroborative evidence from Ms 1, who was able to break down the actual incident in relation to this charge. Ms 1's oral evidence was consistent with her written evidence in that Ms 1 stated in her witness statement dated 7 June 2021, that:

> *"On occasion I had a run in with the Registrant. The Registrant lost her temper and slammed her cup of water on the table. The Registrant wanted to send me upstairs to work in the residential unit. I said that I would not work upstairs. This made me feel very uncomfortable around the Registrant when I worked with her for the following shifts.*

The Registrant was often abrupt with staff, but I did not witness any instances in which the Registrant displayed poor conduct towards other colleagues."

The panel took into account Mrs Austin's explanation that these issues arose as a result of members of staff smoking whilst on their breaks.

The panel found Mr 4, Ms 1 and Ms 5 to be reliable witnesses in respect of this charge. The panel determined that it had sufficient information before it to find that between 1 January 2016 and 15 August 2019, Mrs Austin failed to conduct herself professionally in respect of colleagues in that, she failed to respect and/or reflect upon the contributions of colleagues in respect of her practice.

The panel therefore found charge 1f (i) proved.

Charge 1f (ii)

1) Between 1 January 2016 and 15 August 2019

f) Failed to conduct yourself professionally in respect of colleagues in that:

ii. On one occasion lost your temper with a member of staff and slammed a cup of water onto a table

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1 and Mrs Austin's response to the charge.

Within Mrs Austin's responses to the charges, in an email dated 28 July 2021, she wrote:

"…[Ms 1] made a statement that I slammed my cup on the table - I'd asked her if she could go upstairs , when I was doing the allocation of carers , to work on the Residential floor and she said " NO " I don't have to work upstairs as it causes ne

stress" I wasn't aware carers could state where they worked and with whom .- surely it is up to the Nurse in charge to allocate staff ." I did say " you lot make me sick"

The panel was of the view that her statement above indicated a partial admission.

The panel considered the written evidence of Ms 1 in her witness statement dated 7 June 2021, in which she wrote that:

"On occasion I had a run in with the Registrant. The Registrant lost her temper and slammed her cup of water on the table. The Registrant wanted to send me upstairs to work in the residential unit. I said that I would not work upstairs. This made me feel very uncomfortable around the Registrant when I worked with her for the following shifts.

The Registrant was often abrupt with staff, but I did not witness any instances in which the Registrant displayed poor conduct towards other colleagues."

The panel noted that although Mrs Austin has not accepted the slamming of the cup, there is however an acceptance by her to saying '*you lot make me sick'*. The panel having found Ms 1 to be a reliable witness in respect of this charge, decided that, Ms 1's witness statement which was consistent with her oral evidence and preferred her account to Mrs Austin's untested account.

The panel determined therefore that it had sufficient information before it to find that between 1 January 2016 and 15 August 2019, Mrs Austin failed to conduct herself professionally in respect of colleagues in that, on one occasion lost her temper with a member of staff and slammed a cup of water onto a table.

The panel therefore found charge 1f (ii), on the balance of probabilities, proved.

Charge 1f (iii)

1) Between 1 January 2016 and 15 August 2019

f) Failed to conduct yourself professionally in respect of colleagues in that:

iii. You demonstrated favouritism when allocating work tasks

This charge is NOT found proved.

In reaching this decision, the panel took into account the evidence of Ms 1.

The panel noted that the sole evidence in respect of this charge is from Ms 1. It noted that Ms 1 states in her witness statement dated 7 June 2021, that:

> *"The Registrant definitely had staff she preferred to work with. If she did not like a staff member, the Registrant would send them upstairs, to work in the residential unit."*

The panel was of the view that Mrs Austin may have acted in a way where she had better working relationships with other members of staff, however, there is not sufficient evidence before the panel to demonstrate that she showed favouritism.

In light of the above evidence, the panel found that the NMC has not discharged its burden of proof to the required standard.

Therefore, the panel found charge 1f (iii) not proved.

Charge 1f (iv)

1) Between 1 January 2016 and 15 August 2019

f) Failed to conduct yourself professionally in respect of colleagues in that:

iv. On one or more occasions you adopted an abrupt manner when dealing with colleagues

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 4.

The panel had sight of Mr 4's witness statement dated 5 May 2021 in which he states:

> *"The Registrant was very dismissive of comments about her practice. If the Registrant was on duty and you said something wrong, you would be sent upstairs to the residential unit. This created an atmosphere where Care Assistants felt they could not raise concerns about the Registrant's practice."*

The panel also bore in mind Mr 4's oral evidence where he told the panel that when talking to Mrs Austin about her practice, the manner in which she responded to him would be abrupt. He provided the panel with an example of such an instance: when he had told Mrs Austin that she had not put a pad on a resident properly and was therefore sent to work on the unit upstairs the next day. The panel found this behaviour to be brusque and abrupt. The panel was of the view that that there would be no reason for Mr 4 to make anything up or fabricate events and found him to be a reliable witness in respect of this charge.

The panel also had sight of Ms 1's witness statement dated 7 June 2021 in which she wrote:

> *"The Registrant was often abrupt with staff, but I did not witness any instances in which the registrant displayed poor conduct towards other colleagues"*

Given the evidence above, the panel determined that between 1 January 2016 and 15 August 2019, Mrs Austin, failed to conduct herself professionally in respect of colleagues

in that, on one or more occasions she adopted an abrupt manner when dealing with colleagues.

The panel therefore found charge 1f (iv) proved.

Charge 2a

2) *Between 1 January 2019 and 15 August 2019 in respect of a resident in room 25 who had suffered a fall and sustained injury*
   a) *you failed to respond to an emergency bell*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1, Ms 3 and Ms 6.

The panel had sight of Ms 1's witness statement dated 7 June 2021 in which she wrote:

> "*There was an incident when the resident in Room 25 had fallen. The resident had suffered a skin tear and was bleeding I rang the emergency bell to get the attention of the Registrant because she was in charge of the nursing unit. The Registrant was nowhere to be seen so I had to go and find he. When I found the Registrant, she was completing the drug round. I told her that I needed her help. I then returned to the resident. When I returned the resident asked me "is it the fat one, I don't like her". I do not know why the resident did not like the Registrant.*
> *…*
> *I do not recall the exact date of the incident involving the resident in room 25, but the incident occurred around the middle of 2019. I do not recall the name of the resident, but know that they have sadly passed away since the incident.*

The Registrant used to take ages to respond to emergency bells within the Home. She would never move fast. As a Nurse, the Registrant felt her only responsibility was to complete the medication round. It is all staff's responsibility to respond to emergency bells"

The panel also had sight of Ms 6's witness statement dated 10 June 2021 in which she states:

"During the course of the Whistleblowing Investigation, some staff members raised concerns that the Registrant did not immediately respond to emergency bells when they were pressed. The Registrant should immediately have responded to an emergency bell if one was pressed by another member of staff. Any delay in responding may delay the action required to provide emergency care to a resident."

The panel was of the view, from the evidence before it, that Mrs Austin had failed to respond to an emergency bell. It bore in mind Ms 1's oral evidence in which she told the panel that Mrs Austin was only a few minutes away and therefore she must have heard the emergency bell, although she did not respond. It noted that from Ms 1's evidence above, that there was nothing that Mrs Austin was doing at that time that prevented her from acting immediately. The panel appreciated that she was doing her clinical duties at the time. However, it noted the urgency and importance as stated by Ms 6 above, of the need to respond to an emergency call bell immediately.

The panel further bore in mind that both Ms 1 and Ms 3, during their oral evidence, described to the panel the two types of bells (call bell and emergency bell) and the differences between them.

The panel found Ms 1, Ms 3 and Ms 6 to be credible and reliable witnesses in respect of this charge. The panel was of the view that it had sufficient evidence before it to establish that between 1 January 2019 and 15 August 2019, in respect of a resident in room 25 who had suffered a fall and sustained injury, Mrs Austin failed to respond to an emergency bell.

The panel therefore found charge 2a proved.

Charge 2b

2) Between 1 January 2019 and 15 August 2019 in respect of a resident in room 25 who had suffered a fall and sustained injury

b) having been informed that the resident required help you did not attend in a timely manner

This charge is found proved.

In reaching this decision, the panel took into account the Internal Investigation notes with Ms 6, the evidence of Ms 1 and Mrs Austin's response to the charge.

The panel noted that Mrs Austin, in her email dated 24 June 2021, responds to this particular charge by stating:

> *"[Ms 1] states I came to Room 25 ,5-10 minutes late when the patient had fallen. Once I'd locked the medication trolley I came to the room, to see what the call was about... I was actually dressing a client when she called on the call bell as soon as I considered the client was safe I went to check what the problem was in Room25"*

The panel then had sight of Ms 1's witness statement dated 7 June 2021 in which she wrote:

> "*There was an incident when the resident in Room 25 had fallen. The resident had suffered a skin tear and was bleeding I rang the emergency bell to get the attention of the Registrant because she was in charge of the nursing unit. The Registrant was nowhere to be seen so I had to go and find he. When I found the Registrant, she was completing the drug round. I told her that I needed her help. I then*

returned to the resident. When I returned the resident asked me "is it the fat one, I don't like her". I do not know why the resident did not like the Registrant.

The Registrant arrived after what felt like another five or ten minutes. This seemed like an unnecessary amount of time because all the Registrant had to do was shut up the drug cabinet. When the Registrant arrived, I left to care for the other residents.

I do not recall the exact date of the incident involving the resident in Room 25, but the incident occurred around the middle of 2019. I do not recall the name of the resident, but know that they have sadly passed away since the incident."

The panel bore in mind that Ms 1 identifies in her evidence that she had to leave the room in order to get Mrs Austin as she did not respond to the emergency bell in the time expected. The panel further bore in mind Ms 1's evidence that even after she was called, Mrs Austin took some time to attend to the resident in Room 25. Ms 1 told the panel that Mrs Austin was between rooms 5-7 at the time of the emergency bell being pressed, therefore it should have taken her about a minute to respond.

The panel further noted that within the Internal Investigation Meeting notes dated 1 August 2019 with Ms 6, in answer to the question of *"Have any of the residents ever complained to you about their care of staff members"*, Ms 1 states:

"Room 25 after he had fallen. We pressed the emergency bell and waited and waited. I had to go and tell Ruth and she said ''ill be there in a minute' I went back to his room and apologised…She eventually came between 5 and 10 minutes later ad looked at his arm. [sic]"

The panel noted Mrs Austin's response, that she was dressing a resident to ensure that individual was safe. She also stated that she was locking the drug trolley before responding to the emergency bell. The panel noted the contradiction of her accounts and

because these accounts could not be tested, the panel was unable to form a view about what her position actually was.

In contrast, the panel determined that Ms 1 was a credible witness in respect of this charge and therefore believed her account.

The panel was of the view that, a response time of between 5-10 minutes to an emergency bell could not be considered to be ‘timely manner’ especially after having been informed that the Resident was injured and bleeding. The panel also considered the evidence from Ms 6, where she explained that she would expect Mrs Austin to respond to the emergency bell but not the general call bell during the drug round.

The panel was therefore of the view that it had sufficient information before it to find that between 1 January 2019 and 15 August 2019, in respect of a resident in room 25 who had suffered a fall and sustained injury, having been informed that the resident required help, Mrs Austin did not attend in a timely manner.

The panel therefore found charge 2b proved.

Charge 3a

3) Between 1 March 2019 and 15 August 2019

a) Instructed Patient B to “piss in his pad” or words to that effect

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Ms 3.

The panel bore in mind Ms 3’s witness statement dated 14 May 2021 in which she stated:

"I cannot remember their name, but on one occasion Patient B rang his bell to get the attention of the Registrant. Patient B needed his incontinence pad changing because it was wet. The Registrant went into the room of Patient B and did not change Patient B's incontinence pad. The Registrant also told Patient B to "piss in his pad". I was not present when the Registrant said this to Patient B. I know of this incident because immediately after the event, the Registrant told me she had said this. After the Registrant had told me this, I went and changed the incontinence pad of Patient B."

The panel noted that the evidence in relation to this charge is from Ms 3 alone. The panel bore in mind Ms 3's evidence that she was not a direct witness to this incident, but that Mrs Austin had told Ms 3 she had told the resident to 'piss in his pad'.

The panel bore in mind that Mrs Austin had denied this allegation.

The panel compared the two accounts before it. The panel was of the view that although there was evidence from Ms 3 alone in respect of this charge, it is not direct evidence, in terms of an instruction for patient B to 'piss in his pad'. The panel determined that there are no other witnesses to corroborate this incident.

The panel determined that on the balance of probabilities, the NMC has not discharged its burden of proof. In coming to this conclusion, the panel could find no evidence that the Mrs Austin 'instructed' Patient B to 'piss in his pad'.

In light of this evidence, the panel found charge 3a, on the balance of probabilities, not proved.

Charge 3b

3) Between 1 March 2019 and 15 August 2019

b) Failed to change the wet incontinence pad of Patient B

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3.

The panel bore in mind Ms 3's witness statement dated 14 May 2021 in which she stated:

> *"Some of the residents at the Home have a bell that they can ring when they need assistance.*
>
> *I cannot remember their name, but on one occasion Patient B rang his bell to get the attention of the Registrant. Patient B needed his incontinence pad changing because it was wet. The Registrant went into the room of Patient B and did not change Patient B's incontinence pad. The Registrant also told Patient B … I went and changed the incontinence pad of Patient B.*
>
> *I cannot remember the date of this incident, but I often had to provide incontinence care when the Registrant had failed. These events highlighted to me that the Registrant's standard of care were not good enough."*

The panel bore in mind that Ms 3 in her oral evidence explained in detail the difference between the "wet" and "damp" pads.

The panel noted that Mrs Austin has not provided a response in respect of this charge.

The panel determined that Ms 3 was a credible witness in respect of this charge and believed her account.

The panel was of the view that it had sufficient information before it to find that between 1 January 2019 and 15 August 2019, Mrs Austin failed to change the wet incontinence pad of Patient B.

The panel therefore found charge 3b proved.

Charge 3e

3) Between 1 March 2019 and 15 August 2019

e) On one or more occasions did not answer residents' call bells or did not answer them in a timely fashion

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3.

The panel noted that Ms 3 in her witness statement dated 14 May 2021 stated:

> *"When the bells rang in the night, the Registrant would usually not answer them because she was too lazy or she would asleep and not hear them. I have no specific incidents in mind."*

The panel took into account Mrs Austin's responses in relation to this charge where she says that she did frequently answer call bells and that they would take it in turns in the Home.

The panel bore in mind that Ms 3's oral evidence was consistent with her written evidence. It was able to rely on this evidence as Ms 3 was tested during her oral evidence and the panel found her to be a credible and reliable witness in respect of this charge. The panel therefore determined that between 1 January 2016 and 15 August 2019, on one or more occasions, Mrs Austin, did not answer residents' call bells or did not answer them in a timely fashion.

The panel therefore found charge 3e proved.

Charge 3f

3) Between 1 March 2019 and 15 August 2019

f) On one or more occasions slept whilst on duty

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's evidence, Ms 6's evidence and Mrs Austin's responses to the charges.

The panel had sight of Mrs Austin's responses to the charges within her email dated 24 June 2021, in which she said:

> *"I only slept on my Lunch break, I consider what I choose to do on my break is my concern."*

The panel further noted that in her email dated 4 July 2021, Mrs Austin wrote:

> *"I deny the allegations made against me in these reports. I'm not lazy at work and I have never slept whilst on duty, as they are waking nights. I only slept whilst I was on my meal breaks."*

The panel explored this charge with Ms 6, where she explained in detail that nurses are not supposed to sleep on duty, even during their breaks. Ms 6 explained that although she was unsure whether there was a written policy regarding shifts being a waking night, it was made clear when recruiting for positions that waking nights at the Home meant, being awake for the whole shift including any breaks. The panel was told that numerous meetings had been held to discuss this issue and managers conducted spot checks to ensure compliance. The panel heard evidence from a number of other witnesses who corroborated Ms 6's position.

The panel bore in mind the evidence it had heard, they staff are not allowed to sleep on shift, even during their breaks, as they may need to respond to emergencies.

The panel also considered Ms 3's witness statement addressing this charge, where she stated:

> *"When the bell rang in the night, the Registrant would usually not answer them because she was too lazy or she would be asleep and not hear them. I have no specific incidents in mind."*

The panel considered all the evidence before it and bore in mind that Ms 3's and Ms 6's oral evidence was consistent with their written evidence. It was able to rely on this evidence as Ms 3 and Ms 6 were tested during their oral evidence and the panel found them to be a credible and reliable witnesses in respect of this charge. The panel therefore determined that it had sufficient evidence before it to conclude that between 1 January 2016 and 15 August 2019, on one or more occasions, Mrs Austin, slept whilst on duty.

The panel therefore found charge 3f proved.

Charge 3g

3) Between 1 March 2019 and 15 August 2019

g) On one or more occasions failed to reposition residents who needed to be turned

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3, Ms 1, Ms 6, Ms 2, Ms 5 and Mrs Austin's responses to the charges.

The panel had sight of Ms 3's witness statement dated 15 May 2021, in which she said:

"The Registrant lied about the care she provided to residents. Some of the residents required reposition in the night. The Registrant would fail to reposition some residents, but record the repositioning charts that she had. I know this because I would go into a resident's room after the Registrant had recorded that the resident had been repositioned. The position of the resident and what was recorded on the repositioning chart would not match. I cannot provide any specific dates or examples but this happened on many occasions."

Ms 3 explained her familiarity and frequency for the requirement to reposition the resident. However, she detailed the occasions where she would check care plans in order to comply with expectations, for example, when a care plan had been revised, or when a resident was new to the Home. Ms 3 however told the panel that Mrs Austin would often not turn patients as required by the plan.

The panel heard evidence from Ms 2 and Ms 5, who both corroborated the evidence.

The panel also had sight of Ms 6's witness statement dated 10 June 2021 in which she stated:

"It is important that residents who need to be turned during the night are turned. Residents are at risk of developing precious sores if they are left in the same position for too long.

Turning residents training is provided as part of the People Handling training. This training was completed by the Registrant."

The panel had before it, the relevant training certificate which was completed by Mrs Austin on 15 February 2018.

The panel referred to Mrs Austin's response to the charge within her email dated 24 June 2021. It noted that Mrs Austin states that she may have suffered an injury in May 2019. However, the panel did not have any supporting evidence in respect of this and that Mrs Austin, as a result of this injury, may have been put on 'light duties' at the time of the incident. In this regard, the panel was of the view that it was expected of Mrs Austin to carry out her full duties, which included repositioning residents who needed to be turned.

The panel determined that it had sufficient evidence before it to find that, between 1 March 2019 and 15 August 2019, on one or more occasions, Mrs Austin failed to reposition residents who needed to be turned.

The panel therefore found charge 3g proved.

Charge 3h

3) Between 1 March 2019 and 15 August 2019

h) On one or more occasions documented that you had repositioned a resident when you had not done so

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 6, Ms 3 and Mrs Austin's responses to the charges.

The panel noted that Ms 6, in her witness statement dated 10 June 2021 in which she stated:

> *"It is important that residents who need to be turned during the night are turned. Residents are at risk of developing precious sores if they are left in the same position for too long.*

The panel then had sight of Ms 3's witness statement dated 15 May 2021, in which she said:

> *"The Registrant lied about the care she provided to residents. Some of the residents required reposition in the night. The Registrant would fail to reposition some residents, but record the repositioning charts that she had. I know this because I would go into a resident's room after the Registrant had recorded that the resident had been repositioned. The position of the resident and what was recorded on the repositioning chart would not match. I cannot provide any specific dates or examples but this happened on many occasions."*

The panel reminded itself that Ms 3's written evidence was consistent with her oral evidence. The panel bore in mind that Ms 3 further said in oral evidence that she would often go and check on the residents about 5 minutes after Mrs Austin had seen the registrant as Ms 3 had been warned by other colleagues of Mrs Austin's failures. When asked whether the resident could have moved himself, Ms 3 replied that would not have been the case.

The panel also had sight of Mrs Austin's response to the charge within her email dated 24 June 2021, in which said:

> "…*She comments on my record keeping in care plans -when I've visited or attended to a client, and what I did for them. (ie) I washed them, changed their pads and repositioned them afterwards.[sic]"*

The panel noted the absence of care records in the evidence, however it determined that it found Ms 3 and Ms 6 to be credible and reliable witnesses in respect of this charge. The panel was of the view that that there would be no reason for Ms 3 and Ms 6 to make anything up or fabricate events.

Given the evidence above, the panel determined that it had sufficient evidence before it to find that between 1 March 2019 and 15 August 2019, on one or more occasions, Mrs Austin documented that she had repositioned a resident when she had not done so.

The panel therefore found charge 3h proved.

Charge 3i

3) Between 1 March 2019 and 15 August 2019

i) On one or more occasions failed to wash residents in the morning

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3, Ms 6 and Mrs Austin's responses to the charges.

The panel had sight of Ms 3's witness statement dated 14 May 2021, which was consistent with her oral evidence. Ms 3 wrote:

> *"The night team was responsible for getting around eight residents out of bed in the morning and washed. The Registrant would often not wash Residents because she was too lazy. It also took more time to get residents up in the morning when the Registrant was on duty because she would not help the Care Assistants. This resulted in more work for the day team when they started their shift. All the other nurses I worked with would help the Care Assistant get residents up in the morning."*

The panel then bore in mind Ms 6's oral evidence in which she told the panel, very clearly, that it was part of Mrs Austin's duties and responsibilities as nurse to take part in all care.

The panel then bore in mind Mrs Austin's response to the charge within her email dated 24 June 2021, in which she wrote that:

> "…6.30/7am. RN starts administering early morning medications until about 7.15/7.30am. RN helps with getting up clients who want to get up dressed for breakfast."

The panel noted that this response was non specific to this charge.

The panel determined that in the absence of any further evidence from Mrs Austin and the reliable evidence provided to the panel from Ms 3 and Ms 6, it had sufficient evidence before it to find that between 1 March 2019 and 15 August 2019, Mrs Austin, on one or more occasions failed to wash residents in the morning.

The panel therefore found charge 3i proved.

Charge 3j

3) Between 1 March 2019 and 15 August 2019

j) Regularly failed to assist care assistants to provide personal care for residents when required

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 4, Ms 3, Ms 6, the Internal Investigation Meeting notes with Ms 6 and Mrs Austin's job description.

The panel noted Mr 4's response to the question from Ms 6 within the Internal Investigation Meeting notes dated 25 July 2019, '*how would you describe the care given to incontinent residents overnight?',* where Mr 4 replies:

"Again if Ruth… is on it is not good. They are not washing properly."

The panel also took into consideration the Internal Investigation Meeting notes dated 1 August 2019 with Ms 6. It noted Ms 3's response to the question of *"can you describe anything that worries you when working on nights?",* where she states:

"No I'm just concerned working with Ruth. As much as I don't agree with it I am not a part of it. When these… aren't on we have a laugh and everything is done as it should be. [Another colleague] helps a lot in the mornings. Ruth doesn't answer the bells and doesn't help in the morning so we cant get as many up."

The panel also had sight of Ms 3's witness statement dated 14 May 2021, which was consistent with her oral evidence. Ms 3 wrote:

"The night team was responsible for getting around eight residents out of bed in the morning and washed. The Registrant would often not wash Residents because she was too lazy. It also took more time to get residents up in the morning when the Registrant was on duty because she would not help the Care Assistants. This resulted in more work for the day team when they started their shift. All the other nurses I worked with would help the Care Assistant get residents up in the morning."

The panel then bore in mind Ms 6's oral evidence in which she told the panel, very clearly, that it was part of Mrs Austin's duties and responsibilities as nurse to take part in all care.

The panel finally considered Mrs Austin's job description where it sets out the key responsibilities for the role of a nurse. The panel noted that the key responsibilities include:

"…

- *In conjunction with the Senior nurse, assist in the supervision and leadership of the care staff in all matters of nursing care, to optimal standards, and assist in the monitoring of those standards.*
- *…*
- *To co-ordinate, direct and supervise the duties of the Care Assistants, working alongside them to ensure the performance of informed, safe practices and efficiency, and to report to the Senior Nurse/Deputy Matron/Manager and concerns."*

In reaching its decision, the panel took into account Mrs Austin's response where she states that she would regularly assist once the medication rounds were completed. However, the panel determined that, given all the above information, it had sufficient evidence before it to determine that between 1 March 2019 and 15 August 2019, Mrs Austin regularly failed in her responsibilities in her role to assist care assistants to provide personal care for residents when required.

The panel therefore found charge 3j proved.

Charge 4

4) And your conduct as specified in charges 1 d) ~~and/or 3 d)~~ and/or 3 h) was dishonest in that you sought to give the impression to your colleagues and/or others that you had provided care to residents when you had not done so

This charge is found proved.

In reaching this decision, the panel took into account its decision at charges 1d and 3h above. The panel also considered the NMC Code of Conduct, the NMC Guidance on *'Making decisions on Dishonesty charges'*, Mrs Austin's job description as well as the test set out in the case of *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67.*

The panel found that the job description requires Mrs Austin to adhere to the NMC Code of conduct which included reference to maintaining and keeping accurate records. The panel further noted that the job description includes within its key responsibilities, the need to:

> *"To work as a team member in the assessment of residents individual needs and the planning, delivery, documentation and regular review of care."*

The panel bore in mind that the NMC Code of Conduct is clear on expectations around recording care interventions and the job description breaks down the care and expectations of Mrs Austin clearly. It therefore determined that there was no alternative explanation for Mrs Austin documenting care interventions that had not been completed.

The panel was of the view that a well-informed member of the public, fully aware of all the facts of this case, would find Mrs Austin's actions at charge 4 to be dishonest.

Given the above information, the panel concluded that Mrs Austin's actions at charge 1d and 3h were dishonest in that she sought to give the impression to her colleagues and/or others that she had provided care to residents when she had not done so.

In light of this evidence, the panel found charge 4, on the balance of probabilities, 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 Austin'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, Mrs Austin's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Smalley 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) updated in 2018, in making its decision.

Mr Smalley identified the specific, relevant standards where Mrs Austin's actions amounted to misconduct. He submitted that that there are standards that patients and members of the public expect from health care professionals. He submitted that through Mrs Austin's failures, her practice has fallen far below the standards expected of a registered nurse and therefore invited the panel to find that the charges found proved amounted to misconduct.

Submissions on impairment

Mr Smalley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for*

Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin).*

Mr Smalley submitted that the charges found proved relate to both clinical concerns and concerns about Mrs Austin's trustworthiness as a professional. He submitted therefore that these concerns would be considered more difficult to satisfy a panel or the public that there was not a risk of repetition. Mr Smalley reminded the panel that Mrs Austin has denied the charges and whilst she has supplied positive character evidence, she has not provided any evidence of insight or reflection around the concerns that have been found proved. He therefore submitted that there is a risk that similar incidents would occur again if a finding of impairment were not made.

Mr Smalley submitted that in the circumstances of this case, public confidence in the profession and professional standards would be undermined if a finding of impairment were not made. He said that dishonesty in the context of covering up clinical failures alongside placing patients under Mrs Austin's care at unwarranted risk of harm was at the height of seriousness. He submitted that public confidence would be significantly undermined if the NMC were not seen to act to, both deal with, the risk of repetition and mark Mrs Austin's behaviour as unacceptable. Mr Smalley therefore invited the panel to find Mrs Austin's practice impaired by reason of her misconduct.

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 *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons 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.'

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 Austin's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

> *"**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
> *8.4 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*
>
> *9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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 found that Mrs Austin's actions found proved, save for charges 1 f(i), 1 f(ii) and 1f (iv), did fall significantly short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

The panel determined that Mrs Austin's actions of failing to turn residents, failing to provide or providing inadequate incontinence care, failing to change wet incontinence pads, failing to wash residents and failing to assist care assistants to provide personal care for residents when required was serious. The panel found that Mrs Austin's failures left residents in an undignified state and increased the risk of bed sores and other complications associated with the breaking down of the skin and therefore exposed them

to the potential of harm. The panel was of the view that these were basic standards of dignity and respect which the residents did not receive as a result of Mrs Austin's failures to ensure that residents received an adequate standard of care.

The panel further determined charges relating to not answering call bells in a timely fashion, not responding to emergency bells and being asleep on duty to be particularly serious. The panel bore in mind that whilst staff would press either the call bell or emergency bell, residents would only use the call bell. By failing to respond to the call bell, Mrs Austin posed a significant risk to the residents as it could have been an emergency.

The panel was particularly concerned that the residents at the Home were vulnerable, older persons, some of whom heavily relied on staff to support with activities of daily living. The panel was of the view that Mrs Austin's failings put these residents at potential risk of serious harm.

The panel also noted that knowingly and falsely recording that residents had been turned and their incontinence pads checked highlighted Mrs Austin's lack of honesty and integrity considering the obvious serious clinical consequences to residents. By doing so, Mrs Austin sought to mislead those who she worked for and worked with that she had completed these checks, when she had not. By misleading colleagues through incorrect recording, Mrs Austin compromised further care to residents as her colleagues would not carry out these checks as they thought they had been done. The panel heard compelling evidence from a number of witnesses about Mrs Austin documenting care being given when it had not and found Mrs Austin's behaviour to have persisted in relation to colleagues and residents. It bore in mind that colleagues had warned each other of Mrs Austin's poor care or lack of care and therefore they felt the need to re-check residents following Mrs Austin's checks. The panel found such failures on Mrs Austin's part to be unacceptable.

The panel found that charges relating to 1 f(i), 1 f(ii) and 1f (iv), demonstrated Mrs Austin's poor team working, poor interpersonal skills and a lack of self-awareness. Although they

breached the code, the panel was of the view that Mrs Austin's behaviour in respect of these charges was not sufficiently serious to amount to misconduct.

The panel therefore decided that the clinical charges, individually and cumulatively in this case, put the residents involved at serious risk of harm. Furthermore, charge 4 also relate to dishonesty which reinforces the seriousness of the misconduct.

The panel therefore found that Mrs Austin's actions found proved, except for charges 1 f(i), 1 f(ii) and 1f (iv), did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel finds that all limbs of the Grant test are engaged in this case, both as to the past and the future. At the time of these incidents, Mrs Austin's misconduct placed vulnerable residents at unwarranted risk of harm, brought the nursing profession into disrepute, and breached fundamental tenets of the nursing profession, relating to adequate patient care.

The panel turned its consideration to matters of current impairment. In its consideration of whether Mrs Austin has addressed the failures in her practice, it bore in mind that the

charges found proved include dishonesty. The panel considered that the dishonesty demonstrated a pattern of behaviour, particularly as it was over a sustained period of time with a number of colleagues and a number of residents, to be attitudinal and determined it is therefore not easily remediable.

Mrs Austin has made no acknowledgement of wrongdoing, save for a partial admission to charge 1f (ii), which the panel did not consider to be misconduct in any event, and has denied any responsibility. The panel had sight of a letter dated 13 July 2021 from the Mrs Austin previous representatives at the Royal College of Nursing (RCN) where they made reference to Mrs Austin's reflective piece. However, all the panel has seen are Mrs Austin's responses to a number of the charges. The panel therefore had no evidence of insight into Mrs Austin's misconduct.

The panel had sight of two testimonials provided on Mrs Austin's behalf. The first is from Ms 7 which was undated. Whilst the testimonial was very positive in its endorsements of Mrs Austin's character, compassion and honesty, the panel noted there was no evidence of a recent working relationship. The second testimonial provided by Ms 8, spoke positively of Mrs Austin's good character and professional and clinical skills, however, it attached limited weight due to the superficial nature of their relationship as described by Mrs Austin.

Notwithstanding the two testimonials, the panel determined that Mrs Austin's misconduct involved wide ranging failings in relation to her basic duties as a nurse impacting on basic nursing care. It noted that Mrs Austin's misconduct put residents at risk of harm, and the panel is of the view that in the absence of any evidence of strengthening her practice, the risk of repetition is very high. The panel determined that, in this case, a finding of impairment on public protection grounds was required.

The panel bore in mind that the overarching objectives of the NMC is to protect, promote and maintain the health, safety, and wellbeing 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 had regard to the serious nature of Mrs Austin's failings and determined that public confidence in the profession, particularly as it involved dishonesty in clinical care, would be undermined if a finding of current impairment was not made. For this reason, the panel determined that a finding of current impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mrs Austin's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Austin off the register. The effect of this order is that the NMC register will show that Mrs Austin 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), SAN-2 'Guidance on Sanctions for serious cases' and FTP-3 'How we determine seriousness' (updated 2022) published by the NMC.

The panel accepted the advice of the legal assessor, he referred to the cases of *Parkinson v NMC* [2010] EWHC 1898 (Admin) and *Lusinga v NMC* [2017] EWHC 1458 (Admin).

Submissions on sanction

Mr Smalley informed the panel that in the Notice of Hearing, dated 23 March 2023, the NMC had advised Mrs Austin that it would seek the imposition of a strike-off order should Mrs Austin's fitness to practise be found to be currently impaired.

Mr Smalley identified the aggravating and mitigating features in this case. He submitted that Mrs Austin provided care to vulnerable residents over a number of years which fell significantly short of standards expected from a registered nurse.

Mr Smalley referred the panel to SAN-2 guidance on sanctions for serious cases. He reminded the panel that cases involving dishonesty are considered to be particularly serious by the NMC. Mr Smalley submitted that the following suggestions indicate that the dishonesty in this case was at the higher end of the spectrum, in that Mrs Austin:

- Covered up clinical failings;
- Breached her position of trust as she was the most senior person on duty at the Home;
- Cared for vulnerable residents;
- Placed residents at risk of harm; and
- Failings evidence attitudinal issues that are difficult to put right.

Mr Smalley made submissions in relation to the available sanctions in ascending order. He submitted that no further action or a caution order would not be appropriate given the seriousness of the case. He then submitted that a conditions of practice order would also be inappropriate given Mrs Austin's misconduct relates to her poor attitude rather than areas of practice that requires supervision or further training. Mr Smalley submitted that a suspension order would not address the misconduct identified as Mrs Austin has not reflected on the seriousness of her actions and has not addressed her dishonesty. Mr Smalley told the panel that the concerns in this case raise fundamental questions about Mrs Austin's professionalism. Mr Smalley therefore submitted that a striking off order is the only order which would protect the public and maintain public confidence in the profession.

Decision and reasons on sanction

Having found Mrs Austin'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:

- Poor practice extended over a number of years;
- Abuse of position of trust as a senior experienced nurse in charge of the Unit;
- Vulnerable residents were placed at risk of significant harm;
- Dishonesty in the context of falsifying records in order to cover up clinical failings and shortcomings; and
- No evidence of insight and/or reflection as to her conduct.

The panel also took into account the following mitigating feature:

- Limited evidence of **[PRIVATE]**.

The panel considered the level of Mrs Austin's dishonesty in accordance with the SG. It considered her dishonesty to be at the upper end of the spectrum as Mrs Austin deliberately documented that she had completed resident incontinence checks and the repositioning of the residents when she had not done so. The panel bore in mind that the dishonesty was in a clinical setting and there was a consequential risk of patient harm. Further, this involved a deliberate breach of her duty of care and involved misleading her junior colleagues as to the checks conducted by her.

The panel acknowledged that Mrs Austin **[PRIVATE]**. However, the panel was not presented with any supporting evidence **[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 Mrs Austin'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 Austin's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Austin's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the panel was of the view that some of the clinical concerns could have been addressed through a conditions of practice order, the panel determined that given the seriousness of the misconduct, Mrs Austin's attitudinal concerns and lack of insight into her dishonest actions, there are no practical or workable conditions that could be formulated. Accordingly, a conditions of practice order would not address the significant risk of repetition. The panel had no evidence before it to suggest that Mrs Austin would comply with any conditions of practice. Furthermore, the panel concluded that the placing of conditions on Mrs Austin's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. This was not a single instance of misconduct, furthermore the panel considered there was evidence of attitudinal problems. The clinical concerns in this case occurred over a sustained period of time and involved multiple residents and involved dishonesty. The panel bore in mind that Mrs Austin has provided no explanation for her actions, neither has she demonstrated any insight or remorse. Therefore, the panel concluded 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?*

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve the following factors:

- *A serious departure from the relevant professional standards as set out in key standards, guidance and advice.*

- *Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity. Harm is relevant to this question whether it was caused deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to patients. Harm may include physical, emotional and financial harm. The seriousness of the harm should always be considered.*
- *Dishonesty, especially where persistent or covered up.*
- *Persistent lack of insight into seriousness of actions or consequences.'*

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

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

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

This will be confirmed to Mrs Austin in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Smalley. He submitted that an interim suspension order is the necessary and proportionate interim order in this case. He submitted that given that the panel has determined that a striking-off order is appropriate and proportionate, it follows that an interim suspension order should be imposed to cover the 28-day appeal period in order to properly protect the public as well as being in the public interest. He submitted that this order should be imposed for 18 months in order to satisfy the public protection for the appeal period and to cover the time needed for an appeal to conclude.

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 adequately protect the public if this order is appealed.

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

That concludes this determination.