Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 9 – Friday 13 October 2023

Virtual Hearing

Name of Registrant:	**Elaine Shortt**
NMC PIN	76E0829E
Part(s) of the register:	RN2, Registered Nurse – Adult (Level 2) (1 February 2001)
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	Peter Wrench (Chair, lay member) Susan Field (Registrant member) Anne Rice (Lay member)
Legal Assessor:	Andrew Young
Hearings Coordinator:	Franchessca Nyame
Nursing and Midwifery Council:	Represented by Clarissa Rodio, Case Presenter
Mrs Shortt:	Not present and unrepresented at hearing
Facts proved:	Charges 2, 3a, 3c, 3d, 5a, 5b
Facts not proved:	Charges 1, 3b, 4, 6
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Shortt was not in attendance and that the Notice of Hearing letter had been sent to Mrs Shortt's registered email address by secure email on 7 September 2023.

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

The panel accepted the advice of the legal assessor.

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

The panel next considered whether it should proceed in the absence of Mrs Shortt. It had regard to Rule 21 and heard submissions from Ms Rodio on behalf of the NMC.

Ms Rodio invited the panel to continue in the absence of Mrs Shortt. She referred the panel to a telephone note dated 3 August 2023 recording communication between Mrs Shortt and her NMC Case Officer which states in part:

> '*…[Mrs Shortt] informed me that she can't participate in a case conference…She doesn't want to nurse again…*
>
> *She has confirmed she will not partipcate* [sic] *in the hearing on 9 Oct . I explained the panel will want to know if they can proceed in her absence. She said they can do so. I explained if she changes her mind that's fine, she should just call and let me know*.'

There has been no further communication from Mrs Shortt since the telephone conversation.

Ms Rodio submitted that Mrs Shortt can be considered as having voluntarily absented herself and therefore the panel can proceed in her absence.

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 decided to proceed in the absence of Mrs Shortt. In reaching this decision, the panel considered the submissions of Ms Rodio, the telephone note dated 3 August 2023, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba*

[2016] 1 WLR 3867, and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Shortt had received reasonable notice of the hearing and informed the NMC that she is content for the hearing to proceed in her absence;
- No application for an adjournment has been made by Mrs Shortt;
- There is no reason to suppose that adjourning would secure Mrs Shortt's attendance at some future date;
- Mrs Shortt has recently informed the NMC that she does not wish to return to nursing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Shortt in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to Mrs Shortt at her registered address, she has made no response to the charges. Mrs Shortt will not be able to challenge the evidence relied upon by the NMC 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 Shortt's decisions to voluntarily absent herself from the hearing, waive her rights to attend, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on amendments to the charges

In light of typographical errors in the charges, the panel decided to amend the wording of Charges 4 and 6, and to amend the introduction to the charges.

The proposed amendment was to provide clarity and more accurately reflect the evidence.

Ms Rodio had no objection to the amendments.

> "That you, a registered nurse, **whilst working at Parkside Nursing Home Nottingham ('the Home')**:
>
> 1. Between 21 July and 28 July 2020, failed to follow Covid-19 infection control procedures in relation to Resident A.
>
> 2. On 27 July 2020, failed to manage Resident B's challenging behaviour in line with her care plan and/or the Home's policy on Behaviour that Challenges.
>
> 3. In response to Resident B's challenging behaviour:
>   a. Placed Resident B in the Home's sensory room without her consent.
>   b. Did not turn on or ensure the lights in the sensory room were turned on.
>   c. Did not monitor and/or ensure Resident B was monitored whilst in the sensory room.
>   d. Did not remove Resident B from the sensory room when she became distressed and/or no longer consented to being placed there.
>
> 4. Your actions at ~~charge 4~~ **charge 3** were intended to punish Resident B for her challenging behaviour.

5. On 27 July 2020, you failed to maintain proper records in relation to Resident B, in that you:
    a. Failed to complete the challenging behaviour chart.
    b. Inaccurately completed Resident B's progress notes in that you made no reference to her being placed in the sensory room in response to her challenging behaviour.

6. Your actions at ~~charge 6~~ **charge 5** were dishonest in that you intended to conceal the actions you had taken in response to Resident B's challenging behaviour.

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

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 satisfied that there would be no prejudice to Mrs Shortt and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment to ensure clarity and accuracy.

Details of charge

That you, a registered nurse, whilst working at Parkside Nursing Home Nottingham ('the Home') :

1. Between 21 July and 28 July 2020, failed to follow Covid-19 infection control procedures in relation to Resident A. **[NOT PROVED]**

2. On 27 July 2020, failed to manage Resident B's challenging behaviour in line with her care plan and/or Parkside Nursing Home's (the Home's) policy on Behaviour that Challenges. **[PROVED]**

3. In response to Resident B's challenging behaviour:
    a. Placed Resident B in the Home's sensory room without her consent. **[PROVED]**
    b. Did not turn on or ensure the lights in the sensory room were turned on. **[NOT PROVED]**
    c. Did not monitor and/or ensure Resident B was monitored whilst in the sensory room. **[PROVED]**
    d. Did not remove Resident B from the sensory room when she became distressed and/or no longer consented to being placed there. **[PROVED]**

4. Your actions at charge 3 were intended to punish Resident B for her challenging behaviour. **[NOT PROVED]**

5. On 27 July 2020, you failed to maintain proper records in relation to Resident B, in that you:

    a. Failed to complete the challenging behaviour chart. **[PROVED]**
    b. Inaccurately completed Resident B's progress notes in that you made no reference to her being placed in the sensory room in response to her challenging behaviour. **[PROVED]**

6. Your actions at charge 5 were dishonest in that you intended to conceal the actions you had taken in response to Resident B's challenging behaviour. **[NOT PROVED]**

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

Background

Mrs Shortt was referred to the NMC on 1 September 2020 by the General Manager of the Home. Mrs Shortt began working at the Home as a nurse in 2014.

On 25 July 2020, Mrs Shortt allegedly allowed Resident A to socialise in the lounge at the Home, albeit with social distancing. This was despite the fact that Resident A had recently returned to the Home following an admission to hospital. As such, Mrs Shortt's alleged actions ran contrary to the Home's Covid-19 Risk Assessment Policy and risked spreading Covid-19 among other residents.

On 27 July 2020, Mrs Shortt took Resident B upstairs and placed her in the sensory room because of her behaviour towards other residents. Resident B had been diagnosed with dementia and a personality disorder but had capacity to make decisions about her own wishes. Resident B became very upset at being placed in the sensory room and began to shout loudly and cry. The Care Supervisor at the Home heard Resident B and went to investigate. They said they discovered Resident B in the sensory room with the light switched off, crying and begging for help. It is alleged that Mrs Shortt subsequently entered the room and told Resident B that she could return to the lounge downstairs if she agreed to apologise to the other residents.

The Care Supervisor was alarmed at Mrs Shortt's behaviour towards Resident B and subsequently raised their concerns in an e-mail to the Home Manager dated 28 July 2020. Mrs Shortt was suspended from her duties on the following day, and a local investigation was initiated. The local investigation indicated that Mrs Shortt had also failed to complete the 'Challenging Behaviour' chart with regards the incident with Resident B.

Mrs Shortt subsequently resigned from her position at the Home thus no disciplinary action was taken.

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 Ms Rodio.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Senior Clinical Manager with Monarch Healthcare. Employed as the Clinical Home Manager of the Home at the time of the incidents.
- Witness 2: Nurse Support with Monarch Healthcare working at the Home at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

> "That you, a registered nurse, between 21 July and 28 July 2020, failed to follow Covid-19 infection control procedures in relation to Resident A."

This charge is found NOT proved.

In reaching this decision, the panel took into account the Home's COVID-19 Risk Assessment Policy, the investigatory meeting notes dated 30 July 2020, oral evidence from Witness 1, and Mrs Shortt's written response to the NMC dated 4 May 2021.

The panel was not satisfied that there was sufficient evidence to support this charge on the basis that there is ambiguity in the Home's written policy with respect to what should happen with residents returning from hospital stays. The policy regarding new residents and re-admissions states:

> '*All residents coming from hospital may have their test results pending upon discharge, managers are to follow rules of isolation for 14 days and support the residents with full PPE until test results are confirmed*.'

The panel noted that it is documented in Resident A's hospital discharge information and progress notes that, on the morning of discharge, their COVID test was negative. The result therefore had been confirmed and were not pending.

The panel had regard to Witness 1's oral evidence in which they said that there was a blanket approach in the Home for residents to isolate for seven days rather than the 14 days specified in the policy. The panel noted that there was evidence that Mrs Shortt removed Resident A from isolation before such a seven-day isolation period was complete. However, in their oral evidence, Witness 1 stated that Mrs Shortt twice told them that she thought Resident A "*was cleared*", which the panel considered could have provided a basis for Mrs Shortt's clinical decision to remove Resident A from isolation earlier. Witness 1 did not query this with Mrs Shortt and, in

answering questions from the panel, Witness 1 said they did not know why they did not raise the issue with her. In addition, Mrs Shortt said in her response that Resident A had a history of poor appetite and that they ate better in the lounge with others around, so she took them to the lounge for meals whilst maintaining social distancing.

Taking account of the ambiguity in the written policy, the apparent divergence from the written policy in the Home's practical procedures, and the fact that a negative COVID test result had been obtained for Resident A, the panel was unconvinced that there was sufficient clarity about the rigidity of the seven-day isolation policy to establish that Mrs Shortt had been under a duty to comply with it.

Charge 2

> "That you, a registered nurse, on 27 July 2020, failed to manage Resident B's challenging behaviour in line with her care plan and/or the Home's policy on Behaviour that Challenges."

This charge is found proved.

The panel took into consideration Resident B's care plan, the Home's Behaviour that Challenges Policy and Procedure, the written and oral evidence from Witnesses 1 and 2, and Mrs Shortt's written response.

The panel was satisfied that Mrs Shortt had a duty to manage Resident B's challenging behaviour appropriately. The panel had particular regard to Resident B's care plan which states:

> '*Staff should remove the triggers if possible and offer distraction such as singing to Resident B or putting Daniel O'Donnell onto the Alexa for [Resident B] as this has a calming affect...If this does not work then staff should leave Resident B if safe to do so to calm down*.'

The panel noted that the care plan described a range of responses to Resident B's challenging behaviour, none of which were putting Resident B in a sensory room. The panel also noted the timeline of events as outlined in Resident B's sighting charts which detail that Resident B had been in the lounge from 12:50 until it was recorded that they were in the toilet at 15:32; Resident B was then said to have been in the sensory room at 15:49 and at 16:04 before being recorded as being back in the lounge at 16:18. In their oral evidence, Witness 1 said that they asked Mrs Shortt if she had tried all distraction techniques to which she responded "*yes*". However, the panel had before it no evidence that Mrs Shortt used any of the distraction techniques specified in the care plan. Further, Witness 2 stated in their oral evidence that they heard Resident B in distress which the panel determined to be evidence that the sensory room was not effectively managing Resident B's challenging behaviour at that time.

Although Witnesses 1 and 2 said in oral evidence that Resident B was a vocal resident and at times displayed verbally aggressive behaviour, the panel determined that Resident B being taken to a sensory room suggests that Mrs Shortt considered this to be a departure from Resident B's regular behaviour. For this reason, the panel was satisfied that there was a duty for Mrs Shortt to follow the Home policy which was:

> '*1. Try to stay calm and do not enter into an argument. Reassure the person and try to distract their attention.*
>
> *4. Ask yourself if whatever you are trying to do for the person really needs to be done at that moment. If you are able to give them a little space, come back in five or ten minutes and try again gently − you may be able to avoid a confrontation.*
>
> *5. Watch out for warning signs, such as anxious or agitated behaviour or restlessness, and take action immediately to help the person feel calmer and reassured.*

6. Try to work out what triggers any aggressive behaviour by communicating with other care staff and with those that know the Service User best. It may be something that can easily be addressed, such as changing a battery in a hearing aid so that they can hear you properly.

7. Talk to the Service User about what is upsetting them and involve their loved ones where possible, while being patient and reassuring.

8. Be aware and support other Service Users that may be within the vicinity of the challenging behaviour and distract accordingly. If necessary, encourage and support the other Service Users to move away from the vicinity…'

The panel concluded that, on the balance of probabilities, it is more likely than not that Mrs Shortt failed to manage Resident B's challenging behaviour in line with their care plan and the Home's policy on Behaviour that Challenges.

Charge 3a

"That you, a registered nurse, in response to Resident B's challenging behaviour:

a) Placed Resident B in the Home's sensory room without her consent."

This charge is found proved.

In reaching this decision, the panel had regard to the oral evidence of Witnesses 1 and 2, and Mrs Shortt's response to the NMC regarding the regulatory concerns dated 4 May 2021.

The panel was satisfied that there is no dispute that Mrs Shortt placed Resident B in the sensory room. The panel had clear evidence from Witness 1 that Resident B had capacity to consent. This is also documented in Resident B's care plan which states

‘*Resident B would like staff to ask for permission before assisting her with her care interventions. would always like to be treated with dignity and respect.’*. Witness 1 stated in their oral evidence that consent should have been obtained and documented before being taken to the sensory room. The panel did not have any record of consent being given to Mrs Shortt. In their oral evidence, Witness 1 accepted that it was by no means impossible that Resident B went to the sensory room willingly and became distressed when they got there. However, Mrs Shortt’s response to the NMC states, *‘…I informed [Witness 1] and said I would try the sensory room as it had worked before, this I did*.’. The panel noted that there is no mention of Mrs Shortt discussing moving to the sensory room with Resident B or obtaining their consent to do so.

Given the level of Resident B’s subsequent distress in the sensory room and the lack of any documentation regarding consent, on the balance of probabilities, the panel concluded that it was more likely than not that consent was not obtained by Mrs Shortt to place Resident B in the sensory room.

Charge 3b

> “That you, a registered nurse, in response to Resident B’s challenging behaviour:
>
> b) Did not turn on or ensure the lights in the sensory room were turned on.”

This charge is found NOT proved.

The panel took into account Witness 2’s oral evidence, Resident B’s sighting charts, and an email sent by Witness 2 raising concerns about the incident relating to Charge 3b dated 28 July 2020.

The panel considered it to be unclear whether or not the lights in the sensory room were turned on when Resident B was placed in there. Witness 2 described the sensory room in their oral evidence as being “*pitch black*” but also said that the door was open

with some light coming in from the corridor. The panel considered this an inconsistency in Witness 2's oral evidence. The panel was not convinced that Mrs Shortt did not turn on the light as she claimed that she had done so in the investigatory meeting notes, and there is no other evidence before the panel as to the state of the lighting when Resident B was placed in the sensory room.

The panel accepted that Witness 2 found Resident B in the sensory room with lights off, however it is not satisfied that it has sufficient evidence safely to infer that Mrs Shortt did not turn on or ensure the lights in the sensory room were turned on.

Charge 3c

> "That you, a registered nurse, in response to Resident B's challenging behaviour:
>
> c) Did not monitor and/or ensure Resident B was monitored whilst in the sensory room."

This charge is found proved.

In reaching this decision, the panel considered the oral evidence of Witnesses 1 and 2, the investigatory meeting notes, and Resident B's sighting charts.

The panel heard from Witness 1 that she would expect a staff member to be with a resident in the sensory room, and it heard from Witness 2 that Resident B was very distressed and that there was nobody with them at the time. The panel drew its attention to the investigatory meeting notes, particularly the following passage:

> *'[Witness 1]- Did you allocate any staff member to Resident B to keep an eye on her?*
> *[Mrs Shortt]- No'*

The panel noted that two sightings of Resident B in the sensory room were recorded, but it was informed that in both of these observations in the sightings charts the entries

under the heading '*Resident state when sighted'* were entered inaccurately. In their oral evidence, Witness 2 was asked how a carer would know if someone were in the sensory room and they said that a nurse would tell the carer to make sightings in sensory room. The panel determined that, although there may have been some monitoring, this was not effective or accurately recorded, and was not appropriate in that Resident B was able to get into such an agitated state that Witness 2 needed to intervene.

On the basis that there was not effective or appropriate monitoring, the panel is satisfied that the charge is proved.

Charge 3d

> "That you, a registered nurse, in response to Resident B's challenging behaviour:
>
> d) Did not remove Resident B from the sensory room when she became distressed and/or no longer consented to being placed there."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's oral evidence.

The panel has concluded that Resident B did not consent to being placed in the sensory room and that Mrs Shortt did not ensure they were effectively monitored while they were there.

The panel was satisfied, from Witness 2's evidence, that Resident B became very distressed when they had been left alone in the sensory room, and that Mrs Shortt had not responded to that distress.

The panel concluded that the charge that Mrs Shortt did not remove Resident B from the sensory room at that point must necessarily be found proved.

Charge 4

> "Your actions at charge 3 were intended to punish Resident B for her challenging behaviour."

This charge is found NOT proved.

In reaching this decision, the panel regarded the oral evidence of Witnesses 1 and 2.

The panel bore in mind that it had not heard from Mrs Shortt in relation to this charge and so found it difficult to infer that her intention was to punish Resident B, rather than to try to manage their behaviour. The panel had no evidence to support this charge. The panel heard from Witness 1 that, earlier in the day, Mrs Shortt had expressed frustration about Resident B's behaviour and went outside for a cigarette break but, while "*flippant"* about that behaviour, was overall her normal self. The panel had no evidence that Mrs Shortt was either stressed or angry.

Witness 1 did not suggest that Mrs Shortt intended to punish Resident B, however, Witness 2 implied that this was the case. The panel did not have any firm evidence from which to infer that the intention was to punish. In the investigatory meeting notes and her response to the NMC, Mrs Shortt states that she had a '*lovely working and caring relationship*' with Resident B and that she had '*known Resident B for seven years'* which it determined does not point to her placing Resident B in the sensory room as being a malicious act.

The panel was of the view that there could have been legitimate reasons for Mrs Shortt moving Resident B to the sensory room as it was intended for the use of residents in managing their behaviour, and it was not satisfied that her intention was to punish.

Charge 5a

> "That you, a registered nurse, on 27 July 2020, failed to maintain proper records in relation to Resident B, in that you:

a) Failed to complete the challenging behaviour chart."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's oral evidence and written witness statement.

The panel had seen no evidence that Mrs Shortt completed a challenging behaviour chart. Witness 1 informed the panel that, while Resident B was generally vocal and at time displayed verbally aggressive behaviour, this incident was different in degree and had escalated which would have required an entry on the chart. The panel noted that during the incident another junior member of staff who was drawn to the commotion had to intervene to calm Resident B which it determined also indicated that the situation warranted an entry on the chart.

Moreover, in their witness statement at paragraph 22, Witness 1 said:

> '*Also, it was [Mrs Shortt]'s direct responsibility to complete the challenging behaviour charts for residents herself as she was dealing with the residents' challenging behaviour, however she failed to do so as no challenging behaviour charts were completed for with regard to the incident… [Mrs Shortt] should have recorded antecedent events, definition of behaviours, consequent events and then any additional information on the charts.*'

On the balance of probabilities, the panel found it more likely than not that Mrs Shortt had a duty and failed to complete a challenging behaviour chart in relation to this incident. The panel was satisfied that, in these circumstances, there was a duty for Mrs Shortt to complete one and she did not do so.

Charge 5b

> "That you, a registered nurse, on 27 July 2020, failed to maintain proper records in relation to Resident B, in that you:

b) Inaccurately completed Resident B's progress notes in that you made no reference to her being placed in the sensory room in response to her challenging behaviour."

This charge is found proved.

In reaching this decision, the panel took into account Resident B's sighting charts, Resident B's progress notes, and Witness 1's oral evidence.

The panel had no evidence before it of any documentation relating to Resident B being placed in the sensory room besides the sighting charts. Witness 1 made it clear that Mrs Shortt had a duty to record such an incident before the end of a day. The panel noted that, in Resident B's progress notes, Mrs Shortt had documented, on 27 July 2020 at 15:05:

'*All care needs maintained. Assisted with hygiene and dressing, diet and fluid encouraged. Very vocal throughout the afternoon. Continue to monitor.*'

A further entry at 18:55 on 27 July 2020 by Mrs Shortt:

'*Resident B has been very agitated, vocal and demanding…*'

It is not documented in either entry that Resident B was placed in the sensory room between the time of these two entries.

For the reasons above, on the balance of probabilities, the panel found Charge 5b proved.

Charge 6

"Your actions charge 5 were dishonest in that you intended to conceal the actions you had taken in response to Resident B's challenging behaviour."

This charge is found NOT proved.

The panel took into consideration Resident B's sighting charts, the investigatory meeting notes, and Witness 1's oral evidence.

The panel was of the view that Mrs Shortt made no attempt to conceal her actions. All the evidence before the panel regarding the incident indicates that several staff members knew what had happened, thus the panel determined that there would be no purpose in Mrs Shortt trying to conceal it in her record keeping. For instance, she told Witness 1 that she intended to put Resident B in the sensory room in front of two other members of staff, and the incident was witnessed by other staff and recorded in the sighting charts. In addition, the panel recognised that, if Mrs Shortt, were attempting to conceal the incident, she would not have responded as she did in the following passage from the investigatory meeting notes:

> *'[Witness 1]- Were you aware of the sighting charts whilst Resident B was in the sensory room. One said comfortable and one said asleep. Do you agree?*
>
> *[Mrs Shortt]- No, not at all'*

The panel was not persuaded by the evidence that Mrs Shortt deliberately intended to conceal the incident. The panel accepted that Mrs Short may have had other reasons for not referring to the incident in her record keeping given the context of a very stressful day. The panel noted that Mrs Shortt was not at work the day following the incident and was suspended the day after that. If Mrs Shortt might, on further reflection, have wanted to go back to record the incident on a challenging behaviour chart, there was no real opportunity to do so. Witness 1 confirmed that, although it was good practice to complete records as near the time as possible, staff could amend records retrospectively and document as such.

The panel was not satisfied that there was sufficient evidence to establish that Mrs Shortt's failure to document the incident was dishonest in that she was attempting to conceal her actions.

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 Shortt'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, 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 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 Shortt's fitness to practise is currently impaired as a result of that misconduct.

In her submission, Ms Rodio identified the specific, relevant standards where Mrs Shortt's actions amounted to serious misconduct and a breach of **'**The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code):

> *'**4 Act in the best interests of people at all times***
> *To achieve this, You must:*
> *4.2 make sure that you get properly informed consent and document it before carrying out any action.'*
>
> *'**10 Keep clear and accurate records relevant to your practice'***
>
> *'**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.'

Submissions on impairment

Ms Rodio 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 *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Rodio highlighted that Mrs Shortt made a self-referral to the NMC on 24 August 2019 and a regulatory concern of poor record keeping was identified and investigated. In that case, although Mrs Shortt admitted the regulatory concern, it was found that there was no case to answer.

Ms Rodio submitted that, in this case, there was a serious departure from proper professional standards, and Resident B was put at risk of harm, particularly given their age and vulnerability. She added that Mrs Shortt clearly abused her position of trust by placing Resident B in the sensory room without their consent and allowing them to become distressed.

Ms Rodio acknowledged the training certificates provided by Mrs Shortt dated August – September 2021. However, she submitted that concerns remain in relation to Mrs Shortt's lack of insight into her failings in this case, and the fact that the previous regulatory concern of poor record keeping has been repeated. Ms Rodio further submitted that Mrs Shortt's failure to complete the challenging behaviour chart and accurately complete Resident B's progress notes to reference Resident B being placed in the sensory room in response to their challenging behaviour indicates that there is a risk to patient safety.

Ms Rodio therefore submitted that Mrs Shortt's fitness to practise is impaired on public protection grounds.

Ms Rodio also submitted that a finding that Mrs Shortt's fitness to practise is impaired on public interest grounds is also necessary in the interest of maintaining confidence in the nursing profession and upholding professional standards.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Shortt's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Shortt's actions amounted to a breach of several sections of the Code. Specifically:

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

To achieve this, you must:

1.1 treat people with kindness, respect and compassion.

1.2 make sure you deliver the fundamentals of care effectively.

1.5 respect and uphold people's human rights.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively.

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

2.3 encourage and empower people to share in decisions about their

treatment and care.

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

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

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

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

To achieve this, you must:

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that Mrs Shortt's actions were sufficiently serious to constitute professional misconduct.

The panel bore in mind that Mrs Shortt was not a newly qualified nurse, nor was she new to the environment of the Home. The panel was therefore of the view that, as an experienced nurse, she would have known about the existence of Resident B's care plan and its details, and her failure to follow either Resident B's care plan or the Home's Policy and Procedures on Challenging Behaviour was serious.

The panel noted that, whilst accurate record keeping may not have had an immediate impact on Resident B, it was important for the other staff to be appraised of Resident B's care to allow strategies to be planned to manage their challenging behaviour in the future, and Mrs Shortt's failure to do so could have potentially been detrimental for Resident B's care.

The panel considered Mrs Shortt acts and omissions in placing Resident B in the sensory room without obtaining their consent, failing to monitor them and allowing them to become extremely distressed fell seriously short of what was required, and that such actions put Resident B at significant risk of psychological harm.

The panel concluded that Mrs Shortt's actions went beyond what can be defined as a single misjudgement in the course of providing care. As such, the panel found that Mrs Shortt's actions fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Shortt'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 and to maintain professional boundaries. 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 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 considered the Grant test and, given that none of the charges relating to dishonesty were found proved, was satisfied that the fourth limb is not relevant. However, it determined that all of the first three limbs of the test were engaged.

The panel determined that Mrs Shortt could have caused Resident B physical or psychological harm as a result of her misconduct. The panel found that Mrs Shortt's failure to treat Resident B with compassion, act as their advocate, provide them with appropriate care, and keep accurate records breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Shortt demonstrated a lack of insight in that she repeated her poor record keeping which was the focus of her previous self-referral. The panel considered this to indicate that Mrs Shortt did not learn from her previous mistakes and continued to fail to uphold proper standards. The panel noted that it has no up-to-date evidence from Mrs Shortt which shows an understanding of how her actions put residents at a risk of harm, how her actions negatively impacted the reputation of the nursing profession or how she would handle a similar situation differently in the future.

Further, the panel has not been provided with any evidence that Mrs Shortt has taken steps to strengthen her practice or remediate her actions. The panel had sight of Mrs Shortt's various training certificates dated August – September 2021, however none of the certificates are directly relevant to the charges found proved and they all

expired in 2022. In addition, the panel noted the Case Examiners' Decision letter dated 27 January 2022 which states '*A reference, dated 3 September 2021 states that there are no issues or concerns regarding your conduct'.* The panel did not have sight of the reference in question, but it considered that the reference was probably provided without full knowledge of the regulatory concerns at the time, and also the concerns which led to Mrs Shortt's current referral.

The panel was not satisfied that the misconduct in this case has been addressed, and it determined that it did not have any evidence to satisfy it that Mrs Shortt could practise safely and with compassion or kindness if she were to return to nursing. For all the reasons above, the panel concluded that there is a high risk of repetition and, consequently, a significant risk of harm to patients. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

The panel concluded that not making a finding of impairment in this case would undermine public confidence in the nursing profession and the NMC as a regulator, and go against upholding the proper professional standards for members of the profession. Therefore, the panel also found Mrs Shortt's fitness to practise impaired on the grounds of public interest.

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

Sanction

Having found Mrs Shortt'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 considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Shortt's registration has been suspended.

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

Submissions on sanction

Ms Rodio submitted that the aggravating factors in this case are:

- Mrs Shortt's previous regulatory concern, namely poor recording
- Mrs Shortt's abuse of her position of trust
- Mrs Shortt's lack of insight into her failings and misconduct which put Resident B at risk of suffering harm.

Ms Rodio further submitted that there are no mitigating factors in this case.

Ms Rodio requested that the panel impose a striking-off order on the basis that the charges found proved raise fundamental questions about Mrs Shortt's professionalism. Ms Rodio submitted that public confidence could not be maintained if Mrs Shortt were not removed from the register, and a striking off is the only sanction that would be sufficient to protect patients and members of the public, and maintain professional standards.

Decision and reasons on sanction

The panel bore 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 noted Ms Rodio's submission regarding Mrs Shortt's previous referral and also the Case Examiners' decision that her insight and improvement were such that there was no case to answer at that time. However, the panel found it concerning that the further concerns about Mrs Shortt's record keeping were raised by the events in this case, occurring less than a year later than the earlier incident.

The panel took into account the following aggravating features:

- Earlier concerns raised in a previous referral relating to Mrs Shortt's record keeping
- The abuse by Mrs Shortt of her position of trust in that she was the nurse in charge on the shift at the time of the incident
- Mrs Shortt's lack of insight into her failings and the impact of her actions and omissions
- Mrs Shortt's conduct put a vulnerable resident at risk of suffering harm

The panel determined that there were no mitigating features in this case.

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 Shortt'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 Shortt's misconduct was at the higher end of the spectrum and so a caution order would be inappropriate in view of the facts found proved. 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 Shortt's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel was of the view that there are no workable conditions that could be formulated at this time without any evidence of insight and engagement, and given Mrs Shortt's stated intention of not returning to nursing practice.

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;*

The panel was satisfied that the misconduct in this case was not fundamentally incompatible with remaining on the register, and there was no evidence from the facts found proved, all of which occurred during a single shift, that Mrs Shortt had harmful deep-seated personality or attitudinal problems. Although the previous referral revealed an earlier concern about Mrs Shortt's record keeping, the panel noted that the Case Examiners found that she had shown insight in relation to that incident of poor record keeping and this panel had not heard any explanation from her in relation to the current further incident of poor record keeping.

In making this decision, the panel carefully considered the submissions of Ms Rodio in relation to imposing a striking-off order but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledged that a suspension may have a punitive effect, it would be unduly punitive in Mrs Shortt's case to impose a striking-off order particularly since the most serious elements of the charges against her, namely dishonesty and an intention to punish Resident B, had not been found proved.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction. The panel was of the view that a suspension order would protect the public by preventing Mrs Shortt from practising for a period, and it would give her the opportunity to reflect further on whether or not she would like to return to nursing and, if she does, to demonstrate any insight she may have developed following the panel's findings.

The panel noted the hardship such an order could cause Mrs Shortt. However, this is outweighed by the public interest.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the

profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to allow Mrs Shortt time to think about if she wishes to reengage with the NMC and demonstrate insight, and to satisfy the public interest.

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

Any future panel reviewing this case would be assisted by:

- Mrs Shortt’s engagement with the NMC and attendance at any future hearing
- A reflective statement detailing the impact of Mrs Shortt's conduct on Resident B and colleagues at the Home, the profession as a whole, and the wider public
- Evidence of how Mrs Shortt has kept up-to-date professionally during the period of suspension, and any plans she may have to return to nursing
- If Mrs Shortt has been in employment, testimonials from colleagues either through recent unpaid or paid employment

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 Shortt's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel considered the submissions made by Ms Rodio that an interim suspension order should be made. She submitted that an interim order is necessary on the grounds of public protection and the wider public interest. She invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

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 took account of Mrs Shortt's currently expressed intention not to return to nursing. However, as it had made clear in its decision on the substantive order, Mrs Shortt's intentions may change.

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.

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

This will be confirmed to Mrs Shortt in writing.

That concludes this determination.