Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 27 – Wednesday 28 September 2022

Virtual Meeting

Name of registrant:	**Helen Jones**
NMC PIN:	98Y0227O
Part(s) of the register:	Registered Nurse – Adult Nursing (November 1998)
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Michael Murphy (Chair, registrant member) Jude Bayly (Registrant member) Ian Dawes (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Alice Byron
Facts proved:	Charges 1 and 2 in their entirety
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel noted that Notice of Meeting had been sent to Ms Jones' registered email address on 17 August 2022. Ms Jones has not responded, whether by returning the case management form or otherwise. The panel was informed that Ms Jones has not engaged with the NMC since her referral.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, first possible date, and venue of the meeting.

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Panel Decision and reasons to amend charge 2d)

The panel, of its own volition, decided to amend the wording of charge 2d).

The amendment was to correct a typographical error in the charge, which would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

2) On 12 February 2019:

[…]

d) on the occasions of charges ~~1b) and c)~~ **2b) and c)** above, administered intravenous bolus of propofol to Patient A notwithstanding a reminder from colleague A to stop the sedation.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of (the Rules).

The panel was of the view that such an amendment, was in the interests of justice. The panel was satisfied that there would be no prejudice to Ms Jones and no injustice would be caused to either party by the charge being amended. It was therefore appropriate to amend the charge to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) Between 20 November 2018 and 12 February 2019, on more than one occasion:

    a) Failed to respond appropriately and/or investigate why patient's monitor alarms were sounding.
    b) Failed to exercise proper infection control by refusing to wear gloves and/or aprons and/or failing to change gloves and/or apron when necessary.

2) On 12 February 2019:

    a) Failed to communicate with or gain consent from Patient A before washing them;
    b) Failed to follow instructions from other professionals in that you administered an intravenous bolus of propofol sedative to Patient A having been instructed by a consultant to stop the sedation.

c) On an occasion after that in charge 2 b) above, administered an intravenous bolus of propofol to Patient A notwithstanding a reminder from colleague A to stop the sedation.
d) On the occasions of charges 2 b) and c) above, administered intravenous propofol when you had not been signed off as competent to do so.
e) Failed to preserve patient safety by attempting to move Patient A without assistance from 2 colleagues.
f) Failed to preserve patient dignity in that you attempted to force the non-invasive oxygen mask over Patient A's face despite the patient having capacity and attempting to push the mask off.

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Ms Jones at the local Trust level investigation.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Colleague A: Clinical Nurse Educator, who was Assessing Ms Jones at the time the charges arose;

- Witness 2: Matron on Intensive Care Unit at the time the charges arose;
- Witness 3: Senior Sister in the Intensive Care Unit at the time the charges arose.

Background

The charges arose whilst Ms Jones was employed as a band 5 registered nurse on the Intensive Care Unit (ICU), at Darent Valley Hospital (the Hospital), by Dartford and Gravesham NHS Trust (the Trust).

Ms Jones commenced employment with the Trust in June 2018, and after a short period working on the Acute Medical Unit, she moved to the ICU where she commenced working supernumerary. Concerns were raised by Ms Jones' supervisor about a series of incidents which allegedly occurred during such period. These incidents involved Ms Jones allegedly:

- Administering medication when she was not signed off as competent to do so;
- Disregarding a doctor's instruction not to sedate a patient;
- Administering a breathing device despite refusal by a patient who had capacity; and
- Not acting appropriately on bedside alarms.

[PRIVATE]. On 4 December 2018, the Trust extended Ms Jones' supernumerary period due to the concerns surrounding Ms Jones' clinical competencies and [PRIVATE]. It is alleged that, despite the implementation of an action plan, the concerns continued.

On 12 February 2019, it was arranged that Ms Jones would be assessed by Colleague A. During this shift a number of serious concerns were raised. It is alleged that Ms Jones:

- Failed to gain consent before washing a patient;
- Attempted to move a patient alone when three staff were required to move them;
- Administered IV sedation to a patient on two occasions, despite not being signed off as competent to do so and in contravention of the instructions of a consultant to stop the patient's sedation; and
- Attempted to force a non-invasive oxygen mask on a patient who had capacity and was actively resisting.

Following the report of the Practice Development Nurse regarding the shift of 12 February 2019, Ms Jones was suspended by the Trust. A subsequent investigation took place and a disciplinary hearing was held on 15 May 2019. Ms Jones was dismissed with immediate effect.

Since the referral was made to the NMC, the NMC has been unable to locate Ms Jones within the UK or internationally, despite several traces being conducted. Ms Jones has not engaged with the NMC or the regulatory process.

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

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

Charge 1a)

That you, a registered nurse:

1) Between 20 November 2018 and 12 February 2019, on more than one occasion:

    a) Failed to respond appropriately and/or investigate why patient's monitor alarms were sounding.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A and Witness 2.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019 and

summary of clinical performance, dated 12 February 2019. The panel found this evidence to be clear and consistent with her witness statement which sets out:

> *"There were a few things that happened shortly after I arrived on ICU. I noticed that if a monitor was alarming, Helen rolled her eyes at them and would silence the alarms, without investigating why they were alarming. There were times during the assessment where I intervened and asked Helen why the monitor was alarming, hoping that it would prompt her to assess the patient and investigate. On a few occasions, other nurses working in the cubicle with Helen went to the bed space and informed Helen about the alarms. This happened on several occasions."*

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones, and found her evidence to be credible.

The panel had further regard to the contemporaneous evidence of Witness 2, who sets out concerns relating to Ms Jones' failures to respond appropriately to alarms on 20 November 2018, 12 December 2018, 27 December 2018, 10 January 2019, and 12 February 2019. The panel had regard to the contemporaneous documentation exhibited by Witness 2 including action plans created following these incidents; notes from meetings on 12 February 2019 and the investigation report completed by Witness 2. The panel considered this evidence to be consistent, credible, and reliable in support of charge 1a).

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meeting on 22 February 2019 in which she said that she did not dismiss alarms but adjusted a reading on 12 February 2019.

The panel concluded that there was credible, clear and compelling evidence provided by Colleague A and Witness 2 in respect of this allegation, therefore it found the accounts of these witnesses to be preferable to the denials by Ms Jones. The panel

concluded that, on the balance of probabilities, between 20 November 2018 and 12 February 2019, on one or more occasion Ms Jones failed to respond appropriately and/or investigate why patient's monitor alarms were sounding.

The panel therefore found this charge proved.

Charge 1b)

That you, a registered nurse:

1) Between 20 November 2018 and 12 February 2019, on more than one occasion:

    b) Failed to exercise proper infection control by refusing to wear gloves and/or aprons and/or failing to change gloves and/or apron when necessary.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A, Witness 2, and Witness 3

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from the investigatory meeting, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

> *"When it came to infection control during the shift, Helen also refused to put on gloves at times. Infection control is very strict in ICU but Helen said that she thought it was a waste and didn't pay attention to the infection control practices. There were some aspects that she did adhere to, like central line care, which makes me think that she did have the knowledge of what was needed."*

The panel noted that Colleague A was a experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones and found her evidence to be credible.

The panel had regard to the witness statement of Witness 2, who set out that Ms Jones was reminded to exercise proper infection control on 12 November 2018, 5 December 2018, and 12 December 2018. The panel took into account the contemporaneous reports exhibited by Witness 2, including Ms Jones' record of progress, action plan and reviews and investigation reports and meetings. The panel found this evidence to be clear, credible, and reliable.

The panel further considered that the witness statement of Witness 3 was clear and consistent with the evidence given by Colleague A and Witness 2 in respect of this charge. This statement set out:

> *"When it came to infection control, I had concerns with Helen. She would quite often wear the same apron and gloves for multiple tasks. We are very strict in ICU about this. When I spoke to Helen and told her that we have to change between tasks, she didn't want to do that and said that she thought it was bad for the environment. I also had to speak with Helen about handwashing. She didn't think she was doing anything wrong by not washing her hands. I had multiple conversations with Helen about the infection control concerns and I had multiple members of staff coming to me with concerns about her. Helen was very fixated on the environment and was more concerned about that."*

The panel had regard to Ms Jones' job description, which set out, in respect of infection control:

> *"All Trust employees are required to be familiar with, and comply with, Trust polices and guidelines for infection control and hand hygiene in order to prevent the spread of healthcare-associated infections. For*

clinical staff with direct patient contact, this will include the uniform and dress code policy, the use of personal protective equipment guidance, the guidance on aseptic techniques and the safe handling and disposal of sharps. All staff are required to attend mandatory training in Infection Control and be compliant with all measures known to be effective in reducing healthcare-associated infections."

The panel had regard to the Trust's policies and was satisfied that Ms Jones had a duty to exercise proper infection control by wearing gloves and/or aprons and/or changing gloves and/or apron when necessary.

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meetings between November 2018 and February 2019, in which she reported that she found Personal Protective Equipment to be a "waste of plastic".

The panel concluded that there was a credible, clear and compelling evidence provided by Colleague A, Witness 2, and Witness 3 in respect of this allegation, therefore it found the accounts of these witnesses to be reliable and preferable to that of Ms Jones. The panel concluded that, on the balance of probabilities, between 20 November 2018 and 12 February 2019, on one or more occasion Ms Jones failed to exercise proper infection control by refusing to wear gloves and/or aprons and/or failing to change gloves and/or apron when necessary.

The panel therefore found this charge proved.

Charge 2a)

2) On 12 February 2019:

a) Failed to communicate with or gain consent from Patient A before washing them;

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague A.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from the investigatory meeting, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

> *"After the ward round, Helen informed me that she wanted to wash Patient A. Patient A was becoming more alert and responsive at this time. The issue I identified was that Helen was not communicating with Patient A. She was not giving him a chance to consent or object to what she was doing. I said to Helen that she needed to communicate and speak to Patient A. Patient A got agitated and was breathing fast while Helen was trying to wash him. He seemed uncomfortable.*
>
> *[…]*
>
> *If a patient is agitated, there might be several reasons for this so the nurse needs to communicate and talk to the patient. When going to wash Patient A, Helen could have explained why there was soap and water on his body and asked questions like whether the water felt warm enough on his skin. It does not require specialised care."*

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones and found her evidence to be credible.

The panel bore in mind that it had not received any responses to the charges from Ms Jones, due to her lack of engagement.

The panel concluded that the evidence provided by Colleague A in respect of this allegation to be clear, compelling, and reliable. The panel concluded that, on the balance of probabilities, on 12 February 2019, on one or more occasion Ms Jones failed to communicate with or gain consent from Patient A before washing them.

The panel therefore found this charge proved.

Charge 2b)

2) On 12 February 2019:

b) Failed to follow instructions from other professionals in that you administered an intravenous bolus of propofol sedative to Patient A having been instructed by a consultant to stop the sedation.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A and Witness 2.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from an investigatory meeting with Witness 2, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

"When the ward round took place and the doctors came round, the ICU Consultant made a plan for Patient A. We were told to stop Patient A's sedation infusion because they were looking to extubate Patient A. They

turned off the sedation infusion. They gave us a verbal instruction not to restart the sedation

[…]

Helen went to the infusion pump and turned it on. She gave Patient A a bolus of propofol. I asked Helen why she had done that. She said that she could not wash Patient A and that he needed to be sedated. I asked her why she disobeyed the ICU Consultant's order and she told me that the doctors should not have stopped the sedation and that Patient A needed the sedation as he was still intubated.

I said to Helen that the ICU Consultant had told her not to sedate Patient A because they wanted him to wake up and for him to come off the ventilator.

Sedating Patient A helped Helen to wash him, because she could do it without any objection or having to communicate with Patient A, but it did not help Patient A in any way. Using sedation can also delay extubation."

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones. She outlined, in the investigatory meeting with Witness 2, how she was shocked by Ms Jones' actions. The panel found her evidence in respect of the incident to be credible.

The panel further found the evidence of Witness 2 to be credible and support the account provided by Colleague A. This evidence included notes from meetings with Colleague A, Ms Jones, and the family of Patient A in respect of the incident on 12 February 2019 alongside Witness 2's Investigation Report.

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meeting with Witness 2 on 12 February 2019, in which she reported that she did not feel she was doing

anything wrong as she felt Patient A's sedation should not have been switched off before he was washed. It noted that she resiled from this position in her investigation meeting with Witness 2 on 22 February 2019, in which she said that she made a mistake.

The panel concluded that the evidence provided by Colleague A and Witness 2 in respect of this allegation to be clear, compelling, and reliable, and preferable to that of Ms Jones.

The panel bore in mind that Ms Jones had the opportunity to raise her concerns about ceasing Patient A's sedation prior to his personal care being administered with the consultant on the ward round and failed to do so. The panel determined that, Ms Jones demonstrated a clear disregard for other practitioners and Patient A in her failure to follow the instructions of senior clinicians in administering an intervenes bolus of propofol in contradiction of a consultant's instructions in order to make it easier for her to wash Patient A. The panel concluded that, on the balance of probabilities, on 12 February 2019, on one or more occasion Ms Jones failed to follow instructions from other professionals in that you administered an intravenous bolus of propofol sedative to Patient A having been instructed by a consultant to stop the sedation.

The panel therefore found this charge proved.

Charge 2c)

2) On 12 February 2019:

c) On an occasion after that in charge 2 b) above, administered an intravenous bolus of propofol to Patient A notwithstanding a reminder from colleague A to stop the sedation.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A and Witness 2.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from an investigatory meeting with Witness 2, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

> *"When Helen gave Patient A the bolus of propofol, Patient A fell asleep. I said to Helen that she doesn't need to sedate a patient to wash them and that she should not do that again, as it was not the plan for Patient A.*
>
> *Patient A then woke up a few minutes later while Helen was doing basic care. I think Patient A was in pain. He seemed uncomfortable. Helen needed to investigate that and ask Patient A why he was uncomfortable. Even though he was unable to talk, he was able to respond to questions by nodding. However, the patient got uncomfortable again and Helen then gave Patient A a second bolus of propofol, instead of speaking to Patient A.*
>
> *I spoke to Helen for a second time about administering the propofol against the ICU Consultant's request. I disconnected the propofol because I did not want Helen to do it again. It was conflicting because I was there to observe and not intervene. However, I felt I had to because it was a patient safety breach.*
>
> *Patient A was still on the ventilator so this saved him from having any complications. The ventilator was able to take over breathing but the rate of Patient A's breathing did decrease dramatically when the propofol bolus was administered."*

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones but felt compelled to intervene in Patient A's care as a result of her concerns for his safety. The panel noted that Colleague A outlined, in the investigatory meeting with Witness 2, how she was shocked by Ms Jones' actions and found her evidence in respect of the incident to be credible.

The panel further found the evidence of Witness 2 to be credible and support the account provided by Colleague A. This evidence included notes from meetings with Colleague A, Ms Jones, and the family of Patient A in respect of the incident on 12 February 2019 alongside Witness 2's Investigation Report.

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meeting with Witness 2 on 12 February 2019, in which she reported that she did not feel she was doing anything wrong as she felt Patient A's sedation should not have been switched off before he was washed. It noted that she resiled from this position in her investigation meeting with Witness 2 on 22 February 2019, in which she said that she made a mistake.

The panel concluded that the evidence provided by Colleague A and Witness 2 in respect of this allegation to be clear, compelling, and reliable, and preferable to that of Ms Jones. The panel bore in mind that Ms Jones had the opportunity to raise her concerns about ceasing Patient A's sedation prior to his personal care being administered with the consultant on the ward round and failed to do so. The panel were concerned by Ms Jones' apparent disregard of the instructions of the consultant and Colleague A, who had already told her to cease sedation. The panel determined that, Ms Jones demonstrated a clear disregard for other practitioners and Patient A in her failure to follow the instructions of senior clinicians continuing to administer an intravenous bolus of propofol in contradiction of a consultant's instructions, and following the instruction of Colleague A, in order to make it easier for her to wash Patient A. The panel concluded that, on the balance of probabilities, on 12 February 2019, on an occasion after that in charge 2 b) above, administered an intravenous bolus

of propofol to Patient A notwithstanding a reminder from colleague A to stop the sedation.

The panel therefore found this charge proved.

Charge 2d)

2) On 12 February 2019:

d) On the occasions of charges 2 b) and c) above, administered intravenous propofol when you had not been signed off as competent to do so.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A and Witness 2.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from an investigatory meeting with Witness 2, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

> *"Helen had not been signed off as competent to administer medication on ICU, so anything she did with medication was meant to be reviewed and assessed by a senior member of staff. She was not allowed to make decisions to administer medication in this way. Helen knew this, because earlier in the shift she asked me to assess her giving IV medication. This would suggest that she knew she was not competent to do it, otherwise she wouldn't have asked me to assess her earlier in the day."*

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones and found her evidence to be credible.

The panel had regard to the witness statement of Witness 2, who set out that Ms Jones had not completed the required medications competency, therefore administering the medication as outlined at charges 2c) and d) was a failure to follow the Trust's Guideline on Administration of IV Medicines and Additives on ICU/HDU (High Dependency Unit). The panel bore in mind the evidence exhibited by Witness 2, including action plans and meeting with Ms Jones, in which it set out that Ms Jones had not completed the required medications competency. The panel found this evidence to be clear, credible, and reliable.

The panel had regard to Trust's Guideline on Administration of IV Medicines and Additives on ICU/HDU, which sets out:

> *All registered nurses newly employed by ICU/HDU must adhere to the following:*
>
> - *Provide evidence of training and competency on IV drug administration which is not more than 5 years old from either another NHS Trust, or University as in line with Trust policy. If unable to provide this evidence, registered nurses must attend the Trust IV additives study day.*
> - *Read and sign to confirm understanding of the following policies and guidelines:*
>   - *Trust Guideline – Controlled drugs Procedure and Guidance*
>   - *Trust Guidelines for the Administration of Intravenous Drugs*
>   - *Trust policy for Potassium Chloride Injection*
>   - *Trust Blood Transfusion Policy*

- *Local Guidelines for the Insertion, Management, Removal and Prevention of Associated Infections of all Central Venous Catheters*
- *Trust Guidelines on IV Peripheral cannulation*
- *Patient ID Instructions from Director of Nursing*

- *Successfully complete the Trust IV additives competency document. This must be completed within 3 months of attending the IV additives study day if applicable.*
- *Successfully complete the local ICU/HDU competency document surrounding the administration of IV medication and IV additives. The completion dates are set by the PDN team*

The panel had regard to the Trust's policies and was satisfied that Ms Jones had a duty to follow such policies and not administer IV medications until deemed competent to do so.

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meeting on 22 February 2019, Ms Jones said that she did not think she was aware that she needed to complete drug competency assessments on the ICU, and thought she had completed the relevant workbooks, read the policies, and considered that she was under supervision by Colleague A.

The panel concluded that there was credible, clear and compelling evidence provided by Colleague A, Witness 2, and Witness 3 in respect of this allegation, therefore it found the accounts of these witnesses to be reliable, and preferable to that of Ms Jones. The panel concluded that, on the balance of probabilities, Ms Jones was not signed off as competent to administer intravenous medication and wilfully ignored the Trust policy when administering intravenous propofol on 12 February 2019.

The panel therefore found this charge proved.

Charge 2e)

2) On 12 February 2019:

e) Failed to preserve patient safety by attempting to move Patient A without assistance from 2 colleagues.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from the investigatory meeting, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

> *"After that incident, Helen asked me to assist her to move Patient A. She wanted to turn Patient A with just me assisting her. I told Helen that it would be against the moving and handling guidelines. This is because, if a patient is ventilated, there needs to be three members of staff assisting with any moving and handling. This is so that one person can focus on the ventilator.*
>
> *Despite me telling Helen it was against the rules, she ignored me and tried to*
> *carry on with turning Patient A. There were plenty of staff members for her to ask for help. I had to ask a third nurse in another bed to come and help us move Patient A"*

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones and found her evidence to be credible.

The panel bore in mind that it had not received any responses to the charges from Ms Jones, due to her lack of engagement.

The panel concluded that the evidence provided by Colleague A in respect of this allegation to be clear, compelling, and reliable. The panel concluded that, on the balance of probabilities, on 12 February 2019, failed to preserve patient safety by attempting to move Patient A without assistance from 2 colleagues.

The panel therefore found this charge proved.

Charge 2f)

3) On 12 February 2019:

f) Failed to preserve patient dignity in that you attempted to force the non-invasive oxygen mask over Patient A's face despite the patient having capacity and attempting to push the mask off.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statements of Colleague A, Witness 2, and Witness 3.

The panel considered the contemporaneous documentary evidence before it from Colleague A, such as Colleague A's debrief meeting notes, dated 12 February 2019, summary of clinical performance, dated 12 February 2019 and notes from the investigatory meeting, dated 25 February 2019. The panel found this evidence to be clear and consistent with her witness statement, which states:

"When Helen was trying to put the non-invasive face mask on Patient A, he became really agitated but Helen was forcing it on to his face. He was pushing it off and I heard him saying "get off me".

I was returning from a one to one with Witness 2 at the time. We ran to the bed space and took over from Helen. Patient A's wife and daughter were upset and they were guarding Patient A from Helen and saying "don't touch him".

It was really sad and upsetting to see. I kept apologising to them. Helen was saying that Patient A needed the mask and could not see it from anyone else's point of view. Patient A's wife and daughter made a formal complaint about the incident. It was very upsetting for them to see and witness. It was upsetting for me to see too. I have not seen that before.

The mask is claustrophobic so there needs to be care and communication when putting it on a patient. You have to get the patient to gently breathe into it and let them get used to it, before strapping it on to their face."

The panel noted that Colleague A was an experienced ICU nurse and was a nurse educator who had been tasked with independently assessing Ms Jones, and found her evidence to be credible, and included clear detail of what she witnessed, and how this made her feel.

The panel had regard to the witness statement of Witness 2. The panel found this account to be credible and consistent with the accounts given by Colleague A and Witness 3. The panel bore in mind that Witness 2 had exhibited contemporaneous records which detailed the incident, including the notes from a meeting with Patient A's family on 12 February 2019, which it found to support her witness statement.

The panel further concluded that the witness statement of Witness 3 was clear and consistent with the evidence given by Colleague A and Witness 2 in respect of this charge. This statement set out:

> *"The main incident that I recall with Helen, involved a situation when I was called to go and get Helen away from a patient's bed space.*
>
> *The incident occurred on 12 February 2019, when Helen was looking after a patient (Patient A) who needed a CPAP mask. This mask is tight fitting and uncomfortable.*
>
> *When I walked into Patient A's bed space, I saw Helen pushing the mask on to Patient A's face. He was trying to push Helen away and was saying that he didn't want it on. Patient A had capacity but Helen kept trying to force the mask on to him. Patient A's wife and daughter were at the bed space and they were very upset. I told Helen to leave and I put a normal oxygen mask on Patient A. Helen wouldn't leave. Patient A was saying that he didn't want her there. I asked Helen to leave again, which she did.*
>
> *Once Helen left the bed space, Patient A calmed down but he said that he didn't want her near him. I called for the Matron and we spoke to Patient A's wife and daughter to calm them down too.*
>
> *Witness 2, Colleague A and I spoke to Helen about what had happened. We tried to explain to Helen that when a patient has capacity, which was the case with Patient A, they are allowed to refuse treatment. Helen just said that Patient A needed the mask and she couldn't see or understand that a patient can refuse treatment. I don't know if it was maybe different back when she was working as a nurse in South Africa. She thought she was the one in the right though."*

The panel bore in mind that it had not received responses to the charges from Ms Jones, however it considered her responses in the investigatory meeting on 22

February 2022, in which she said that Patient A did not verbalise that he wanted the mask removing, and that she readjusted the mask, and did not keep the mask on Patient A against his wishes. She said that she was assisting Patient A in taking off the mask whilst reassuring him.

The panel concluded that there was credible, clear and compelling evidence provided by Colleague A, Witness 2, and Witness 3 in respect of this allegation, therefore it found the accounts of these witnesses to be reliable and preferable to that of Ms Jones. The panel concluded that, on the balance of probabilities, on 12 February 2019 Ms Jones failed to preserve patient dignity in that you attempted to force the non-invasive oxygen mask over Patient A's face despite the patient having capacity and attempting to push the mask off.

The panel therefore found this charge 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 Ms Jones' 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, Ms Jones' fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Ms Jones' actions amounted to misconduct and suggested the provisions of the code which Ms Jones' actions had breached, which the NMC submitted constitute fundamental tenets of the profession. The NMC stated that cumulatively the misconduct is serious and Ms Jones' conduct is a serious departure from the standards of behaviour expected of a registered nurse.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

The NMC invited the panel to find Ms Jones' fitness to practise impaired on the grounds that:

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

2) Ms Jones has in the past brought and/or is liable in the future to bring the nursing profession into disrepute; and/or
3) Ms Jones has in the past committed a breach of one of the fundamental tenets of the nursing profession and/or is liable to do so in the future; and

In respect of limb one, the NMC submitted that Ms Jones actions have clearly put patients at risk of harm in that the allegations concern a series of incidents that took place at the end of a period of Ms Jones working in a supernumerary capacity, and subject to informal and formal performance-management. It stated that these incidents involved administering
medication when she was not signed off as competent, disregarding a doctor's instruction not to sedate a patient, administering a breathing device despite refusal by the patient who had mental capacity, and not acting appropriately on bedside alarms therefore having no regard for patient care. The NMC stated that these are serious incidents and had potential of causing serious and significant harm to patients in Ms Jones' care. It outlined for the panel that 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Ms Jones' behaviour, as outlined, clearly had the potential to place patients at unwarranted risk of harm.

In respect of limb two, the NMC submitted that Ms Jones' actions have brought the nursing profession into disrepute by virtue of her failing to follow basic nursing principles. Ms Jones acted in a way which would cause harm to patients and displayed a lack of compassion for
vulnerable patients who are reliant on nurses. The NMC state that she failed to treat her patients with dignity and respect and members of the public would rightly be concerned to know that a registrant was conducting herself in a manner that clearly fell far below the standards expected of a nurse.

In respect of limb three, the NMC submitted that Ms Jones actions have breached fundamental tenets of the profession by the numerous and wide-ranging incidents that

occurred leading to the charges she faces. In the absence of any evidence supplied by Ms Jones to demonstrate insight, acknowledgement of wrongdoing and remorse, it is submitted that, at present, she is liable to engage in conduct that would breach fundamental tenets of the profession in the future.

The NMC further submitted that Mrs Jones' failure to engage with her regulator and comply with the investigation, undermines a fundamental tenet of nursing practice as it calls into question her integrity as a registered professional. It said that it is arguable that members of the public would be concerned to know that a registered nurse was unwilling to co-operate and comply in an investigation. The NMC invited the panel to consider whether paragraph 23 of the Code is also engaged which requires all registered professionals to *"Cooperate with all investigations and audits".* It submitted that the Code confirms that this includes investigations against registrants. The NMC stated that, by virtue of not responding to any of the NMC's numerous requests for Ms Jones to make contact the panel may conclude that this section of the Code is engaged.

In respect of remediation, the NMC invited the panel to consider NMC's guidance on remediation, in which it is noted that examples of conduct which may not be possible to remedy, and where steps such as training course or supervision at work are unlikely to address the concerns include where there are concerns of an attitudinal nature.

The NMC submitted that there is no evidence before the panel to show that Ms Jones has any insight. It is submitted that her behaviour and lack of engagement indicates possible attitudinal issues which are of course more difficult to remediate, therefore the risk of the behaviour being repeated remains

It further stated that Ms Jones has not demonstrated evidence of putting these concerns right and continues to pose a risk to the reputation of the profession and a risk to the public. It is therefore submitted Ms Jones' fitness to practise is impaired on the ground of public protection.

It is further submitted on behalf of the NMC that a reasonable and fully informed member of the public would expect a finding of impairment to follow such behaviour and

would be shocked if impairment were not found. Any other outcome would undermine confidence in the profession and in its regulation and therefore a finding of current impairment is also necessary on grounds of public interest.

The NMC submitted that, to date, there has been no evidence of remediation by Ms Jones, so the conduct is, at present, likely to be repeated. In the absence of any evidence supplied by Ms Jones to demonstrate insight, acknowledgement of wrongdoing and remorse, it is submitted that, at present, she is liable to engage in conduct that would continue to pose a risk to the public and a risk to the reputation of the profession. Therefore, the NMC submitted that a finding of impairment is necessary on both public protection and public interest grounds.

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 *Cohen v GMC*.

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 Ms Jones' actions did fall significantly short of the standards expected of a registered nurse, and that Ms Jones' 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

1.3 - avoid making assumptions and recognise diversity and individual choice

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

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

2.6 - 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

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

8.6 - share information to identify and reduce risk

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1- accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 - make a timely referral to another practitioner when any action, care or treatment is required

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

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered each charge individually, and the charges collectively, to determine whether Ms Jones' actions were misconduct.

The panel considered that charge 1a) was misconduct. It found that the evidence related to a deliberate and repeated failing to respond appropriately to alarms which are in place to flag potential issues, and failure to respond them could result in serious harm. The panel considered that responding to such alarms was a fundamental nursing skill and to fail to do so constitutes serious misconduct.

In respect of charge 1b), the panel considered following protocols for proper infection control to be a fundamental duty of a nurse, as failure to do so can put patients at significant risk of harm. It found that Ms Jones failed to adhere to this duty despite numerous reminders from colleagues. The panel bore in mind that Ms Jones was a nurse with several years of experience and determined that her failure to follow such infection control procedures constituted serious misconduct.

In respect of charge 2a), the panel considered the circumstances of the incident and the context of the vulnerability of Patient A in an ICU setting and receiving one to one care from Ms Jones. The panel concluded that, in this setting, where a patient has become distressed and no reassurance has been offered, Ms Jones' actions constituted serious misconduct as she did not put her patient's needs above her own.

The panel considered charge 2b) to be serious misconduct as Ms Jones had blatantly disregarded the instruction of a consultant and failed to follow the instructions which she was duty bound to do. Had Ms Jones had concerns about the instructions of the Consultant she had the opportunity to raise these during the ward round but failed to do so. The panel considered that Ms Jones had put her own convenience in administering personal care above those of Patient A in following his clinical action plan. The panel considered that Ms Jones' fellow practitioners would be appalled by her actions in relation to this charge.

The panel concluded that Ms Jones' actions in charge 2c) were serious misconduct for the reasons as outlined in charge 2b) and due to Ms Jones' disregard to Colleague A's specific instructions to stop the sedation of Patient A. The panel found Colleague A's evidence that Patient A was distressed by this, and that Colleague A was required to disconnect the intravenous pump due to concerns about patient safety to be compelling evidence towards the seriousness of this misconduct.

The panel found charge 2d) to amount to serious misconduct as Ms Jones' wilfully ignored the instructions of her managers and the procedures set out by the trust for the protection of patients and administered IV medication in the knowledge that she was not assessed as competent to do so.

In respect of charge 2e) the panel bore in mind the reasons why three members of staff are required to move patients in the ICU, for example to ensure ventilators and medical monitoring equipment remains properly in place whilst patients are moved. The panel concluded that by ignoring instructions to seek assistance before moving Patient A, Ms Jones created a serious risk of unwarranted harm and distress to Patient A and failed to understand a clear basis duty to preserve patient safety by moving him properly. The panel determined that this amounted to serious misconduct.

The panel found Ms Jones' conduct at charge 2f) to be serious misconduct in that, due to her failure to communicate to Patient A, she forced a non-invasive mask onto Patient A's face causing him discomfort. The panel determined that this likely caused distress to

both Patient A and his family members who were present at the time of this incident, which amounts to serious misconduct.

The panel considered the charges as a whole, as a pattern of behaviour and an indication of an attitudinal issue. The panel concluded that the charges both individually and collectively fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

The panel accepted the advice of the legal assessor.

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 competent, professional 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

The panel finds that patients were put at risk of serious harm and there is evidence before the panel that Patient A was caused physical and emotional harm as a result of Ms Jones’ misconduct. The panel further considered that it was likely that Ms Jones’ conduct likely caused emotional harm to Patient A’s family members who were reportedly distressed by the incident on 12 February 2019.

The panel determined that Ms Jones’ lack of care and misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that, due to Ms Jones’ total failure to engage with her regulator, there was no information before it which demonstrated her level of insight in respect of the charges. It noted that Ms Jones made partial admissions in her

local investigations to some of the concerns before the panel today, however the panel found that these admissions were highly qualified in that Ms Jones gave excuses as to why she behaved a certain way. [PRIVATE].

The panel considered that Ms Jones has demonstrated a very limited understanding of how her actions put patient at a risk of harm and has not demonstrated any understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession, nor has she demonstrated how she would act differently in the future.

The panel was satisfied that the misconduct relating to the clinical concerns in this case may be capable of being addressed. However, as Ms Jones has failed to engage with the NMC since her referral, there was no information before the panel as to where, or if, Ms Jones is currently working, and whether she has taken any steps to strengthen her practice. The panel also considered that, on the basis of the evidence before it, there is a serious and concerning attitudinal issue displayed by Ms Jones in her interactions with, and disregard of the instructions and requests of, her colleagues, patients and senior clinical practitioners which cannot be easily remedied through retraining.

The panel is of the view that there is a risk of repetition based on Ms Jones failure to engage with her regulator and demonstrate any steps which she has taken to address her attitudinal issues, the regulatory concerns and strengthen her practise. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Jones' fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Jones' off the register. The effect of this order is that the NMC register will show that Ms Jones' has been struck-off the register.

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

Representations on sanction

The panel noted that in Case Management Form sent to Ms Jones, the NMC had advised Ms Jones that it would seek the imposition of a suspension order, with review, for a period of between six and 12 months if it found Ms Jones' fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Jones' 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:

- Risk of serious harm to members of the public;
- Lack of co-operation with the NMC investigation;
- No evidence of remorse, insight, or remediation; and
- Repeated failures and wilful breaches of Trust policy over a sustained period of time despite clear directions, support and guidance provided by colleagues.

The panel considered that there were no mitigating features present in this matter.

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 and public interest issues identified, an order that does not restrict Ms Jones' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Jones' 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 Ms Jones' 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 and Ms Jones' lack of engagement with the NMC. The panel considered that the misconduct relating to Ms Jones' attitudinal issues, lack of

compassion and extremely poor communication and persistent failures in following directions and policies identified in this case was not something that can be addressed through retraining. The panel found that Ms Jones had already received an admirably high level of support from the Trust and given every chance through supervision and support to address her failings, which she did not take. Furthermore, the panel concluded that the placing of conditions on Ms Jones' 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:

- *No evidence of repetition of behaviour since the incident;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Jones' actions is fundamentally incompatible with Ms Jones remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate, or proportionate sanction.

The panel determined that the majority of breaches of the Code related to basic, fundamental nursing skills of which a nurse of Ms Jones' experience would be expected to have full knowledge and understanding in order to deliver safe patient care.

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?*

Ms Jones' 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 Ms Jones' 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 matters it identified, in particular the effect of Ms Jones' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

In making this decision, the panel carefully considered the submissions in relation to the sanction that the NMC was seeking in this case. However, the panel considered that the attitudinal concerns displayed by Ms Jones, including resisting the interventions of senior staff, displayed a concerning pattern of behaviour is fundamentally incompatible with remaining on the NMC register. The panel considered that the Trust was highly supportive of Ms Jones, who took no personal responsibility for her failings and put her own interests above those of her patients. The panel concluded that other registrants and members of the public would be appalled were Ms Jones permitted to remain on the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Ms Jones' 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 Ms Jones 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 Ms Jones own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that it is necessary for the protection of the public and otherwise in the public interest.

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 cover the period of any potential appeal of this order.

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

That concludes this determination.

F