Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Wednesday 8 November – Friday 10 November 2023
Monday 13 November – Friday 17 November 2023

Virtual Hearing

Name of Registrant:	Lisa Marie Unsworth
NMC PIN	86J0738E
Part(s) of the register:	RN1: Adult nurse, level 1 (20 February 1990)
Relevant Location:	Wigan
Type of case:	Misconduct
Panel members:	Bernard Herdan (Chair, Lay member) Jodie Jones (Registrant member) Catherine Cooper (Registrant member)
Legal Assessor:	John Moir (8 November 2023) Graeme Henderson (9-20 November 2023)
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Matt Ward (Counsel), Case Presenter
Mrs Unsworth:	Not present and unrepresented
Facts proved:	Charges 1b, 2, 3a, 3b, 4c, 6a and 6b
Facts not proved:	Charges 1a, 4a,4b, and 5
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (8 months) with review**
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 Unsworth was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 5 October 2023.

Mr Ward, 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 allegations, 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 Unsworth's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Unsworth 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 Unsworth

The panel next considered whether it should proceed in the absence of Mrs Unsworth. It had regard to Rule 21 and heard the submissions of Mr Ward who invited the panel to continue in the absence of Mrs Unsworth.

Mr Ward submitted that there had been no recent engagement by Mrs Unsworth with the NMC in relation to these proceedings, nor any indication that she has sought to instruct new legal representation. As a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.
The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs Unsworth;
- Mrs Unsworth has not responded to any communications sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness is due to attend today to give evidence and others are due to attend in the coming days;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 and 2021 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Unsworth in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her email address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can

explore any inconsistencies in the evidence which it identifies. The panel has received a response bundle from Mrs Unsworth. Furthermore, the limited disadvantage is the consequence of Mrs Unsworth's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

1. On 12 September 2020, failed to keep accurate patient records, in that you:

    a. Used the same set of acronyms for each patient when they did not require the same care,
    b. Recorded that you gave continence care to a patient that did not require continence care,

2. On 31 October 2020, failed to escalate Patient A's high NEWS scores,

3. On 17 December 2020, were:

    a. Verbally aggressive with colleagues,
    b. In the presence of a patient,

4. On 29 January 2021, failed to keep accurate patient records, in that you:

    a. Used the same set of acronyms for each patient when they did not require the same care,
    b. Made catheter notes without recording that Patient D was incontinent,

c. Recorded Patient D’s NEWS scores as both 4 and 0 in the same observation,

5. On 2 April 2021, failed to escalate the deteriorating condition of Patient B and/or Patient C,

6. On 12 May 2021, acted unprofessionally, in that you:

    a. Entered into an argument with a patient,
    b. Positioned yourself close to said patient’s face,

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

Background

The charges arose whilst Mrs Unsworth was employed by Wrightington Wigan and Leigh NHS Foundation Trust (the Trust) as a band 5 registered nurse, working on the Orrell Ward at Royal Albert Edward Infirmary (the Ward). Mrs Unsworth resigned from the Trust on 13 April 2021 left in June 2021 for a nursing role elsewhere.

On 3 June 2021, the Trust made a referral to the NMC, focusing primarily on allegations of an incident which is said to have occurred on 31 October 2020 involving a patient who had been cared for by Mrs Unsworth on the day shift. The previous night, the patient had been unwell and had been having frequent observations and was reviewed by the medic on call and the Critical Care Outreach Team (CCOT). The last set of observations was documented to have been taken at 07.10 by the night staff when the patient's National Early Warning Score (NEWS) was 5. The patient's care was then handed over to Mrs Unsworth who repeated observations at 11.00 and the NEWS was documented as 10, and again later recorded as 9, however, the allegation was that there was no escalation to relevant teams.

This incident was only highlighted in April 2021, following a complaint from the deceased patient's relative. The regulatory concern was that there had been a missed opportunity for the patient to be placed upon an Individualised Plan of Care (IPOC) for end of life, and therefore the family could have been informed of the patient's deterioration. They would have been allowed to come and visit their family member before he passed away.

Although this incident triggered the referral to the NMC there were other concerns raised by the Trust covering a period from 12 September 2020 until 12 May 2021. These concerns include inaccurate record keeping, further failures to escalate and unprofessional aggressive behaviour and are reflected in the charges.
.
The Ward was initially a 26-bed surgical ward but it changed to being a 17 bed medical ward around the end of 2019. Mrs Unsworth was usually responsible for a bay of ten beds within the ward. At the time of the charges there were other stressors on those working in the ward other than its change of use. As these events occurred during the COVID-19 crisis staff working at the ward were under greater pressure. There were staff shortages as a result of members of staff falling ill, testing positive for COVID-19 or having to isolate. The Ward contained a significant number of patients who had contracted the virus and would require end of life care.

The Panel took these background factors into account.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all of the oral and documentary evidence put before it, together with the submissions made by Mr Ward on behalf of the NMC. The panel has drawn no adverse inference from the non-attendance of Mrs Unsworth.

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 evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Divisional Director of Nursing for Surgery and Child Health at the Trust on the Ward and a registered nurse, at the relevant time
- Witness 2: Nurse and Ward Manager at the Trust on the Ward, at the relevant time
- Witness 3: Doctor working for the Trust, at the relevant time
- Witness 4 Nurse and Elective Matron at the Trust on the Ward, at the relevant time
- Witness 5 Band 7 Nurse and Surgical Matron at the Trust on the Ward, at the relevant time
- Witness 6 Ward Manager at the Trust on the Ward, at the relevant time

Panel considerations on case presentation

Prior to considering each of the disputed charges, the panel clarified the following:

- During the presentation of evidence and fact-finding stage, the panel considered the use and meaning of the word *'acronym'* in the charges. For the avoidance of doubt, the panel distinguished it from the ordinary definition (*a group of initial*

letters used as an abbreviation for a name or expression, each letter or part being pronounced separately as a word), to the use and meaning in this case. The panel concluded that it is being used to describe pre-populated, computer stored templates of sample entries that the nurse needs to either accept or amend to reflect the correct care given and then go through and create a record tailored to each patient.

- The panel noted that they were not provided with an anonymisation key to identify Patients B, Patient C and Patient D. The panel considered that it would approach this matter based on the evidence it has been presented with, when considering each of the facts of the relevant charges in turn.

- The panel also considered that that these charges occurred during Covid-19 pandemic and heard evidence in support of this. The Trust and its staff were under considerable pressure and this created unusually severe challenges for them.

Panel decisions on facts

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

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

Charge 1a

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 12 September 2020, failed to keep accurate patient records, in that you:

a. Used the same set of acronyms for each patient when they did not require the same care,

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement of Witness 2 and the electronically signed patient's notes by Mrs Unsworth dated 12 September 2020. The panel considered that these notes relate to one specific patient. The panel was not provided examples of other patient's notes to prove the charge on the day in question.
The panel was not provided with several examples of instances where Mrs Unsworth failed to keep accurate patient records by using the same acronyms on this specific date.

The panel therefore determined that this charge was found NOT proved.

Charge 1b

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 12 September 2020, failed to keep accurate patient records, in that you:

b. Recorded that you gave continence care to a patient that did not require continence care,

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 2 and the electronically signed patient's notes by Mrs Unsworth dated 12 September 2020. The panel considered that the patient's notes state *'Continence care given – pads changed 2/4 hourly prn'* and '...*stoma active*...*Catheter patent and draining good amounts of clear urine...'.* The panel considered the contradiction in the care plan in that

if the patient has a stoma and a catheter fitted, they would not have required continence care. The panel determined that there is evidence to show that this happened and Mrs Unsworth recorded something that was not possible as the patient could not have required this care. The panel determined Mrs Unsworth was under a duty to keep accurate records and this was not an accurate record.

The panel therefore finds this charge proved.

Charge 2

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 31 October 2020, failed to escalate Patient A's high NEWS scores,

This charge is found proved.

In reaching this decision, the panel took into account the written statements and oral evidence of Witness 2 and Witness 3. The panel also had sight of the patient complaint form dated 24 March 2021, Patient A's electronic patient notes of 31 October 2020, the local meeting notes with Mrs Unsworth dated 9 April 2021 and the written response (undated) from Mrs Unsworth. The panel considered Patient A's NEWS record in the patient's notes. It considered that during the night, when Patient A was being cared for by another nurse, the patient was scoring on the NEWS and this was clearly escalated and the results documented by two junior doctors and the CCOT. By contrast, the panel considered the day shift records for Patient A when in Mrs Unsworth's care. The panel noted that Mrs Unsworth recorded that the patient had a NEWS score of 5, and later on in the day, NEWS scores of 9 and 10. there was no evidence to show that the patient was escalated during the day. There was no documentation by Mrs Unsworth regarding any unsuccessful escalation attempts, nor any documentation by the CCOT or doctor until the patient's death was being verified.

The panel was of the view that a patient going from a NEWS score 5 to 10, which is a very high score, within approximately one hour, should have prompted the immediate escalation by Mrs Unsworth. The panel considered Mrs Unsworth's (undated) response bundle in which she states:

> *'...I informed the sister in charge and bleeped the doctor, I have no control over the attendance or not of the doctor and to be presented with the fact that she was not bleeped is simply untrue.'*

The panel considered that a number of witnesses gave evidence in relation to this. There has been no evidence put before the panel to show that Mrs Unsworth escalated the Patient A's high NEWS score. To the contrary, the doctor who was on duty (Witness 3) gave convincing evidence that she had not been bleeped until she was asked to attend to speak to the patient's wife but there was no indication that this was urgent and no mention of his clinical deterioration. Since the message contained no information that the matter was urgent, it was not at the high end of her list of priorities. She was subsequently bleeped to certify the death of the patient.

The panel noted that in the patient's record at 12:56 there is both a Modified Early Warning Score (MEWS) score of 9 and a MEWS of 4 (MEWS was the previous system that was replaced by NEWS in 2018). The panel found, having seen other examples of the same error in Mrs Unsworth's documentation, that she did not correctly amend the acronym template she selected to record this entry.

The panel therefore finds this charge proved.

Charge 3a

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

> On 17 December 2020, were:

a. Verbally aggressive with colleagues,

b. In the presence of a patient,

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 6. The panel considered Witness 6 to be a credible, measured and balanced witness. The panel also considered that Witness 6 made a contemporaneous file note on 17 December 2020 in relation to a conversation held between herself and Mrs Unsworth. Witness 6 was clear that the incident occurred and that Mrs Unsworth was being verbally aggressive with Witness 6 and a staff nurse, in front of an end of life patient. In her evidence, Witness 6 stated that the incident took place in the patient's room which was inappropriate.

The panel considered Mrs Unsworth's (undated) response in which she states:

> *'The ward during this period was completely out of control and I was screamed at in the office by [Witness 6] to an extent that other members of staff heard, this was completely unprofessional and abusive, I contacted my union following this incident.'*
>
> *...*
>
> *'The content of this file note is full of untruths and inconsistencies'*

In her evidence, Witness 6 admitted that she was emotional in the office, having witnessed the poor condition and care being provided to the patient. She recognised she did not respond appropriately, however Mrs Unsworth was being verbally aggressive.

In the file note of 17 December 2020, Witness 6 states:

‘When this situation had been brought to my attention lisa was really upset that a staff nurse had informed me of her concerns about the NEWS” score and also the appearance of the patient sat out in the chair.

It was noted that the IV fluid were running via the grasby but not attached to the patient. I had also asked when the last time analgesia had been given to which lisa was very abrupt with me.

Lisa had asked myself and the other staff nurse in the side room why we was getting involved? I had informed Lisa that this was not to be discussed at the patient bedside and would be discussed in private [sic].’

The panel heard from a number of witnesses some disturbing details of high stress situations during the Covid-19 pandemic and that things were not as they should be, which could be a reason why tempers were understandably running high. The panel questioned Witness 6 as to whether Mrs Unsworth’s behaviour could have been caused by the Covid-19 pandemic stressors. She told the panel that she did not think it was the cause of her behaviour. The panel is satisfied that this incident did occur and it was very unprofessional. The panel determined that Mrs Unsworth was verbally aggressive and the incident did take place in front of the patient.

The panel determined that this charge is found proved in its entirety.

Charge 4a

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 29 January 2021, failed to keep accurate patient records, in that you:

a. Used the same set of acronyms for each patient when they did not require the same care,

This charge is found NOT proved.

In reaching this decision, the panel took into account of the witness statement and evidence of Witness 2. The panel considered her to be a credible and professional witness. The panel had sight of an email from Mrs Unsworth to Witness 2 dated 31 January 2021, in which she acknowledged the possibility of inaccurate documentation concerning the recording of NEWS scores:

> *'As for the news/mews I usually leave it on to fill in where necessary but from now on will delete unless it is needed as for acronym use I feel I'm ok for the time being.'*

The panel concluded that Mrs Unsworth had again made inappropriate use of the acronym system. Despite this, the panel had no evidence put before it of several sets of patient notes relating to several patients on the same day (29 January 2021), other than an excerpt of some patient notes which were copied into an email and commented on by Witness 2.

The panel therefore finds this charge NOT proved.

Charge 4b

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

> On 29 January 2021, failed to keep accurate patient records, in that you:
>
> b. Made catheter notes without recording that Patient D was incontinent,

This charge is found NOT proved.

In reaching this decision, the panel took into account of the witness statement and evidence of Witness 2. The panel noted in her evidence she stated *'ten patient's notes all appeared very similar',* however the panel saw no evidence to identify which patients these notes referred to. The panel saw notes of an unidentified

patient which had been annotated by Witness 2 as a learning exercise to show where there were errors and inconsistencies.

In the notes within the email dated 30 January 2021, the patient records appear to state '*continence care given – pads changed 2/4 hourly. prn'.* In the panel's view this contradicts the assertion that Mrs Unsworth did not record that Patient D was incontinent. The panel had no evidence before it to establish that Mrs Unsworth had a duty to make records beyond this.

The panel was also unclear why Mrs Unsworth should have had to record that Patient D was incontinent in order to make notes concerning the catheter.

The panel therefore finds this charge NOT proved.

Charge 4c

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

> On 29 January 2021, failed to keep accurate patient records, in that you:
>
> c. Recorded Patient D's NEWS scores as both 4 and 0 in the same observation,

This charge is found proved.

In reaching this decision, the panel took into account of the witness statement and evidence of Witness 2. The panel had sight of the annotated patient notes in Witness 2's email to Mrs Unsworth dated 30 January 2021 in relation to her MEWS documentation:

> *'I needn't remind you of the importance of accurate documentation. Your progress notes will form the basis of assessment of care delivered in coroners*

court – and the contradicting nature of your writing will place you at a disadvantage both in credibility and your recall of the events of provision of care'.

To which Mrs Unsworth responded on 31 January 2021:

'As for the news/mews I usually leave it on to fill in where necessary but from now on will delete unless it is needed as for acronym use I feel I'm ok for the time being.'

The panel was of the view that although it is disadvantaged by not having the correct anonymisation in relation to the actual patients, Mrs Unsworth did record two scores but the essence of it is that it was for the same patient. The panel determined that this was a significant failure on Mrs Unsworth's part which she admitted, and therefore finds this charge proved.

Charge 5

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 2 April 2021, failed to escalate the deteriorating condition of Patient B and/or Patient C,

This charge is found NOT proved.

In reaching this decision, the panel took into account witness statements and oral evidence of Witness 1, Witness 4 and Witness 6. The panel had sight of an email from Witness 5 dated 8 April 2021 which included a summary of the extracts of patient notes of 1 / 2 April 2021 night shift, with commentary from Witness 5. However the panel was of the view that it did not have actual patient clinical notes nor was it able to identify who the *'first patient'* and *'second patient'* referred to were. Similarly, the panel had regard to the file note exhibited by Witness 1 from 8 April 2021 to 12 May 2021, however Witness1 was not able to tell the panel who had written these file notes.

The panel also had regard to Witness 4's notes of a meeting which took place on 9 April 2021 between herself, Mrs Unsworth and her union representative in which there was a discussion about patients:

> *'[Witness 4] Explained the reason we are here is that it has come to light that the management of a further 2 patients NEWS wasn't appropriate and wasn't escalated'*
>
> *...*
>
> *[Mrs Unsworth] I think I can tell you the patients – 1st patient [Ms 1], was at 7.30am in the morning and was difficult getting a doctor.'*

The panel determined that there is no evidence in the clinical notes to demonstrate that there was a failure by Mrs Unsworth to escalate, nor that a doctor did not attend when called in relation to Patient B and/or Patient C.

The panel considered that there was insufficient information in the notes of this meeting about the clinical concerns raised in these two cases and insufficient evidence. There is also a file note produced by Witness 1 dated 19 April 2021 of a meeting between Mrs Unsworth and members of the professional practice team, where Mrs Unsworth is said to have made an admission:

> *'I asked LU what she thought the concerns were, LU had reiterated the concerns as [Witness 6] had stated with the first incident, she admitted that she had used acronyms though out her documentation and had not escalated her concerns, LU states that it had been really busy, it was when Covid was high on the wards and patients were deteriorating LU admitted that her documentation was poor and realised what she should have done and has learnt from this incident and doesn't use acronyms any more.'*

which she later denies in her response:

I have never admitted I have not escalated any patient as that would simply not be true, I always escalate as required.'

The panel was of the view that there is no evidence of the provenance of this file note which is also unsigned and the panel applied limited weight to this hearsay evidence. There is also no way that the panel could link details of patients mentioned in this file note with the anonymised Patient B and Patient C. Further, the panel determined that whilst there had been concern raised about Mrs Unsworth's failure to escalate and a lot of discussion around there not being any escalation, there was insufficient evidence put before it, such as a complete set of patient's notes, to show that there was no escalation. The panel determined there to be a lack of identification of the patients and a lack of detail to say what happened. The panel determined that whilst concern had been expressed about Mrs Unsworth's nursing care practice, without a full summary of the care given to these patients, the panel concluded that this charge on the balance of probabilities is found not proved.

Charge 6

That you, a registered nurse, whilst working at Wrightington, Wigan and Leigh NHS Foundation Trust:

On 12 May 2021, acted unprofessionally, in that you:

a. Entered into an argument with a patient,

b. Positioned yourself close to said patient's face,

This charge is found proved in its entirety.

In reaching this decision, the panel took into account witness statements and oral evidence of Witness 2 and Witness 6. The panel also had regard to Mrs Unsworth's (undated) response, which states:

‘The patient was abusive to me whilst I was administering medication down a nasogastric tube as she had received some bad news from the doctor who was refusing surgery that she thought she needed. As I was leaving to get additional anti-sickness medication, she requested she confronted me shouting at me in the doorway and I did lose my patience with her which I of course regret.’

The panel recalled Witness 6’s evidence in which she said she had to step in between Mrs Unsworth and the patient because Mrs Unsworth would not step away which caused her to have to ask the patient to step back. The panel determined that Mrs Unsworth and the patient were in very close proximity to each other, enough that it could be categorised as Mrs Unsworth positioning herself very close to the patient’s face.

The panel considered Witness 2’s oral evidence when she said she was present at the time and overheard the altercation. The panel also considered that this this was a potentially a difficult patient who was young and vulnerable. Witness 6 in her evidence said that Mrs Unsworth had been given the opportunity to not look after this particular patient because of the issues that had been ongoing but had declined.

The panel determined Mrs Unsworth acted unprofessionally. As such, it finds this charge proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Unsworth’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 has therefore exercised its own professional judgement.

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

Submissions on misconduct and impairment

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

Mr Ward identified the specific parts of the NMC Code that were breached and relevant standards where, in his submission, Mrs Unsworth's actions amounted to misconduct. He submitted that the charges found proved fall into three areas: 1) attitudinal and interpersonal issues; 2) clinical errors in failing to escalate patients and 3) inaccuracies in clinical record keeping.

Mr Ward submitted that Mrs Unsworth's failure to escalate and the poor record keeping, was compounded and aggravated by her accompanying behavioural issues, which of themselves had given rise to two separate charges. He submitted that these issues demonstrate a number of breaches of the Code, namely 8.2, 8.3 and 8.5.

In relation to inaccurate record keeping, he referred to Charge 2 and 4c and the inaccurate recording of a patient's NEWS scores. He submitted that it compromises the ability of other health workers to make evidence based decisions about the care and treatment the patient ought to be receiving.

In relation to Charge 1b where Mrs Unsworth recorded that she gave continence care to a patient that did not require continence care. Mr Ward submitted that Mrs Unsworth

was clearly in breach of Code 10.3. He submitted that so much of what ultimately needs to be provided rests on the foundation of working from correct, complete and accurate records, which was not done in this case.

Mr Ward referred to Charges 3a and 3b in relation to Mrs Unsworth behavioural and interpersonal shortcomings. He submitted that Mrs Unsworth demonstrated poor and sloppy clinical practice, which brought about an intervention by another nurse which prompted Mrs Unsworth's unwarranted and aggressive outburst. He submitted that a similar set of facts in Charges 6a and 6b some six months later saw a recurrence of similar behaviour by Mrs Unsworth with her being confrontational with a young patient and getting in their face.

Mr Ward submitted that there are a range of provisions in the Code that Mrs Unsworth has breached, including: the overarching provision to treat people as individuals and uphold their dignity; 1.1, to treat people with kindness, respect and compassion; 20, to uphold the reputation of the profession at all times, and finally 20.5, the need to treat people in a way that does not take advantage of their vulnerability or cause them upset or distress. Mr Ward submitted that Mrs Unsworth's actions as proved, fell far short of what would properly be expected of a registered nurse. He further submitted that, even more importantly, this is mirrored by what the public would have expected of the nursing profession.

Mr Ward therefore invited the panel to make a finding of misconduct.

Submissions on impairment

Mr Ward moved on to address the panel on impairment and the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards of conduct 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 *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Ward referred to the *"test"* endorsed in the case of *Grant* and submitted that the first three limbs were engaged in this case. He submitted that in relation to the matter of failing to escalate patients is self-evidently a real risk. He submitted that Mrs Unsworth's repeated aggressive and hostile behaviour towards both patients and fellow registrants is also a very real risk. In relation to the question as to whether Mrs Unsworth's behaviour is capable of being remediated, he submitted that, as found in the charges proved, Mrs Unsworth has plainly brought the profession into disrepute across a number of different areas of key competencies. She has provided an unsatisfactory level of care, not least and as well as an unprofessional and improper way of communicating with both colleagues and patients alike. He submitted that Mrs Unsworth has therefore breached certain fundamental tenets of the profession.

Mr Ward submitted that there is no evidence of any steps taken by Mrs Unsworth to remedy the behavioural, clinical and attitudinal failings that gave rise to this referral. He submitted that the only document submitted appears to be a reference from a post that she held in in a different sounding clinical environment and most importantly, a position that she held prior to her time at the Trust.

Mr Ward commented on Mrs Unsworth's non-attendance at this substantive hearing. He submitted that the panel quite properly drew no adverse inference from her decision not to attend. However, the reality is she is not here to give any input or sworn testimony as to any remorse and any insight, or indeed any recent efforts she may or may not have made in order to improve her practice.

Mr Ward submitted in conclusion, that the important need to uphold proper professional standards and that public confidence in the profession would be gravely undermined if a finding of impairment were not made in this case.

Mr Ward therefore invited the panel to make a finding of current impairment.

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, *Schodlok v General Medical Council* [2015] EWCA Civ 769, *Cohen* and *Grant.*

Decision and reasons on 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 panel was of the view that Mrs Unsworth's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches 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*
>
> ***8 Work co-operatively***
> ***To achieve this, you must:***
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing*
> *the care of individuals with other health and care*
> *professionals and staff*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to***
> ***your practice***
> *This applies to the records that are relevant to your scope*
> *of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
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
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went on to consider whether each of the charges found proved amounts to misconduct.

Charge 1b: the panel considered that Mrs Unsworth breached that part of the code relating to keeping clear and accurate records, this would not have affected patient care in this instance. This mis-recording was in contradiction to all other information presented in the records. However it determined that as a standalone charge, relating to one specific date, it did not meet with the threshold for misconduct.

Charge 2: The panel considered that Mrs Unsworth failed to escalate more than one high NEWS score throughout the night. The panel determined that there has been no adequate explanation for the lack of adequate escalation. On the basis of the evidence before it, it appears that Mrs Unsworth allowed Patient A, who was recognised to require end of life care, to deteriorate without escalation of his high NEWS score. The panel determined Patient A was potentially deprived of his loved ones being present at the end of his life and also from being appropriately medicated for his deteriorating

condition. The panel concluded that Mrs Unsworth's conduct fell way below the standard expected of a registered nurse.

Charge 3a & b: The panel considered that Mrs Unsworth was verbally aggressive with members of staff who were trying to help her, and judged this to be totally unacceptable. Further, Mrs Unsworth spoke to her senior in an aggressive manner in front of a patient who was at the end of their life and apparently tried to defend her poor level of care. The panel determined Mrs Unsworth's misconduct to be serious and fell way below the professional standard and risked undermining the public trust in nurses.

Charge 4c: The panel considered the training, repeated feedback and input given to Mrs Unsworth in relation to her record keeping and use of acronyms. The panel was of the view that looking at this in the wider context, it was not a one-off incident. The panel determined that Mrs Unsworth's differing and therefore ambiguous NEWS/MEWS scores in the same observation to be serious, as the next nurse taking over on shift receiving the erroneous record, would not have proper insight into what was going on with the patient. The panel determined this surpassed the threshold for misconduct.

Charge 6a & 6b: The panel acknowledged that patients with an eating disorder can bring additional challenges. The panel considered that Mrs Unsworth was given the option not to be allocated this patient which she declined. The panel determined that for Mrs Unsworth to enter into an argument with a young vulnerable patient and not back down, meets the misconduct threshold. The panel determined it was very unprofessional and undermined the nursing profession.

The panel concluded that Mrs Unsworth's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

In coming to its decision, the panel had regard to the case of *Grant* and the NMC Guidance DMA-1 on impairment.

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

In this regard the panel considered the test of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, she said:

> *'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*
>
> *d) ....'*

The panel was of the view that all three limbs a) b) and c) of the above test were engaged and that Mrs Unsworth's misconduct had put patients at unwarranted risk of harm, had brought the nursing profession into disrepute and had breached the fundamental tenets of the profession.

Regarding insight, the panel considered that Mrs Unsworth has demonstrated very poor insight and understanding of how her actions put patients at a risk of harm. The panel noted that in her undated response to the regulatory concerns she makes a mere passing reference to being rude to a patient and appears to put the blame on others.

The panel determined that Mrs Unsworth has not demonstrated an understanding of why her conduct was wrong and how it impacted negatively on the reputation of the nursing profession. The panel noted that her responses were deflective and did not show how she would handle the situation differently in the future. She seems to have shown extremely limited remorse.

In its consideration of whether Mrs Unsworth has addressed her practice, the panel took into account that she has not engaged or provided any evidence of any training to address the areas of concern identified. The panel noted that Mrs Unsworth had left the Trust two and a half years ago and there is no information as to what she had been doing in the intervening period. The panel determined that her failure to engage has made it impossible to determine whether she has remediated.

The panel is of the view that Mrs Unsworth's clinical care giving was unprofessional, however her inaccurate record keeping and poor escalation issues should be easily remediable through training. However the panel noted that she has had multiple opportunities to adapt and amend her practice to avoid these sorts of errors and it has not made a difference. Mrs Unsworth's attitudinal and interpersonal failings might be harder to remediate. The panel determined that it has seen no evidence of remediation. The panel determined that there is a real risk of repetition and therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that members of the public and members of the profession would be very shocked and would find it unacceptable were it not to make finding of impairment.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of eight months with a review. The effect of this order is that the NMC register will show that Mrs Unsworth'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

Mr Ward submitted that no further action or a caution order would not be the proportionate or appropriate course of action where a registrant, as in this particular case, presents a continuing risk to patients in relation to the seriousness of the misconduct found proved.

He submitted that Mrs Unsworth's misconduct involves a number of concerns relating to a failure to escalate a patient's deteriorating condition, inaccurate record keeping and serious concerns relating to her treatment of both colleagues and patients alike. He submitted that Mrs Unsworth's responsiveness and attitude towards those incidents, appear to have been at best ambivalent and quite unpredictable. He submitted that the panel has heard evidence from past colleagues at the Trust who knew Mrs Unsworth well in relation to her attitudinal problems. He submitted that these concerns cannot be addressed by way of a conditions of practice order as it would not reflect the seriousness of Mrs Unsworth's misconduct.

Mr Ward submitted that a suspension order with review would allow Mrs Unsworth the necessary time and space to demonstrate any insight and strengthening of practice in order to properly move on from her misconduct, taking into account the need to protect

the public in the intervening period. He invited the panel to impose a suspension order for a period of six months with review.

Decision and reasons on sanction

The panel was aware that in the Notice of Hearing, dated 5 October 2023, the NMC had informed Mrs Unsworth that it would seek the imposition of a 6 month suspension order with review, if it found her fitness to practise currently impaired.

Having found Mrs Unsworth's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

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

The panel took into account the following aggravating features:

- Lack of insight into her failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm.
- Her repeated bursts of loss of temper, aggression with colleagues and getting angry with a young vulnerable patient

The panel also took into account the following mitigating feature:

- Notwithstanding that the panel has concluded that the Covid-19 pandemic was not a key factor in the key issues identified, it noted that these incidents occurred

during the Covid-19 pandemic when there were additional stressors in the workplace, including staff shortages.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of Mrs Unsworth's failings. The panel decided that it would neither be 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 Unsworth'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 Unsworth's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would neither be proportionate nor in the public interest to impose a caution order.

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

- *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 some of the misconduct found could be addressed through retraining. However, in the absence of any evidence of Mrs Unsworth's insight into her misconduct and her willingness to adhere to any conditions of practice imposed this would not be appropriate. It noted that relevant training, creation of action plans, and support from her more senior colleagues had all been provided in the period in question but Mrs Unsworth had not responded positively and learned from her mistakes. Moreover, the panel has no information on whether Mrs Unsworth is still practising as a nurse and, if so, whether workable conditions could be devised which would be practical and relevant in her current workplace if any.

With regard to the attitudinal and behavioural misconduct the panel concluded that there are no practical or workable conditions that could be formulated, given the nature of these charges. The behavioural misconduct identified in this case was not something that can be addressed through clinical retraining.

Furthermore, the panel concluded that the placing of conditions on Mrs Unsworth's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel noted that, to a greater or lesser extent, some of the factors in the SG cited above are not present in this case. This was not a single incident of misconduct, and there is no evidence to demonstrate that Mrs Unsworth has insight, so she continues to pose a risk of repeating her behaviour. However, the panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate at this stage. Given a further period of reflection and retraining, it would be feasible for Mrs Unsworth to deal with her issues and safely return to nursing. The panel also noted that the public interest would be served by a period of suspension and the requirement for a further review.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Unsworth's case to impose a striking-off order.

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

The panel noted there may be potential hardship that such an order may inevitably cause Mrs Unsworth. However this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse. The panel determined that a suspension order for a period of eight months with review was appropriate in this case to mark the seriousness of the misconduct.

Towards 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.

During the period of suspension, Mrs Unsworth would have an opportunity to demonstrate remediation or, alternatively, discuss the prospect of Agreed Removal with the Registrar.

Any future panel reviewing this case would be assisted by:

- Mrs Unsworth's engagement with the NMC process and participation in the review hearing
- A reflective statement evidencing insight into the misconduct found
- Details of what Mrs Unsworth has been doing since May 2021 to demonstrate her ability to escalate concerns appropriately and to keep accurate records
- Evidence of what Mrs Unsworth has done to maintain her nursing knowledge and any further training she has undertaken
- Testimonials supporting Mrs Unsworth's good attitude at work or at voluntary organisations

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Unsworth'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 took account of the submissions made by Mr Ward. He submitted that an 18-month interim suspension order is appropriate and proportionate in this case given the panel's determination on sanction.

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 on the basis that the appeal process, if commenced by Mrs Unsworth, might last for that period of time.

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

This will be confirmed to Mrs Unsworth in writing.

That concludes this determination.