Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting
28 February 2024 - 1 March 2024

Virtual Meeting

Name of Registrant:	Mrs Shaoli Wang
NMC PIN	09Y0005C
Part of the register:	Registered Adult Nurse
Relevant Location:	Weymouth
Type of case:	Misconduct
Panel members:	Anthony Griffin (Chair, Lay member) Alison Thomson (Registrant member) Derek McFaull (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Leigham Malcolm
Facts proved:	1.2, 2, 3.1, 3.2.1, 3.2.2, 3.2.3, 3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.4.1, 3.4.2, 3.4.3, 3.5.1, 3.5.2, 3.5.3, 3.5.4, 3.5.5, 4, 5 & 6
Facts not proved:	1.1
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 was shown at the start of this meeting the Notice of Meeting which was sent to Mrs Wang's registered email address by secure email on 23 January 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations along with a timeframe during which a virtual meeting would be held.

In the light of all of the information available, the panel was satisfied that Mrs Wang 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).

Details of Charge

That you, a Registered Nurse,

1. During a shift on or about 7 February 2021, following Resident E presenting with 'coffee ground' vomit,

1.1 Failed adequately or at all to assess Resident E

1.2 Failed to escalate Resident E's symptoms to their GP

2. During a night shift of 8-9 April 2021 gave Resident F a double dose of Paracetamol

3. During a night shift on 9-10 April 2021:

3.1 Photographed one or more Residents without their consent;

3.2 On finding that Resident A did not have bedding on their bed, and was positioned with their legs over the edge of the bed:

3.2.1 Failed promptly or at all to try to give Resident A the duvet and/or, give them the choice as to whether they wanted it, and/or failed to record that you had done so in their care notes or ensure these were done

3.2.2 Failed promptly or at all to reposition Resident A and/or request assistance to reposition them, and/or record that you had done so in their care notes.

3.2.3 Failed promptly or at all to record the incident in Resident A care notes

3.3 On finding that Resident B's bed bumpers were folded down, that Resident B had a foot down one side of the bed, and that Resident B did not have bedcovers on, you:

3.3.1 Failed promptly or at all to move Resident B's feet to the bottom of the bed and their head to the middle of the pillow, and/or request assistance to do so and/or record that you had done so in their care notes

3.3.2 Failed promptly or at all to ensure that the bed bumpers were in the correct position and secure, and/or record that you had done so in their care notes

3.3.3 Failed promptly or at all to check Resident B for injury and put the bedcovers over them, and/or record that you had done so in their care notes

3.3.4 Failed promptly or at all to conduct wellbeing checks on Resident B and/or record that you had done so in their care notes

3.3.5 Failed promptly or at all to record the incident in Resident B's care notes

3.4 On finding that Resident C was positioned with their head against their bedframe and one leg between the wall and the bed, and that the lower half of their body was uncovered you:

3.4.1 Failed promptly or at all to check Resident C's head and skin for injury, and/or request assistance to do so, and or record that you had done so in their care notes

3.4.2 Failed promptly or at all to reposition Resident C and/or ensure they were adequately covered by bedclothes, and/or record that you had done so in their care notes

3.4.3 Failed promptly or at all to record the incident in Resident C's care notes

3.5 On finding Resident D without a bedsheet, wholly or entirely unclothed, with their incontinence pad on the floor, without bed bumpers attached to their bed, with their legs against the bedrail, with sensor mat placed away from their bed, with their call bell placed out of their reach:

3.5.1 Failed promptly or at all to place a sheet on Resident D's bed, and/or correctly position the bedrail bumpers, and/or record that they had done so in their care notes

3.5.2 Failed promptly or at all to and/or reposition and/or seek assistance to reposition Resident D and/or record that you had done so in their care notes

3.5.3 Failed promptly or at all to reposition Resident D's sensor mat and/or the call bell and/or record that you had done so in their care notes.

3.5.4 Failed promptly or at all to check them for physical harm and/or hygiene and/or record that you had done so in their care notes

3.5.5 Failed promptly or at all to record the incident in Resident D's care notes

4. In respect of one or more of the failures alleged at charges 3.2-3.5 above, where you did not carry out the care required, yourself, you failed to ensure it was carried out promptly by delegation to others on the shift

5. In respect of one or more of Residents A-D, on finding them in the circumstances described at charges 3.1-3.5 above, failed to ensure they were not left alone until the care required had been carried out

6. On 10 April 2021, you shared one or more of the photographs at 3.1 above with colleagues when there was no clinical, or care ground for doing so.

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

Background

Mrs Wang was employed at Queen Charlotte Nursing Home ("the Home") from 28 August 2020 until her dismissal in April 2021.

It is alleged that on 7 February 2021, Mrs Wang failed to appropriately act on or escalate concerns about a resident vomiting 'coffee grounds' substance.

The remainder of the concerns in this case relate to night shifts on 8/9 and 9/10 April 2021. It is alleged that during the shift of 8/9 April 2021 Mrs Wang deliberately gave a resident a double dose of paracetamol (1000mg rather than the 500mg prescribed).

During the following night shift, of 9/10 April 2021, Mrs Wang is also alleged to have taken photographs of four residents without their consent between midnight and 4am. The residents are reported to have been asleep at the time the photographs were taken and in unsafe and undignified positions, several being in a state of undress.

It is alleged that Mrs Wang failed to take steps to properly care for the residents, thereby failing to safeguard them and preserve their dignity.

Mrs Wang was dismissed in April 2021 as the result of a local investigation into the matters.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case including Ms Wang's reflective statement dated 12 March 2021 and the written representations made by the NMC.

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:

- Ms 1, Care Coordinator at the Home at the time of the alleged incidents.
- Ms 2, Support Worker at the Home at the time of the alleged incidents.
- Ms 3, Deputy Manager at the Home at the time of the alleged incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It then considered each of the charges and made the following findings:

Charge 1.1

1. During a shift on or about 7 February 2021, following Resident E presenting with 'coffee ground' vomit,

1.1 Failed adequately or at all to assess Resident E

In relation to Charge 1.1 the panel had regard to Resident E's records from 9 February 2021. Within the records there was clear evidence that Mrs Wang did carry out and record an assessment at 05:25am. The record stated:

> *"Res E vomited about 12.45 with coffee ground fluid. Cleaned up and OBS done. She was felt cold at the time. Recovered the quilt and blanket. Assisted 105mls warm milk taken. Hourly checking maintained on the duty. She became to normal after a couple of hours. OBS had done this morning and normal in range. Continue to monitoring. [sic]."*

The panel considered that the contents of this note did amount to an adequate assessment. In view of this evidence, the panel found Charge 1.1 not proved.

Charge not proved.

Charge 1.2

1.2 Failed to escalate Resident E's symptoms to their GP

In relation to Charge 1.2 the panel took account of the written witness statement of Ms 3 whose statement sets out that it is standard nursing practice to contact a GP if a resident produces 'coffee ground' vomit:

> *"Producing "coffee ground" vomit could be a sign of internal bleeding or an overflow of the bowels. More often than not it is something that the resident has eaten but the risk is still there that the cause is more serious. A nurse cannot make this differentiation and so in every circumstance the GP should be contacted in the first instance when a resident exhibits coffee ground vomiting.*

This is standard practice at the Home but I am not aware of any policies stating it. I learnt the process of assessing vomit at university as part of our basic nursing training. We were taught then that standard practice was that the GP should be contacted if vomit looked any different to regular food vomit."

Within Resident E's patient notes there was no record of Mrs Wang contacting 111 or a GP to escalate the symptom. There is evidence of a call at 8:30am made by a nurse who took over the care of Resident E later that morning. In the absence of any evidence that Mrs Wang contacted a GP, the panel found this charge proved.

Charge proved.

Charge 2

2. During a night shift of 8-9 April 2021 gave Resident F a double dose of Paracetamol

The panel had sight of Resident F's MAR chart from 9 April 2021. It is recorded within the MAR chart that two 500mg tablets of paracetamol were administered and Mrs Wang's initials appear next to the entry.

Further, within her written response to the allegation Mrs Wang wrote:

"I had phoned for an ambulance, as she was in severe pain. I gave her 1000g [sic] paracetamol and informed the paramedic of all the actions I took."

The panel also had sight of an email from Mrs Wang to one of her colleagues which stated:

"I had worried that she had broken her toe due to bond [sic] back of bedrail. If so, she needs to go to hospital. I knew that she was on 500mg Paracetamol. I had given 1000mg Paracetamol to her as she was very painful at the time."

There were several pieces of clear evidence before the panel that Mrs Wang administered 1000mg of paracetamol to Resident F when she knew that the correct dose was 500mg. In view of this evidence the panel found charge 2 proved.

Charge proved.

Charge 3

3. During a night shift on 9-10 April 2021:

(Mrs Wang accepted that she was on duty that night)

3.1 Photographed one or more Residents without their consent;

The panel had a series of photos before it, all displaying residents in their beds and in apparently uncomfortable or undignified positions. There was no evidence before the panel that the residents had consented to the photos being taken, or that the residents were capable of providing consent.

In an interview with the Home Manager and the Deputy Home Manager on 10 April 2021 Mrs Wang stated that she was unaware that consent was required from the Residents before taking the photographs.

During the interview it is recorded that Mrs Wang expressed concern over the care that the residents were receiving from the carers and that she took the photos to illustrate her concerns and escalate them. In response to being asked if she considered it acceptable to leave vulnerable patient in this manner, Mrs Wang is recorded to have said: ‘yes as she wanted management to see the pictures’.

On the basis of the record/notes of the interview on 10 April 2021, and Mrs Wangs admission to taking the photos unaware that she needed consent, along with her explanation, the panel found charge 3.1 proved.

Charge proved.

Charge 3.2

3.2 On finding that Resident A did not have bedding on their bed, and was positioned with their legs over the edge of the bed:

The panel had regard to the photograph of Resident A in which the resident did not have bedding on their bed and their leg hung over the edge of the bed.

The panel also had regard to Resident A's patient notes. From the evidence provided to the panel, it was satisfied that Resident A was found as described in the charge. It was documented that Resident A appeared uncomfortable and had their legs off the edge of the bed. This and the photograph showed that the stem of Charge 3.2 was made out. The panel therefore considered the substance of the sub-charges below.

Charge 3.2.1

3.2.1 Failed promptly or at all to try to give Resident A the duvet and/or, give them the choice as to whether they wanted it, and/or failed to record that you had done so in their care notes or ensure these were done

The panel had regard to the photographs of Resident A along with the written statement of Ms 3. Within her statement Ms 3 states:

"My concerns with the photograph of Resident A are that the resident does not have any bedding on their bed. This is not unusual for Resident A as they often remove their bedding but on discovering the resident, the Nurse [Mrs Wang] should have tried to give Resident the duvet or given them the choice as to whether they wanted it. Resident has intermittent capacity and so sometimes would understand and take the duvet. On other occasions they would refuse the care and so would have to be encouraged."

The panel observed the photo which showed Resident A without a duvet. The panel also took account of Resident A's notes, in which there was no record of any action taken to make the resident comfortable. The panel also took account of the interview notes from 10

April 2021 during which Mrs Wang was asked what action she took to assist the residents between taking the photographs, and she replied that she took no action.

In view of this, and in the absence of any evidence that Mrs Wang made efforts to address the deficiencies in Resident A's care, as set out in the charge, the panel found Charge 3.2.1 proved.

Charge proved.

Charge 3.2.2

> *3.2.2 Failed promptly or at all to reposition Resident A and/or request assistance to reposition them, and/or record that you had done so in their care notes.*

Again, the panel had regard to the photos of Resident A with their leg hung off the bed along with their patient notes. During the night shift, between 23:47 and 05:21 there is no record of any effort to reposition Resident A and make them comfortable. There was nothing within the notes to suggest that Mrs Wang, or anybody else, attempted to reposition the resident.

The panel also took account of the interview notes from 10 April 2021 during which Mrs Wang was asked what action she took to assist the residents between taking the photographs, and she replied that she took no action.

In view of the photograph illustrating Resident A with their legs hung off the bed, and in the absence of any record in Resident A's patient notes that they were repositioned, the panel found this charge proved.

Charge proved.

Charge 3.2.3

3.2.3 Failed promptly or at all to record the incident in Resident A care notes

Within Resident A's patient notes the only records made by Mrs Wang were at 23:47 and 05:51. At 23:47 it was recorded that Resident A was in an uncomfortable position and at 05:51 it was recorded that they had had an uncomfortable night's sleep. There was nothing to suggest that any attempts had been made to make Resident A comfortable.

On the evidence before it, the panel found this charge proved.

Charge proved.

Charge 3.3

3.3 On finding that Resident B's bed bumpers were folded down, that Resident B had a foot down one side of the bed, and that Resident B did not have bedcovers on, you:

The panel had regard to the photograph of Resident B along with their care notes and the written statement of Ms 3. From the evidence provided to the panel, it was satisfied that Resident B had been found as described in the stem of the charge.

Charge proved.

Charge 3.3.1

3.3.1 Failed promptly or at all to move Resident B's feet to the bottom of the bed and their head to the middle of the pillow, and/or request assistance to do so and/or record that you had done so in their care notes

In relation to this charge the panel took account of the written witness statement of Ms 3 which sets out the following:

"Upon finding Resident in this way, the Nurse should have requested assistance to put Resident in a better position, with their feet at the bottom of the bed and their head in the middle of the pillow."

Again, the panel bore in mind that during the interview on 10 April 2021 Mrs Wang admitted that she took no action to move Resident B into a more comfortable position. The panel also had regard to Resident B's care notes in which there was no record that any attempt had been made to move Resident B's feet to the bottom of the bed and their head to the middle of the pillow.

On the evidence available the panel found this charge proved.

Charge proved.

Charge 3.3.2

> *3.3.2 Failed promptly or at all to ensure that the bed bumpers were in the correct position and secure, and/or record that you had done so in their care notes*

The panel had evidence from Ms 3 which stated:

> *"They also should have ensured that the bed bumpers were in the correct position, lining the length of the rail, and that they were secure."*

Again, the panel had regard to Resident B's care notes in which there was no record of any adjustments being made to Resident B's bed bumpers. Mrs Wang admitted during the interview on 10 April 2021 that she took no action with regard to this patient's care (the motivation being to see how long it would be before the carers did anything).

On the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.3.3

> *3.3.3 Failed promptly or at all to check Resident B for injury and put the bedcovers over them, and/or record that you had done so in their care notes*

Ms 3's written statement also set out:

> *"The Nurse should have checked Resident for any damage that may have been caused and put the covers over them."*

Within Resident B's care notes there was no record of them being checked for injury or the bed covers being put over them. Mrs Wang admitted during the interview on 10 April 2021 that she took no action with regard to this patient's care.

On the basis of the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.3.4

> *3.3.4 Failed promptly or at all to conduct wellbeing checks on Resident B and/or record that you had done so in their care notes*

The panel took account of the written statement of Ms 3 which stated:

> *"…the Nurse should also have performed wellbeing checks. Resident would not be able to verbalise if something was upsetting them so I would have expected the Nurse to monitor their behaviour and look for signs, in their actions or temperament, as to their emotional state."*

There was evidence before the panel that the Home had examined the photographs of Resident B and set out the actions that it expected to have been taken in the circumstances. However, there was no evidence before the panel, in Resident B's care notes or otherwise, to indicate that Mrs Wang had undertaken wellbeing checks as expected by the Home. Again, Mrs Wang admitted during the interview on 10 April 2021 that she took no action with regard to this patient's care.

In view of the photographs, and in the absence of any evidence that wellbeing checks were carried out, the panel found this charge proved.

Charge proved.

Charge 3.3.5

> *3.3.5 Failed promptly or at all to record the incident in Resident B's care notes*

The panel took account of Resident B's care notes. There is an entry within the notes made by Mrs Wang at 04:35 which states: 'settled night. No issues stated or expressed'. There are also many entries made by other staff. However, none of the entries throughout the night shift relate to Resident B's position being adjusted or wellbeing checks being carried out. Mrs Wang's entry at 04:35 does not suggest anything untoward or provide any details.

In view of the photographs of Resident B appearing uncomfortable, and in the absence of any details of issues within the care notes, the panel found this charge proved.

Charge proved.

Charge 3.4

> *3.4 On finding that Resident C was positioned with their head against their bedframe and one leg between the wall and the bed, and that the lower half of their body was uncovered you:*

In relation to this charge the panel took account of the written witness statement of Ms 3 which sets out the following:

> *"My concerns with the photograph of Resident C are that they are positioned in an unacceptable way. Their head is against the wooden bedframe and their leg is down the side of the wall between the bedframe and the bed. This could cause pressure damage and opening of the skin, both on the head and the leg."*

The panel accepted the statement of Ms 3 and accepted that Resident C was found by Mrs Wang in the circumstances set out in the stem of the charge.

Charge proved.

Charge 3.4.1

> *3.4.1 Failed promptly or at all to check Resident C's head and skin for injury, and/or request assistance to do so, and or record that you had done so in their care notes*

Ms 3's written witness statement set out that:

> *"Upon finding Resident in this state, the Nurse should have requested assistance to reposition them and checked their skin and their head for damage."*

The panel observed one photograph of Resident C in an awkward position. Within Resident C's care notes there was no record of them being checked for injury, despite the awkward position that they appeared to be in within the photograph.

Within the interview notes from 10 April 2021, when asked if she attempted to reposition Resident C, fit the bed rail cover and give resident C their call bell, Mr Wang replied to say that she did not.

Further, in her written response to the allegations, sent to the NMC, Mrs Wang wrote: 'I know the resident looked uncomfortable in the pictures, but they were safe'.

In the absence of any patient records, and in view of Mrs Wang's admission that she did not take any positive action, the panel found this charge proved.

Charge proved.

Charge 3.4.2

3.4.2 Failed promptly or at all to reposition Resident C and/or ensure they were adequately covered by bedclothes, and/or record that you had done so in their care notes

The written witness statement of Ms 3 set out the following:

"Upon finding Resident in this state, the Nurse should have requested assistance to reposition them and checked their skin and their head for damage. I believe that this resident was on an end of life pathway so the priority should have been ensuring that they were comfortable. I am not aware of any policies in relation to this. From the photographs Resident does not look comfortable and their lower half is uncovered, so if they were left in that position, it is below the standard I would expect of a registered nurse."

There is no evidence within the care notes of Resident C that Mrs Wang repositioned the resident, covered the resident with the bedclothes. During the interview on 10 April 2021 Mrs Wang admitted to taking no action in relation to Resident C.

Based on all the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.4.3

3.4.3 Failed promptly or at all to record the incident in Resident C's care notes

Within Resident C's patient notes the only entries made by Mrs Wang relate to blood glucose levels. There is no record of Resident C being in an uncomfortable position or that any action had been taken to make them more comfortable.

In view of the photographs of Resident C appearing uncomfortable, and in the absence of any record within the care notes to say that they were made comfortable, the panel found this charge proved.

Charge proved.

Charge 3.5

> *3.5 On finding Resident D without a bedsheet, wholly or entirely unclothed, with their incontinence pad on the floor, without bed bumpers attached to their bed, with their legs against the bedrail, with sensor mat placed away from their bed, with their call bell placed out of their reach:*

In relation to this charge the panel took account of the written witness statement of Ms 3 which set out the following:

> *"In the photograph it shows that the bed rail bumpers have been removed from the bed and placed on the chair, allowing Resident 's legs to lean against the bed rail. The photograph also shows that the sensor mat is nowhere near the bed, meaning staff would not be informed if Resident fell out of bed. This is serious because Resident [D] could be suffering physical harm or require assistance and staff would not know."*

The panel also had sight of the photograph of Resident D. In view of all the evidence the panel was satisfied that Resident D was found by Mrs Wang as set out in the stem of this charge.

Charge proved.

Charge 3.5.1

> *3.5.1 Failed promptly or at all to place a sheet on Resident D's bed, and/or correctly position the bedrail bumpers, and/or record that they had done so in their care notes*

The panel took account of the written witness statement of Ms 3 which set out the following:

> *"Upon finding Resident in that situation, the Nurse should have put a sheet on their bed, correctly positioned the bed rail bumpers…"*

During the interview on 10 April 2021 Mrs Wang admitted to taking no action in relation to Resident D.

The panel had regard to Resident D's care notes. Within the notes there is no record by Mrs Wang of Resident D being provided with a bedsheet or their bedrail bumpers being correctly positioned.

Based on all the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.5.2

> *3.5.2 Failed promptly or at all to and/or reposition and/or seek assistance to reposition Resident D and/or record that you had done so in their care notes*

The panel had regard to the written statement of Ms 3 which stated:

> *"Upon finding Resident in that situation, the Nurse should have … and requested assistance to reposition Resident D…"*

Within Resident D's patient notes there is no record by Mrs Wang of Resident D being moved and more comfortably positioned. During the interview on 10 April 2021 Mrs Wang admitted to taking no action in relation to Resident D.

Based on all the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.5.3

> *3.5.3 Failed promptly or at all to reposition Resident D's sensor mat and/or the call bell and/or record that you had done so in their care notes.*

The panel took account of the written witness statement of Ms 3 which set out the following:

> *"Upon finding Resident in that situation, the Nurse should have … given Resident their call bell back, repositioned the sensor mat..."*

Within Resident D's patient notes there is no record by Mrs Wang repositioning Resident D's sensor mat and/or call bell. Further, during the interview on 10 April 2021 Mrs Wang admitted to taking no action in relation to Resident D.

Based on this evidence the panel found this charge proved.

Charge proved.

Charge 3.5.4

> *3.5.4 Failed promptly or at all to check them for physical harm and/or hygiene and/or record that you had done so in their care notes*

The panel took account of the written witness statement of Ms 3 which set out the following:

> *"They should also have checked them for damage and ensured that their hygiene was of a good standard."*

Within Resident D's patient notes there is no record by Mrs Wang that she checked them for harm or considered potential hygiene concerns.

Within the interview notes from 10 April 2021, Mrs Wang is asked if she felt that she was preserving Resident D's dignity by taking photos of him unclothed from the waist down whilst asleep. The notes state that Mrs Wang responded by shrugging her shoulders and stating that she took the photos to show management the bad care and admitted to taking no action to address the concerns between taking the photographs.

On the basis of the evidence before it the panel found this charge proved.

Charge proved.

Charge 3.5.5

> *3.5.5 Failed promptly or at all to record the incident in Resident D's care notes*

Within Resident D's patient notes the only record made by Mrs Wang is at 05:06 and states: 'Resident D has had uncomfortable night. Slept most time of night in between interventions'. There was no record available to the panel highlighting the issues with the care provided to Resident D.

On the basis of the evidence before it, the panel found this charge proved.

Charge proved.

Charge 4

> *4. In respect of one or more of the failures alleged at charges 3.2-3.5 above, where you did not carry out the care required, yourself, you failed to ensure it was carried out promptly by delegation to others on the shift*

There was evidence before the panel, specifically within the interview notes from 10 April 2021 in which Mrs Wang admitted that she took no action to carry out the care herself, or to seek assistance from colleagues to ensure that the residents were cared for. The panel therefore found this charge proved.

Charge proved.

Charge 5

> *5. In respect of one or more of Residents A-D, on finding them in the circumstances described at charges 3.1-3.5 above, failed to ensure they were not left alone until the care required had been carried out*

Within the interview notes from 10 April 2021, Mrs Wang admitted to taking no action to address the concerns between taking the photographs. Mrs Wang also stated that she did not seek help from colleagues to address the concerns. In view of the evidence before it and Mrs Wang's admissions on 10 April 2021, the panel found this charge proved.

Charge proved.

Charge 6

> *6. On 10 April 2021, you shared one or more of the photographs at 3.1 above with colleagues when there was no clinical, or care ground for doing so.*

The panel bore in mind that by 10 April 2021 Mrs Wang had finished her shift and had already reported the incidents to her manager. The panel was unable to identify any clinical or care grounds for sharing the photographs on 10 April 2021.

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 Mrs Wang's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Wang's 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") and identified the specific, relevant standards where Mrs Wang's actions amounted to misconduct.

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).

In relation to misconduct, the NMC submitted that the facts amount to misconduct, which they considered serious. Mrs Wang's behaviour towards the residents was a significant departure from the standards expected of a registered nurse leaving them uncared for over a period of four hours and caused them to feel vulnerable and uncomfortable. Her behaviour raised fundamental concerns about her attitude as a registered professional as she failed to preserve their dignity by taking inappropriate photos and failed to escalate concerns to a GP. Restrictive action was necessary to protect the public and maintain public confidence in the profession.

The NMC invited the panel to find Mrs Wang's fitness to practise impaired on the grounds that Mrs Wang has displayed no insight. There was no evidence of insight on the part of Mrs Wang and therefore no explanation for the behaviour or evidence of steps taken to address it.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mrs Wang's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code; specifically:

> ***1.1*** *treat people with kindness, respect and compassion;*
> ***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*
> ***8.2*** *maintain effective communication with colleagues*

8.5 *work with colleagues to preserve the safety of those receiving care*
8.6 *share information to identify and reduce risk*
10. *Keep clear and accurate records relevant to your practice*
20.1 *keep to and uphold the standards and values set out in the Code;*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel did not consider the failure to escalate Resident D's symptoms to their GP to amount to misconduct. However, it did find that knowingly giving an incorrect double dose of drugs and the poor treatment of the residents to amount to misconduct.

The panel was of the view that the issues in this case involved degrading treatment of patients and an intentional withholding of care, even though this was a genuine attempt to demonstrate poor care on the part of care assistants. The panel considered the Mrs Wang left vulnerable residents at risk of harm and of poor physical hygiene. Mrs Wang's actions were therefore unprofessional and unkind.

The panel found that Mrs Wang's actions did fall 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, Mrs Wang's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:
"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 *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*
>
> *d) …*

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Mrs Wang's misconduct. Mrs Wang's misconduct had breached fundamental tenets of the nursing profession and thereby brought its reputation into disrepute.

Regarding insight, the panel took account of Mrs Wang's reflective statement dated 12 March 2021 and considered that it demonstrated very little insight into the failures, concerns and no insight into the impact on the residents.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Wang has taken steps to strengthen her practice. There was no evidence of training or professional development before the panel. There was no evidence to suggest that Mrs Wang has taken any steps to develop her insight or address the deficiencies in the care that she provided to residents at the Home or an understanding, of why, despite a genuine motivation, it was unprofessional.

The panel is therefore of the view that there is a risk of repetition based on Mrs Wang's lack of insight and remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel also determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Wang's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Wang's 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 Mrs Wang off the register. The effect of this order is that the NMC register will show that Mrs Wang 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 the Notice of Meeting, dated 23 January 2024, the NMC had advised Mrs Wang that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired.

Decision and reasons on sanction

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 identified the following aggravating features:

- Mrs Wang's lack of insight into her failings;
- It was conduct which put patients at risk of harm;

The panel also identified the following mitigating features:

- Mrs Wang was acting in good faith, to show the failings of carers;

- Mrs Wang had previously raised concerns about the care provided to residents at the Home by these carers, but no action had been taken;
- Genuine attempt to improve the care provided to residents, although it was misguided;
- The night shift ended with the residents all properly attended to;
- The matter only arose because Mrs Wang showed management the photos she had taken.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Wang'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 Wang's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Wang's registration would be a sufficient and appropriate response. The panel was of the view that conditions could be formulated to address the concerns in this case. However, in view of Mrs Wang's failure to participate, it could not be satisfied that Mrs Wang would be willing or able to comply with any conditions imposed. Furthermore, the panel concluded that in the absence of sufficient evidence of insight the placing of conditions on Mrs Wang's registration would not protect the public.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. n this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Wang's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Wang's actions were so serious that 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 Mrs Wang actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mrs Wang in writing.

Decision and reasons on interim order

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

The panel took account of the representations made by the NMC.

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 due to allow for any potential appeal period.

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

That concludes this determination.